Chapter 5

Training Exempt Providers to Deliver High-Quality Child Care Programs

Jonathan Prince
Michael J. Austin

In meeting the child care needs of low-income working parents, child care advocates have recently discussed the urgent need to increase the capacity and training of infant and toddler child care providers (Carnegie Corporation of New York, 1998; Annie E. Casey Foundation, 1998; Kahn and Kamerman, 1998; Modigliani, 1994). One way to increase the capacity and quality of these providers is to recruit, train, and support exempt providers in the community.

Providers are considered *exempt* from licensure when they care for their own children, the children of relatives, and/or the children of only one other family. This case study describes and analyzes the Exempt Provider Training Project sponsored by the Child Care Coordinating Council in San Mateo County which provides outreach, training, and other forms of assistance to child care professionals. The study includes a brief review of literature on child care training, a description of the project's dramatic growth since its establishment in 1997, a description of the project's goals and services, and the experiences of a project participant. It concludes with lessons learned and future challenges.

BRIEF LITERATURE REVIEW

Training of providers has been shown to increase the quality of child care as well as help providers view child care as a profession (Debord and Sawyers, 1996; Kendrick, 1994; Kontos, Howes, and Galinsky, 1996; Mueller and Orimoto, 1995; Pence and Goelman, 1991). In California, license-exempt providers that care for children in their own homes are called *home*

care providers. Because they are not monitored by local regulators, license-exempt home care providers are typically viewed as being a hidden child care resource in the community, operating with limited outside support (Bailey and Osborne, 1994; Fiene, 1995; Pence and Goelman, 1991). Once trained and licensed, these formerly exempt providers become *family child care homes* (California Child Care Resource and Referral Network [CCCRR], 1999) and thereby increase the availability of licensed child care in the community.

Despite the lack of licensure, many parents prefer exempt providers because (1) they tend to be more affordable and convenient than licensed professionals (Pence and Goelman, 1991), (2) there are usually fewer children in exempt-provider homes, resulting in a greater potential for individual attention (CCCRR, 1999), and (3) they are seen as a valuable hidden community resource for working parents (Pence and Goelman, 1991).

Providers have their own reasons for choosing unlicensed over licensed child care as a vocation. Almost all are female (Mueller and Orimoto, 1995), and most have children of their own and limited education and family income (Bailey and Osborne, 1994). They tend to have a traditional view of the family in that the father is seen as the primary wage earner while the wife cares for the children (Bailey and Osborne, 1994). Becoming a home care provider allows these women to (1) care for their own young children at home, (2) provide companionship for their children, and (3) earn extra income as a provider.

Many home care providers intend to change careers once their own children enter school (Mueller and Orimoto, 1995), thus viewing child care as a temporary occupation, which often acts as a disincentive for seeking licensure. Other disincentives include (1) the lack of substantial increase in compensation for providing licensed care and (2) the lack of career development in the child care profession (Bailey and Osborne, 1994).

It is generally agreed that the training of license-exempt providers will increase the quality of child care in the community. Improving the recruitment and training of license-exempt providers is necessary because exempt child care providers may have less access to training (and other resources) than their licensed counterparts (Bailey and Osborne, 1994). Second, research has demonstrated that, compared with licensed providers, exempt providers spend less time with young children in planned activities related to shared tasks that facilitate healthy development (Pence and Goelman, 1991).

Most child care training is offered on evenings and weekends, when providers are most likely to be available (Bailey and Osborne, 1994). Three types of training are available for providers (Kendrick, 1994). Before entering the profession they can receive *preservice training,* or they can receive *orientation training* that highlights essential skills when they first begin the

job. *Ongoing training* is provided periodically during the child care provider's career. Typical training needs include child development, health and safety, food and nutrition, discipline, educational methods, activity planning, collaboration with parents, and business practices such as record-keeping and business contracts. In addition, Bailey and Osborne (1994) found that many providers desire training in stress management. Most providers complete training once they have started (Mueller and Orimoto, 1995). Those that do not complete training have somewhat less experience as providers and tend to use fewer business and safety practices (Kontos, Howes, and Galinsky, 1996).

Several authors have made the following recommendations to improve the quality of training offered to child care providers:

- Trainers need to learn the context in which child care providers work every day and use terminology that is relevant, nontechnical, and easily understood (Kendrick, 1994).
- Trainers need to encourage participants to learn from one another by fostering active participation and interaction among people with different experiences and backgrounds (Bailey and Osborne, 1994; Kendrick, 1994).
- Administrators need to reimburse or provide vouchers to child care providers who wish to receive additional training in their homes or at colleges, conferences, seminars, or workshops (Fiene, 1995).
- Scholarships are needed to help unlicensed providers afford the cost of training (Fiene, 1995).
- Training needs to be linked to the ongoing monitoring of child care, such as monitoring child immunizations (Fiene, 1995).
- More training and support to people who have been providing child care for longer periods of time are needed in order to increase provider retention and decrease turnover (Mueller and Orimoto, 1995).

As these recommendations suggest, provider training is generally accompanied by a variety of other services which include home visits, support groups, financial assistance, assistance obtaining licensure, ongoing consultation, and the opportunity to observe and interact with an experienced child care mentor (Mueller and Orimoto, 1995). Financial assistance can be offered to pay for business start-up costs that include licensing fees, the purchase of safety devices, and the construction of fences around backyards. In addition, trainers often help providers coordinate with local zoning departments, insurance companies, and other community agencies.

This combination of training and support activities typically produces very positive outcomes, including (1) success in recruiting providers, (2) signifi-

cant gains in knowledge and skills, (3) increases in confidence, commitment, patience, interest, and job satisfaction, and (4) a better awareness of children's abilities and needs (Mueller and Orimoto, 1995). Kontos, Howes, and Galinsky (1996) found that training increases both the amount of planned, daily activities shared with children and financial accountability, with increased reporting of incomes and expenses on tax returns. Finally, training has been shown to increase compliance with health standards (Kendrick, 1994).

Despite these positive findings, at least two major challenges are noted in the literature with respect to the recruitment and training of child care providers: (1) retaining providers after they have been trained, where it is estimated that only about half of all family child care providers remain in the field twelve to eighteen months after they receive training (Mueller and Orimoto, 1995) due, in part, to low status, long hours, and limited financial rewards (Bailey and Osborne, 1994), and (2) ensuring that training reaches those providers that need it most. Kontos, Howes, and Galinsky (1996) point out that providers who seek out training are more motivated and middle class than those that do not attend and may provide a higher quality of care to begin with.

With this brief literature review in mind, it is clear that many of the issues are reflected in the Exempt Provider Training Project in San Mateo County. It provides outreach, training, and support to a population of child care providers that would not otherwise receive these services. Almost 75 percent of participants are Latina women with limited English-speaking abilities. Without the help of this training project, many of these women would have remained in the hidden child care community as a result of language barriers, lack of time, transportation issues, and other factors which reduce access to services. Most live in close proximity to one another, and, as illustrated in the next section, the program has grown significantly by word of mouth in its first two years of operation.

A HISTORY OF THE EXEMPT PROVIDER TRAINING PROJECT

The Exempt Provider Training Project of San Mateo County, California, was established in June 1997 to provide training and support to child care providers to increase the overall quality of care. The project's original plan was to offer training to licensed or exempt providers whom low-income working parents selected to care for their children. In other words, an employed woman receiving health services from Medi-Cal's Prenatal to Three

program could choose any local provider to care for her children and the project would train the selected provider.

This original goal needed to be modified, as the project staff (at the time composed of one and a half full-time employees) quickly found that most mothers in the Prenatal to Three program were not working outside the home. They had instead decided to become exempt providers themselves by staying at home, caring for their own children, and caring for the children of friends or relatives to earn extra income. They chose themselves, therefore, to receive training and support from the project instead of designating a provider in the community. Despite this departure from the original goal, staff agreed to train them and help with licensure, if desired, to provide high-quality child care in the community. Project staff even began to train stay-at-home mothers who did not care for other children. They simply expressed an interest in providing high-quality care to their own children and possibly taking care of children in the future.

The dramatic early growth of the program can be understood, in part, by examining the child care services that are provided for the participants in the training program. Within the first year of the project, the informal child care service for less than six children had grown into a structured program for twenty-four to thirty children during each provider training session. To accommodate these children, a pool of child care providers were recruited and trained, and the program was relocated to larger space in schools and community-based organizations.

Program growth was not spontaneous. In fact, staff members were concerned in the first two months of operation because there were so few participants. Initially, it was planned that parents would refer themselves to the project after learning of it from staff at the Prenatal to Three Initiative. When this resulted in fewer referrals than expected, project staff called interested parents directly after obtaining their names and telephone numbers from the staff at the Prenatal to Three Initiative. In addition, project staff sent flyers about the program to collaborative organizations such as Head Start and WIC (Women, Infants, and Children). Finally, individuals that had received training recommended it to friends and relatives, and shortly thereafter a snowball effect occurred and referrals arrived at increasing rates.

In the second year of operation, the number of project staff increased from one and a half to two full-time members, and class sizes increased from three or four people in the first class to as many as forty in later classes. To preserve the individualized attention offered to trainees drop-ins were no longer accepted and all participants were required to register for the program in advance. In addition, many parents interested in becoming a provider were placed on a waiting list for as long as two months. Project staff

began to increase their training emphasis on economic development and the advantages of licensure. More and more providers became interested in pursuing their license and receiving technical assistance.

As the project entered its third year of operation, as many as sixty people would arrive at a single training. While about forty people stayed for training, others were told to register and are placed on the waiting list. The essence of the training experience can be found in the program's goals, services, participants, and outcomes.

PROJECT GOALS AND SERVICES

The project has five major purposes:

1. increase the quality of care offered by exempt child care providers,
2. promote the healthy development of infants and toddlers served by exempt providers,
3. increase the availability of child care for low-income parents receiving services from Medi-Cal's Prenatal to Three Initiative and other community services,
4. educate providers about the economic benefits of family child care as a profession, and
5. evaluate the effectiveness of outreach services and education to exempt child care providers.

Staff members continuously encourage providers to promote healthy child development, such as reading to the child rather than letting the child watch television alone all day.

Staff provide extensive outreach in Spanish and English through flyers, phone calls, presentations at community-based organizations, and the media. These efforts yield referrals from Prenatal to Three Initiative staff members, human services agency staff members, community-based programs such as Healthy Start and Head Start, family resource centers, previous program participants, and self-referrals. When they first began the training program, the participants were mostly interested in learning about

1. physical and social development related to ages and stages of walking, talking, and other aspects of child development,
2. nutrition, such as what is a normal lunch for a two-year-old,
3. appropriate and fair discipline,
4. neatness, and
5. child safety.

Training needs are assessed as part of a sixteen-hour training program that is organized into four four-hour sessions. Classes are conducted in Spanish and English and are usually held on Saturdays to meet the needs of working providers. Topics include

1. how quality child care experiences can facilitate healthy early child development,
2. the importance of self-assessment in providing patient and consistent care,
3. teamwork and relationship building with children and their parents, and
4. creating an environment for infants and toddlers that fosters healthy child development.

Incentives are used to encourage attendance at the training sessions. Initially all participants were paid twenty-five dollars for each session they attend and another twenty-five dollars for coming to all four, but these payments were reduced to twenty dollars after class sizes became larger. In addition, the project offers forty-dollar scholarships to attend CPR/first aid training and ninety dollars for becoming Trustlined. Trustline is a registry of child care providers that have submitted fingerprints, and parents use this registry to ensure that their provider of choice does not have a criminal conviction. Incentives such as toys and books are also given to participants that agree to informal, voluntary home visits by project staff. In these visits, staff members assess the living and child care environment of providers and offer feedback which supplements classroom training. Much of this feedback concerns household safety issues, the licensing process, and community resources. Staff use these opportunities to strengthen their rapport with participants and to model appropriate and nurturing interaction with children. Other support staff, including nurses and mental health clinicians, may be contacted to visit the home of families in the Prenatal to Three Initiative if needed. Home visits may also be requested by providers who are unable to attend classroom instruction but plan to attend in the future.

The project offers many other services, in addition to trainings and home visits, including the following:

- *Support groups:* These groups are scheduled informally by participants. Initial efforts to establish a set time and place for support groups were abandoned after the diversity of provider schedules became apparent.
- *Transportation:* Participants are encouraged to carpool, reimbursed for public transportation, or provided with taxi vouchers if no other means of transport is available.

- *Child care:* The children of participants are cared for during training sessions and other project events.
- *Referrals:* Participants are referred to licensing orientations, Trustline, CPR/first aid classes, a technical assistance hotline, other training and educational forums, seminars, and workshops such as the Family Child Care Conference.
- *Mentors:* The opportunity to talk with licensed providers is offered to participants who wish to learn more firsthand information about operating child care programs.

Primary sources of revenue for the Exempt Provider Training Project are annual grants from the Peninsula Community Foundation (PCF) and a contract with the San Mateo County Human Services Agency. During fiscal year 1999-2000, the project expected to receive $110,000 from PCF and $90,000 from the county human services agency. These funds would cover annual expenditures of about $200,000 for child care during training sessions, participant transportation, books and program literature, incentives and scholarships, food, home health and safety repairs/additions, and other necessary items. In addition, the project receives about $30,000 from Bank Street College in New York for participant support groups. Information obtained from these groups is used to inform research (sponsored by the Packard Foundation) on the training needs of exempt providers.

The sections that follow provide a closer look at project participants, their progression toward licensure, and other project outcomes, as well as lessons learned and future challenges. Introducing these sections is a description of a single participant's experience in the program.

PROJECT PARTICIPANTS

At the age of forty, Marta began providing child care ten years ago after migrating to the United States from Mexico. She is married and has two teenage children. With halting English she describes her experience as a project participant: "I found out about the training from a friend that had attended. She told me, 'I know you do a very good job with the children, but you should go to these meetings. They really teach you a lot.' I decided to attend because I like to do the best job that I can at baby-sitting. They help me when I have many questions and nobody tells me how to do things. I was thinking the other day that I have been in this area for ten years but there is no one who speaks my language who can help when I have stress, or problems with my own children, or the children that the parents drop off. My boys are older now and I feel really comfortable with them. But when they were little—I wish

I could have had somebody to help me at that time. [Staff at the project are] the only people I know that are working with this community.

"Every Wednesday I go to baby-sitting school. They teach us many things, such as how to be very patient, very alert to all the signs with the baby, to connect with the baby, and how they change from six months to twelve, eighteen, twenty-four, and so on. Ana, the other day she taught us how to use *Sesame Street* to connect with the baby. The teachers, they speak Spanish and they explain everything and ask us many questions. I enjoy it a lot. Every time I go to these meetings I meet more persons in the community. It's really important.

"They also give out information in papers and books, books that tell you how to take care of children—not just babies but older kids too. This one book tells you how to prepare your house when you are about to start caring for a new baby. It is just terrific. I also go to a support group and they give you invitations to go to different things, different events.

"I plan to get licensed. Last year—before this class—I thought, 'I don't think I can get my license because of the ladies who come by my house every day to bring the kids. I don't have enough time to shop, or do other things, or things you have to do before the license.' But two months ago I did the CPR class, so I have started already. Just a few things I have to do before I get my license. When I went to the first meeting with Ana, she asked us how many years have we been doing this job, and she asked us 'Who is taking care of children in your own home?' I said 'me,' and she asked me how many kids I take care of and I told her. Ana, she said, 'that's illegal—you can't take care of all those kids in your house without a license.' So they are helping me to get one.

"When I first moved here I started taking care of kids in my friends' houses for two or three years. Then we got our own house and they dropped off the kids. But I didn't know I needed a license. I never worked for many families. Maybe two at a time. My husband and my brothers try to convince me to get another kind of job, but I am not interested in another job. I like babies and kids. I don't know if it's because when I was very young I always say, 'I want to be a teacher.' Baby-sitting kids right now I feel like I am a teacher. I really want to get my license, so that when I get it, it's like 'Yes, I am ready. I am a teacher.' I will feel like I have something very legal. They say I do a very good job right now, but I don't have the paper where they say I am approved for being a baby-sitter.

"I know a lot of persons—my neighbors—that say, 'When you have your license maybe you can take care of my kids part-time.' I know many mothers that don't work because they haven't had very good experiences at the places where they leave their kids. They come to visit my house and ask, 'Can you take care of my kids?' And I say, 'Let me get my license first please.' Right now I only care for one baby full-time and a little boy part-time. When I go to the meetings I hear many struggles of other baby-sitters, maybe because they are taking care of many, many kids or many different families. But with me it's only two kids. It's really easy.

"I work from seven in the morning to six at night, but I am very flexible. Other places open at seven or seven-thirty, but you have to come pick up the kids by five p.m. I don't have exact hours. They come before seven sometimes or on weekends. In the future I want to care for four or five every day. I want one baby and three or four others between one and a half and four years old."

In their second year of operation project staff developed a questionnaire to learn more about the participants. Initially used as a screening form, the completed questionnaires yielded a great deal of data about participant characteristics, employment outside the home, and provider business practices. Information from this questionnaire and from staff observation provides the following description of participants:

- About 75 percent of the first-year participants were Spanish-speaking immigrant women. Most of their children were born in the United States. Some are undocumented and are concerned about involvement with public services. As a result, staff do not ask questions about documentation but will refer them for help with the citizenship process when the subject is broached by the participant.
- Many women were educated in their country of birth in professions such as teaching and nursing but were unable to continue their professions in the United States.
- Most are married or live with a partner or one or more adult relatives. There is usually another working adult in the home in addition to the exempt provider, and many homes contain two families. Usually the women work inside and the men work outside the home.
- About 63 percent of last year's participants were parents of children under the age of four. Most are not first-time mothers and their ages vary. Some grandmothers participate as well.
- Most homes have low combined incomes from work, resulting in difficulties finding affordable, adequate housing and providing for the needs of children. Men often hold down two or three jobs simultaneously.

Although not typical, participant difficulties include custody battles, child abuse or neglect, marital problems, and substance abuse. As a result of their cultural beliefs, some men do not support their wives in pursuing child care as a profession because they do not believe their wives should work, while others are very supportive and bring their wives to the training sessions. Most men do not participate in home visits, and only two have attended training since the project began.

Many women in training have remarked that obtaining a child care license and starting a business offers them an opportunity to elevate their own economic and social status. While many participants choose this path, others face serious obstacles to obtaining their license. The next section describes these obstacles as well as successes in pursuing licensure. In addition, other project outcomes are highlighted.

PROJECT OUTCOMES AND PROGRESS TOWARD LICENSURE

Project outcomes are difficult to quantify, but the following staff observations provide some highlights:

- an increase in attention paid to children in care instead of primarily completing household chores,
- an increase in the safety and utilization of child care environments such as covering electrical outlets and clearing more space for the children to play,
- an increase in provider patience and a decrease in overprotectiveness (as well as improved parenting abilities displayed by husbands/partners),
- an increased connection between participants and public services, leading to increased utilization of support services, and
- an increased connection among participants leading to continued support of one another personally and professionally.

Participants face many serious barriers in progressing toward licensure. These barriers include the following:

1. the scarcity of local Spanish-speaking licensing classes (e.g., CPR/first aid), orientations, paperwork, or staff,
2. the requirement that participants be citizens to advance to licensure when many are not documented,
3. housing that often does not meet licensing requirements because too many adults and children are sharing a residence,
4. the requirement that all residents of the child care home be fingerprinted when some residents may have criminal backgrounds,
5. the requirement that participants must let the owners of their homes know about their child care business when too many people, families, or children are living there that are not on the lease or known by the owner,

6. a lack of support from some husbands of participants, and
7. a lack of money that participants need to furnish the home with child care supplies (e.g., cribs, latches, fire extinguishers) which are required for licensure.

Despite these barriers, a significant number of participants have received their pediatric CPR certificate (33 percent), have gone to a licensing orientation, or have completed a licensing application. Seventeen percent have completed the licensing process. Still others have had project staff come to their homes for a prelicensing visit to prepare them for the State Department of Social Services licensing visit.

With a description of program operations, it is now important to note the lessons learned as well as future challenges.

LESSONS LEARNED AND FUTURE CHALLENGES

In addition to the barriers to obtaining licensure, a few organizational challenges have presented themselves in the first two years of the project's operation. First, some child care professionals disagree with the goal of providing training to exempt providers. They believe that such training undermines the professionalism of licensure by devoting limited resources to unregulated providers. Licensed providers may attempt to limit project growth to protect their own access to public resources (i.e., "gate-keeping"). Second, the explosive growth of the program has required project staff to explore the possibility of adding more staff time and resources. For example, there are over 300 participants who can request home visits from only two full-time project staff. Finally, the diverse needs of participants have generated many ideas for additional supportive services. Although these ideas would improve the quality and scope of the program, they tend to require increased funding.

Several lessons have been learned by project staff in the first two years of operation:

- Most low-income women with infants and toddlers that receive health services from Medi-Cal's Prenatal to Three Initiative do not plan to leave their children in child care but instead choose to care for their own children at home while providing exempt care to the children of friends or relatives. Most choose this form of self-employment instead of finding work in the community in accordance with welfare reform legislation.

- When self-referral was not effective in reaching this hidden community of exempt providers, staff greatly increased participation through phone calls, flyers, and community presentations. Participation increased even more rapidly after the first few groups of participants spoke positively of the project to friends and family members.
- Parents that care for only their own children (i.e., they are not child care providers) are also interested in attending project trainings. The program uncovered a general need for public child care training that goes beyond the realm of professional providers.

Having identified these lessons, staff members suggested several courses of future action that include the following:

1. contracting to hire a Spanish-speaking instructor to facilitate licensing orientations in San Mateo,
2. hiring additional staff (especially support staff) to accommodate program expansion,
3. making efforts to involve more men in training to improve the child care they provide and to enlist their support in their wife/partner's child care business,
4. increasing the quality of child care provided during classes by training the providers of care and increasing the availability of space and resources (e.g., toys, games, books),
5. expanding outreach to other communities that need project services, and
6. placing training classes in locations that are more accessible to low-income individuals with limited transportation.

Although there is no shortage of ideas, project staff members are limited by the availability of resources. In the future, program administrators hope that the program will be seen as a model for exempt provider training and become funded by the Department of Social Services and/or the state Department of Education. These sources of revenue are more stable and flexible than grant funding, enabling project staff to continually deliver a wide range of supportive services that enhance the quality and quantity of child care in the community.

REFERENCES

Annie E. Casey Foundation (1998). Confronting the child care challenge. *Governing,* 12, June, 44-52.

Bailey, S. and Osborne, S. (1994). Provider perspectives on the content and delivery of training for family day care. *Child and Youth Care Forum,* 23(5), 329-338.