

Abstract

Family child care programs is the most frequently requested type of child care in Alameda County, California. While family child care is in demand, national studies show family child care generally to be of adequate to mediocre quality. It is important that family child care programs serving many infants, toddlers and preschoolers achieve higher levels of quality for healthy child development. First 5 Alameda County funds and administers Quality Counts, an 8- month child care quality improvement program based on the University of North Carolina's Partners for Inclusion consultation program. This paper summarizes the results of an evaluation of Quality Counts using the Family Child Care Rating Scales to measure quality, both before and after program implementation, and 2-4 years after program completion. The evaluation was designed to learn whether quality improved and was maintained over time, and to understand whether factors such as intervention dosage, types of program strengths and challenges and goals addressed were related to quality improvements. The results showed that similar to the Quality Interventions for Early Care and Education- Partners for Inclusion evaluation, quality improved modestly in each of the domains measured and were maintained 2 to 4 years later. Greatest improvements were sustained in the domain that measures health and safety-related practices. Implications of these results are discussed as well as recommendations for establishing a multidisciplinary and collaborative quality improvement model that may achieve more significant gains in the relationship and learning opportunities domains of quality.

Keywords: family child care, child care quality, Environmental Rating Scales, child care consultation, infant-toddler care

Introduction

Family child care is defined as non-parental, paid care that takes place in a provider's home and is regulated by the state. In contrast to child care centers, family child care providers often care for mixed-age groups, siblings and their own children (Morrissey, 2007). In the United States about 1.4 million children are served by family child care providers (Hamm, Gault, & Jones-DeWeever, 2005). In Alameda County there are 1,890 licensed family child care homes contributing to 34% of the licensed child care supply in the county (California Child Care Resource & Referral Network, 2009) compared to 566 child care centers contributing to 66% of the child care supply. However, the majority (81%) of requests made to the local resource and referral agencies for child care is for family child care. These requests may reflect greater convenience and flexibility of family child care programs compared to centers (Bromer, Van Haitzma, Daley & Modigliani, 2009). Ninety percent of the county's family child care programs offer both full and part-time care options as well as the majority of the county's evening and weekend care (California Child Care Resource & Referral Network, 2009).

Family child care is a common arrangement for infants and toddlers and is more commonly used by low income families than is center-based care (Porter & Paulsell, 2011). The quality of care in many family child care homes is reported to be low, especially for those serving low income children (Kontos, Howes, Shinn & Galinsky, 1995; Karoly, 2009; Dearing, McCartney and Taylor, 2009). ¹Because this group of children tends to benefit even more from high quality early care and education (ECE) experiences than higher income peers, improving the quality of care provided for these children is very important (Bromer et. al., 2009).

¹In Alameda County, 14% of children 0-5 live in poverty compared to 19% of children statewide.

One approach to improving the quality of ECE is to strengthen the knowledge and skills of providers through professional development including formal coursework, informal training and onsite consultation, coaching, mentoring or technical assistance (Isner, Tout, Zaslow, Soli, Quinn, Rothenberg & Burkhauser, 2011). Other strategies used to support general quality improvement in family child care include playgroups, peer support, grants to pay for enhancing the program environment or provider training, materials and mailings to enhance the care environment or caregiver knowledge and reading vans (McCabe, Peterson, Baker, Dumka, Brach & Webb, 2011; Porter & Paulsell, 2011). The majority of published evaluations of these strategies focused on onsite consultation and training workshops (Porter & Paulsell, 2011). First 5 Alameda County approached improving the quality of family child care by using onsite consultation to improve the quality domains established by the environmental rating scales (Harms & Clifford, 1989) including, health and safety, building positive relationships and stimulating opportunities for learning.

Partners for Inclusion

Between 2005 and 2008, First 5 Alameda County participated in a national evaluation of the effectiveness of onsite consultation in ECE. The Quality Interventions for Early Care and Education (Quince- PFI) study compared the Partnerships for Inclusion (PFI) approach to onsite consultation for ECE quality enhancement with a variety of other types of consultation offered to family child care and center-based programs across the country (Bryant, Wesley, Burchinal, Sideris, Taylor, Fenson, & Iruka, 2009). The underlying philosophy of the PFI model was that greater change was possible when individuals worked together to develop a shared knowledge base, were involved in assessing their own needs, received ongoing staff development over an extended period of time and had opportunities to apply their new knowledge and skills in work settings. These principles applied both to consultants as they learn more effective consultation

skills and to providers who received consultation. The goals of consultation were to address current concerns and equip those who received consultation with skills to deal effectively with future concerns (Caplan & Caplan, 1999).

According to the PFI logic model of change, characteristics of consultants, of providers and of children and families affected the quality of the ECE environment, which in turn influenced provider and child outcomes. (See Figure 1)

[Insert Figure 1 here]

The PFI model of onsite consultation included the following service steps:

1. Gain entry and build relationship
2. Provide training on environmental rating scale
3. Jointly assess needs
4. Develop written action plan based on joint needs assessment
5. Implement action plan and monitor progress
6. Evaluate changes (consultant and provider) administer environmental rating scale again
7. Write final report and hold summary conference
8. Identify future needs

The PFI consultants used the Family Day Care Rating Scale (FDCRS; Harms & Clifford, 1989) to guide the collaborative consultation process. According to Harms and Clifford, three essential elements of quality are: a) protection of children's health and safety, b) building positive relationships and c) opportunities for stimulation and learning. The scale examines the use of language and literacy, interactions among children and providers as well as children and peers, learning activities, physical space and materials and routine care. Consultants began their work with providers by teaching them how to use the FDCRS: They first administered the tool to

establish an initial profile of the site, discussed their observations, reached consensus on the ratings and developed an action plan for change. Throughout the process, the consultant worked on establishing a trusting, non-hierarchical relationship with the provider. She ensured that the provider's needs and perspective were reflected in the action plan, although health and safety items received priority for improvement.

The primary question addressed by the Quince- PFI evaluation was: How effective was the PFI model compared to "business as usual" quality improvement programs? Twenty-four agencies offering quality improvement to the ECE community (mostly resource and referral agencies) in five states (CA, IA, MN, NE, and NC) participated in the evaluation. One hundred and one consultants (most with BA degrees and 4-5 years consultation experience) were randomly assigned to the PFI or other quality improvement programs, including First 5 Alameda County's quality improvement program. Two hundred and sixty three family child care providers, 22 of whom were from Alameda County (75% had less than an AA degree and between 10-11 years experience providing care) were randomly assigned to the PFI model or "business as usual" quality improvement program. About 25% of children enrolled in these programs received child care subsidies.

The results of the PFI evaluation of family child care programs showed the PFI group made significant gains in quality, from the beginning to the end of consultation, while the "business as usual" quality improvement programs made no gains (Bryant et. al., 2009). The PFI group improved on indicators of teaching and interactions and provisions for learning but did not improve in provider tone or discipline practices. The quality gains made by the PFI group during the intervention were maintained six months after the intervention ended. Most of the treatment

effect sizes however were in the moderate range (.32 - .37) and even at the end of intervention, it is interesting to note, the average family child care home was still rated low, around a 4 on the FDCRS factors (Bryant et. al., 2009).

In terms of provider characteristics, more experienced family child care providers had more significant gains in quality compared to less experienced providers and family child care providers with higher professional motivation were rated higher on teaching and interactions and provisions for learning. PFI consultation was more effective in improving provisions for learning and health when the provider held more child-centered values. Dosage did not appear to account for the greater quality improvements in PFI family child care programs because the amount of onsite consultation visits were approximately the same in the PFI and the “business as usual” programs.

Only 8% of the PFI consultants had high fidelity to the PFI model. The researchers suggested the need for earlier, more frequent and more specific communication between consultants and program managers and a greater focus on measuring the intervention delivery process (Bryant et. al., 2009).

A brief survey in 2006 of providers in Alameda County who participated in the Quince-PFI evaluation showed that 90% of providers assigned to the PFI sites were “very satisfied” doing a self-assessment and 53% of the Alameda County participants enrolled in the “business as usual” onsite consultation program preferred a self-assessment of their child care environment. In 2006, First 5 Alameda County created Quality Counts, a modified quality improvement program that included provider self-assessment.

Quality Counts Model

In response to findings from the Quince-PFI study, First 5 Alameda County changed its consultation to reflect the joint-assessment PFI consultation model. From 2006 through 2009, Quality Counts served 51 family child care programs. In the Quality Counts model, a trained consultant provided 6-month, intensive, individualized, onsite, relationship-based consultation after jointly completing a Family Child Care Environmental Rating Scale (FCCERS –R; Harms, Cryer & Clifford, 2007) with the provider. Each consultant served 4-5 sites over a 6-8 month period. The Quality Counts consultants had 29 combined years of experience as ECE providers, preschool teachers or therapists with expertise and certification in infant-toddler development and serving children with special needs. On average they each provided consultation for three years. Each of the consultants attained a bachelor's degree in psychology and two attained master's degrees in social work or educational psychology with an emphasis in ECE. One consultant was bilingual in English and Spanish and another in English and Cantonese.

Onsite visits strived to be weekly for approximately two hours. Consultants and providers worked together to identify needs and developed an action plan. Participants agreed to an independent environmental assessment of their program before it began and at the end to measure any improvements. Most participating sites were located in neighborhoods with low performing schools and served children with special needs. Participants were eligible to apply for a one-time quality improvement grant for up to \$5,000. Consultation focused broadly on health and safety practices, enhancing the physical environment and children's learning activities. To address concerns about intervention fidelity, Quality Counts consultants used an online data collection monitoring system that allowed consultants and managers to track the progress made by sites receiving consultation.

Purpose of First 5 Alameda Quality Counts Evaluation

The purpose of the current evaluation was to address the following questions:

- Were there improvements in the quality of family child care following a 6- 8 month consultation program?
- Were improvements maintained 2 to 4 years after program completion?
- Were there any relationships between goals addressed, amount of consultation time received, program strengths and challenges and quality improvements?

Materials and Methods

Participants

Twenty-one family child care providers in Quality Counts between 2007 and 2009 participated in an independent evaluation of the program. Two to 4 years later, of the 21 who were initially evaluated, 4 were no longer licensed or reachable and 4 were reached but refused to participate in the follow-up. A total of 13 providers (62%) were revisited by the same evaluator between August and September 2011. Of the 4 providers who were no longer reachable or licensed, 1 changed from a family child care to a center-based program, 1 had her license revoked, and 2 moved and were unreachable. Reasons for refusals included, “this is not a good time,” “I am too stressed out,” and “I prefer not to do it.” The time elapsed between participation in Quality Counts and the follow-up evaluation was between 2 and 4 years.

Each of the Quality Counts providers cared for more infants and toddlers and operated for significantly less time than the population of family child care providers in Alameda County (Table 1). The 13 providers who participated in all 3 assessments (follow-up providers) were more likely to speak languages other than English, primarily Spanish, and cared for a higher

proportion of special needs children than the population of providers in the county.

Demographic characteristics of providers and children served in their sites are shown in Table 1.

[Insert Table 1. here]

Measures

Family child care quality improvement.

Quality of family child care was measured using either the Family Day Care Rating Scale (FDCRS; Harm, Clifford, 1989) or the Family Child Care Environmental Rating Scale -Revised (FCCERS- R; Harms, Cryer & Clifford, 2007), a global, comprehensive and widely used measure of quality (Zellman & Perlman, 2008).

The FDCRS (Harms & Clifford, 1989) was a 32-item scale covering six categories: Space and furnishings for care and learning, basic care, language and reasoning, learning activities, social development and adults needs. The FDCRS was revised in 2007 to be consistent with revisions to other Environmental Rating Scales (ERS). While scoring and format remained the same, there were some noteworthy content changes including the addition or deletion of items to the space and furnishings, personal care routines, and listening and talking subscales. Math and number and nature and science were added to the activities subscale. The interaction subscale replaced the social development subscale and “tone” was replaced by provider-child interaction and interactions among children. Program structure subscale was added and the provisions for professional needs item was added to the parents and provider subscale. Other remaining FDCRS items were changed significantly, including helping children use language, art, use of T.V., video, computer, schedule, adaptations for special needs and relationships with parents (Harms, Cryer & Clifford, 2007).

The FCCERS- R scale consists of 38 items measuring a range of attributes associated with quality care based on three essential elements of quality: a) protection of children's health and safety, b) building positive relationships and c) opportunities for stimulation and learning.

Studies evaluating the validity of the ERS showed a relationship between higher scores on the ERS and more positive child development outcomes in domains considered important for school success (Harms, Cryer & Clifford, 2007).

First 5 Alameda County also developed a 15-minute interview protocol, conducted with providers at the time of the observation. The interview was designed to learn about the providers' perceptions of the impact of quality improvements on children, staff and parents. Providers were also asked about other professional development activities they had engaged in, challenges they faced and resources they had obtained or would like to obtain.

Consultant, provider, child and family characteristics.

Providers completed an application to participate in the program which included information about the number and ages of children enrolled, primary languages spoken by providers and children, number of low income children and number and types of special needs children served.

Documentation of the implementation of Quality Counts.

The Quality Counts database includes five templates that allow consultants to document program implementation and progress and monitor fidelity to the model (see Table 2 for a list of data sources):

1. Initial Strengths and Challenges template documents strengths and challenges in the three essential elements of quality: a) health and safety, b) relationships with children, families and staff, and c) opportunities for learning based on the consultants' initial observation of the environment.

2. The Strengths and Challenges template documents strengths and challenges based on a discussion between the consultant and provider following the FCCERS-R self-assessment. This form also includes a list of proposed quality improvement goals the consultants and providers can choose from to address challenges.
3. The Action Plan template lists each goal defined in the Strengths and Challenges Form based on quality improvement domains, along with strategies designed to achieve the goal, obstacles to achieving the goal, a target date for achieving the goal and the status of goal achievement (i.e., met or not). The status of goal achievement can be continually updated.
4. Technical assistance (TA) logs document the content of consultation. There are multiple TA logs per site documenting the mode of consultation (e.g., onsite, e-mail, telephone), the dose (i.e., amount of time spent), the topics covered and the details of each interaction.
5. The Final Report includes consultant and provider identified improvements as well as areas for improvement, remaining obstacles and additional resources that were provided.

Procedures

Quality Counts program implementation and pre –post evaluation.

After the initial introduction and orientation to the Quality Counts program, the consultant completed the Initial Strengths and Challenges form and trained the provider on how to use the rating scale. She and the provider independently conducted the ratings and met to discuss the results, and to develop goals and the action plan. The independent pre assessment was also conducted during this time.

The initial steps took place in the first four months of the program and were documented in the database. The implementation of the action plans took place in the next four months, including technical assistance to complete the action plan goals, the application for a grant and the selection of materials for the program. During the implementation phase the consultant completed a TA log with every contact and the final report at the end of the 6-8 month period. The independent post assessment was also conducted at the end of 6-8 months.

Quality Counts follow-up evaluation.

The follow-up assessment and interview took place between 2 and 4 years after program completion. Each of the remaining reachable and licensed providers was contacted by letter informing them of the purpose of the follow-up observation. Two weeks later each of the providers were contacted by telephone and recruited to participate in the follow-up observation. The follow-up observation was conducted by the same independent evaluator as the pre and post assessments. Each follow-up observation and interview occurred over a half-day and the provider received a \$25 gift certificate for participation.

Data Analysis

From the original Quality Counts applications, data on specific provider characteristics including the number of children enrolled by age, years in operation, languages spoken by providers and children, number of low income and children with special needs were gathered and compared to the Alameda County population of family child care providers as a whole.

The FDCRS scores were mapped to the FCCERS scores for the 5-7 providers who were observed using the FDCRS at the pre and/or post time periods. Those who were observed with the FDCRS were missing program structure subscale scores. Mean subscale, total scale and

difference scores were computed as was the difference between the means from the pre to post and from the post to the follow-up time periods, using paired samples *t*-tests, in SPSS 19.0.

A frequency count of the number and types of goals addressed across all follow-up sites was generated. The average amount of consultation time was calculated as the total hours of consultation over the 6 -8 month intervention period for each of the follow-up providers. A Pearson Correlation coefficient was computed for the correlation between pre assessment scores and total consultation time across each of the follow-up providers.

A list of all strengths and challenges in health and safety, relationships between children, families and staff, and the learning opportunities domain was generated for the follow-up providers; the challenges were then rank-ordered from highest to lowest. In addition, information from the final reports, interviews and applications was used qualitatively to understand the relationships among goals addressed, amount of consultation time received, program strengths and challenges, quality improvements and program fidelity.

Results

Quality and Maintenance of Improvements

Table 3 shows the mean FDCERS or FCCERS-R subscale, total scale and difference scores for pre to post assessment periods. There was a significant increase in the total FDCERS and FCCERS-R scores from pre assessment to post assessment periods, $t(12) = 8.89$, $p < .001$, as well as significant increases in each of the subscales from the pre assessment to the post assessment period (see Table 3).

Table 4 shows the mean FDCERS or FCCERS-R subscale, total scale and difference scores from post to follow-up assessment periods. There was a significant increase in the personal care routines subscale scores from the post to follow-up assessment periods, $t(12) = 2.28, p < .05$; all other subscale and total scores remained the same (see Table 4).

Goals Addressed

Half of the consultation goals addressed by the follow-up providers were in the domains of space and furnishings and personal care routines. Twenty-nine percent of consultation goals centered on improving space and furnishings, 23% on personal care routines, 20% on activities for learning, 11% on listening and talking, 9% on interactions, and 4% each on parents and providers and the program structure.

Amount of Consultation

The follow-up providers received an average of 41 hours of consultation over the 8- month intervention, with a range of 13 hours on the low end to 69 hours on the high end. Providers with lower pre assessment scores received more hours of consultation than those with higher pre assessment scores ($r = -.49, p < .05$).

Strengths and Challenges Encountered

Table 5 shows the list of strengths and challenges addressed in the quality domains of health and safety, relationships with children, families and staff and opportunities for learning during consultation with each of the follow-up providers. Consultants documented more challenges in opportunities for learning (e.g., not having enough learning materials), followed by health and safety (e.g., improper hand washing techniques) with the fewest challenges in the relationships with children, families and staff domain (e.g., needing more information regarding discipline techniques).

Discussion

The Quality Counts model is a local replication of the PFI model that documented quality improvements in family child care programs receiving consultation. The Alameda County providers who applied for and were selected to participate in Quality Counts differed somewhat from the general population of licensed family child care providers in the county in that they were relatively new providers, more likely to speak a language other than English and served higher proportions of infants, toddlers and children with special needs. This was expected because enrollment priority was given to programs serving infants, toddlers and children with special needs. In fact, the subset of providers who received the Quality Counts intervention but were unreachable, no longer licensed or who refused the follow-up observation, served the highest proportion of children with special needs in each of the three groups. It was satisfying to affirm that the Quality Counts providers were serving perhaps the greatest child care needs in the county.

The Quince-PFI study showed that while family child care programs improved following the PFI intervention, the improvements were modest and few programs reached a quality score greater than 4 on the 7-point FDCERS scale (Bryant et. al., 2009). The Quality Counts evaluation showed similar results. While we were able to document improvements greater than one-point, the average quality improvement score did not exceed a 4 on the 7-point scales and this was true both immediately following the intervention and at the follow-up period 2 to 4 years later. The Quince-PFI model was able to demonstrate stability in changes at a 6 month follow-up and the Quality Counts evaluation demonstrated stability over a longer period of time. However, the Quince-PFI study showed that dosage or amount of time spent with a site was not related to improvements while the Quality Counts evaluation showed that dosage was related to pre scores in that providers with lower initial quality scores received a greater amount of consultation than

those providers with initially higher quality scores. This is a useful indicator of fidelity to the Quality Counts model and we were able to monitor with the aid of an online documentation system.

Another important result of this evaluation was further improvement in personal care routines. Personal care routines are practices such as, napping, meals, diapering and toileting and health and safety. This is also consistent with the Quality Counts model program philosophy of health and safety as an intervention priority. This is further documented because greater than 50% of the goals addressed were activities designed to improve the design of the environment and furnishings as well as health and safety. However, this is particularly interesting given the challenges to implementing health and safety standards in an ongoing manner (McCabe et. al., 2011). It is important to note that all but one provider received a monetary incentive that could be put toward physical changes to their program. For example, many providers purchased new, updated and easier to clean diaper changing tables. Also, two of the providers purchased and installed sinks for outdoor use. These resources may contribute to improved and maintained health and safety practices.

This evaluation attempted to address fidelity to the Quality Counts model by examining the relationships among strengths, challenges, goals and dosage. Similar to the Quince-PFI study, despite highly variable doses of intervention providers were able to initiate and maintain improvements over a significant amount of time. While we were able to document a relationship between dosage and initial quality scores as well as a relationship between goals addressed and domains of improvement, capturing the complexity of these relationships is challenging.

Significant monetary incentive to make environmental changes may be the chief motivating factor in the quality improvements made.

To address the complexity of onsite consultation, First 5 Alameda County's future directions for Quality Counts will be to integrate consultation from multiple disciplines, such as infant/toddler specialists, health and safety consultants, mental health consultants and business consultants. The increasing complexity of infant-toddler care contributes to the growing need for consultation practices that are collaborative across disciplines, providing efficient, accessible and informed resources for family child care providers (National Infant & Toddler Child Care Initiative, August, 2010).

Limitations

While the Quality Counts evaluation did not collect provider level data regarding attitudes toward work, children and families and education level these variables could affect willingness and ability to make changes.

Also, an important limitation of the Quality Counts evaluation is that unlike the Quince-PFI study we did not have a comparison group so that significant improvements must be approached cautiously and may not generalize beyond the group of providers that participated.

Conclusion

This evaluation showed that the Quality Counts model has been shown to modestly improve and sustain family child care quality, especially in the area of health and safety. While it is unknown exactly what factors contribute to the improvements, significant incentives may contribute to overall and sustained improvements in health and safety. It may be useful to consider other

quality improvement models, such as a multidisciplinary consultation model to create and sustain improvements in the quality of relationships and opportunities for learning.

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Figure 1. PFI Logic Model

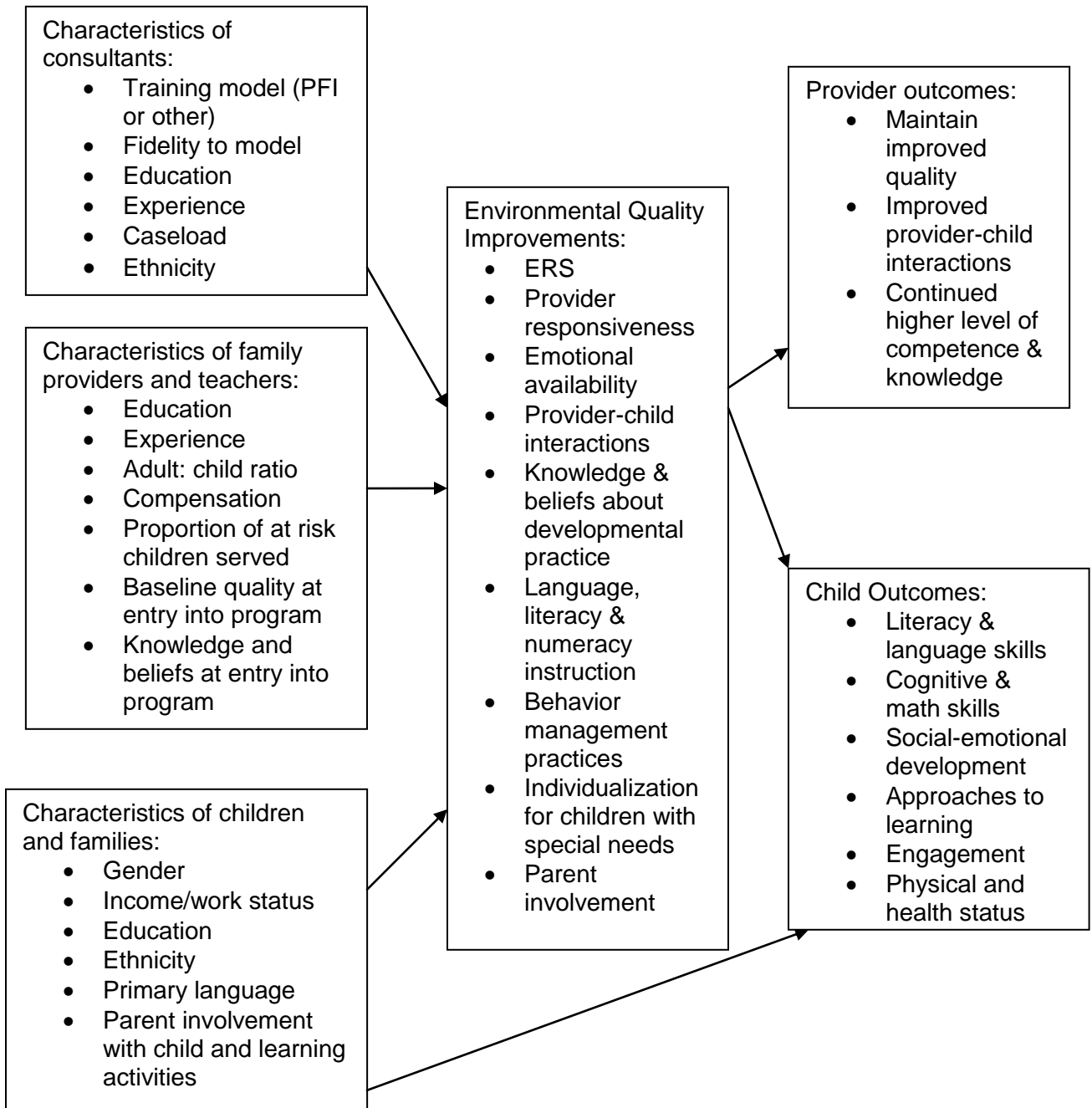


Table 1.

Demographic characteristics of Quality Counts (at time of enrollment) and Alameda County family child care providers

Characteristic	Follow-up providers (N = 13) Average or Percent (range)	Non Follow-up providers (N = 8) Average or Percent (range)	Alameda County ² Average or Percent
Children enrolled/age:			
• 0 – 3 years old	3 children/site (0 – 12 children/site)	5 children/site (4 – 7 children/site)	2 children/site
• 3 – 5 years old	3 children/site (1 – 12 children/site)	2 children/site (0 – 12 children/site)	2 children/site
Years in operation	4 years/site (1 – 11 years/site)	4 years/site (1- 12 years/site)	12 years/site
Languages other than English spoken by provider	31% of providers (Spanish) 25% of providers (Other)	13% of providers (1 Spanish-speaking) No other language	13% (Spanish) 19% (Other)
Children speaking language other than English	2 children/site (0 – 6 children/site)	2 children/site (0 – 4 children/site)	40% of entering kindergarteners (2004-05)
Low income children	5 children/site (1 – 10 children/site)	4 children/site (0- 5 children/site)	14% (16,901/122,309) ³ of children 0-5 live in poverty
Children with special needs	46% of sites (0 – 2 children/site)	63% of sites (0 – 4 children/site)	25% of sites (1+ children/site)
Consultation contacts	15 contacts/site (5 – 27/site)	15 contacts/site (11 – 22/site)	Not applicable
Providers belonging to a family child care network	15% of providers (2 providers)	Unknown	Not applicable

² Based on a survey of 402 providers in Alameda County from Whitebook, Sakai, Kipnis, Lee, Bellm, Speigelman, Almaraz, Stubbs & Tran (2006)

³ Retrieved from: http://www.kidsdata.org/data/topic/table/child_poverty20.aspx and www.rnetwork.org.

Table 2.

Data sources by evaluation questions

Evaluation Question	Data Source
Were there improvements in the quality of family child care following a 6- 8 month consultation program?	Pre and post Environmental Rating Scales (FDCERS; FCCERS-R)
Were improvements maintained 2 to 4 years after program completion?	Post and follow-up Environmental Rating Scales (FDCERS; FCCERS-R)
Were there any relationships between goals addressed, amount of consultation time received, program strengths and challenges and quality improvements?	Quality Counts application Initial strengths and challenges template Action plan template TA logs Final report Provider interview

Table 3.

Mean and difference quality rating scale scores for pre and post assessment periods (N = 21; 1-7 point scale; 1 being “inadequate” to 7 being “excellent”)

Time period	Total Scale	Space & Furnishings	Personal Care Routines	Listening and Talking	Activities	Interaction	Program ^a Structure	Parents and Provider
	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)
Pre assessment	2.97 (1.38-5.09)	2.81 (1.29-4.00)	2.55 (1.00-5.00)	3.10 (1.00-6.00)	2.99 (1.55-6.00)	3.66 (1.00-6.50)	2.91 (.75-4.67)	2.58 (1.00-5.00)
Post assessment	4.26 (2.18 – 6.11)	4.35 (1.29-5.67)	3.57 (1.25-6.00)	4.07 (2.33-7.00)	4.07 (2.56-6.30)	4.98 (2.50-7.00)	5.09 (3.75-7.00)	3.57 (2.00-6.00)
Difference	+1.30***	+1.54***	+1.02**	+.98*	+1.08***	+1.32***	+1.83***	+.99***

^a Program Structure scores are computed only for those providers who were observed with a FCCERS-R.

* p<.05; ** p<.01; *** p≤.001

Table 4.

Mean and difference quality rating scale scores for post assessment time period and follow-up assessment time periods (n = 13; 1- 7 point scale; 1 being “inadequate” to 7 being “excellent”)

Time period	Total Scale	Space & Furnishings	Personal Care Routines	Listening and Talking	Activities	Interaction	Program Structure ^a	Parents and Provider
	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)	Mean (Range)
Post assessment	4.26 (2.18 – 6.11)	4.35 (1.29-5.67)	3.57 (1.25-6.00)	4.07 (2.33-7.00)	4.07 (2.56-6.30)	4.98 (2.50-7.00)	5.09 (3.75-7.00)	3.57 (2.00-6.00)
Follow-up assessment	4.28 (2.22-5.86)	4.17 (2.00-5.67)	4.44 (2.67-6.40)	4.05 (1.33-6.33)	4.15 (2.18-6.00)	4.79 (1.25-6.75)	4.63 (2.67-6.33)	3.87 (2.00-5.25)
Difference	+.01	-.19	+.87*	-.02	+.07	-.19	-.44	+.30

^a Program Structure scores are computed only for those providers who were observed with a FCCERS-R.
* p<.05

Table 5. *Strengths and challenges addressed*

Quality Domain	Strengths	Challenges
Health and Safety	Children feel safe Cleaning supplies locked up Facility is cleaned daily and uncluttered Small parts kept from infants Wash hands often Healthy meals- home cooking Natural lighting and ventilation Belongs to nutrition program Practices disaster preparedness with children Sleeping mats appropriately spaced and cleaned First aid certification Attends health and safety workshops	Hazards (loose cords, un sturdy furniture, outlets uncovered) Improper diapering, hand washing and disinfecting; children use same towel to dry hands Unsafe outdoors; outdoor shade and proper surfacing Not enough space either indoors or out Poor hygiene Documenting children's accidents Child sized furniture No consent to administer drugs Infants not held when fed CPR/first aid training expired Health policies unclear Food choking hazards
Relationships with Children, Families and Staff	Good provider and parent communication Parents get along with each other Frequent opportunities for parents to be involved Positive discipline; eye contact Good supervision Provider shares child-related information with parent Flexibility w/families Loves what she does Explains rules to children; sets limits; involves children in problem solving Models good social behavior Warm relationships with children Provider has BA degree Provider empathy for working parents Difficult drop offs handled	Helping children with circle time Creating parent handbook Evaluation of program Consistent communication with parents Poor disciplinary practice Maintaining boundaries and respect Finding appropriate assistants Dealing with conflict with parents and difficulty communicating about differences in practices with parents and assistants Personal isolation Transitions and parents sneaking out Not enough time to plan Supervising assistants Posting schedule Professional development opportunities

Quality Domain	Strengths	Challenges
	sensitively	Helps children complete activities Different cultural practices
Opportunities for Learning	Daily routine and schedule Gardening activity Field trips Connected with R&R Informal use of language with children Creative activities Brings in additional supports/activities (dance; music; art) Comfortable and child-friendly environment No T.V. Singing & dancing activities Provider talks about numbers/letters Experience in preschool setting Dictation of children's ideas Adaptations for children with special needs Staff ask open-ended questions Frequent interactions that promote language and literacy Thematic display of children's work Hands-on learning materials Balance of child-initiated and adult –initiated activities	School readiness Lack of materials and equipment Limited storage; disorganization Mixed age group activities Children's access to materials Little art materials/activities Limited math and science activity Little diversity in materials Little display and writing what children say Poor outdoor materials No group time Expand conversations with children Limited books and cozy area No sand/water play Poorly defined play areas and lack of labeled storage Need more materials for children with special needs (e.g., scissors) Age-appropriate expectations & developmental milestones Encouraging language and communication