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**The Enhanced Home
Visiting Pilot Project:
How Early Head Start
Programs Are Reaching
Out to Kith and Kin
Caregivers**

Final Interim Report

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EXECUTIVE SUMMARY

In summer 2004, the Head Start Bureau funded 24 Early Head Start programs to implement the Enhanced Home Visiting Pilot Project, an initiative designed to support the quality of care that kith and kin caregivers provide to infants and toddlers enrolled in home-based Early Head Start programs. Pilot sites provide home visits to caregivers, organize group training and support group events, and give or lend materials and equipment. In addition, the pilot sites must collaborate with community partners in their work with caregivers.

The Head Start Bureau contracted with Mathematica Policy Research, Inc. (MPR) and its subcontractor, the Urban Institute (UI), to conduct a two-year evaluation of the pilot project. Because so little is known about the needs of kith and kin caregivers, the quality of care they provide, and the effectiveness of service delivery strategies for this population, the evaluation is designed to be descriptive. Data collection activities focus on learning about program operations and service delivery strategies rather than on assessing the pilot's effects on child care quality and children's outcomes. Data sources for the evaluation include interviews and focus groups conducted during two rounds of site visits to the pilot programs, a program recordkeeping system maintained by the pilot sites, and observational assessments of the quality of the caregiving environments and of interactions between children and caregivers participating in the pilot.

Six primary research questions guide the evaluation:

1. What are the characteristics of families served by kith and kin caregivers in the pilot program? What are their child care needs and usage patterns?
2. What are the characteristics and needs of kith and kin caregivers participating in the pilot program?
3. What program models are the pilot sites developing?
4. How is the pilot program being implemented, and what services are sites providing?

5. What community partnerships have sites developed to support the pilot program?
6. What is the quality of care provided by kith and kin caregivers participating in the pilot program?

This interim report describes the early implementation experiences of the pilot projects. It is based primarily on site visits to participating programs after approximately one year of pilot operation, as well as information collected by programs on the characteristics of children, families, and caregivers enrolled in the pilot. It describes programs' initial designs for their pilot projects, as well as pilot staffing and the community partners that programs selected. It also examines key characteristics of children, families, and caregivers enrolled in the pilot; describes programs' methods for recruiting pilot participants and the services the pilot sites provide; and examines the early implementation successes and challenges programs experienced.

During their first year of implementing the Enhanced Home Visiting Pilot Project, participating Early Head Start programs broke new ground in efforts to reach out to and support kith and kin caregivers. Although each pilot site is unique in its design, target population, service delivery strategies, and community partnerships, some common themes have emerged in programs' early implementation experiences. Below, we examine two broad categories of themes: (1) design themes, and (2) service delivery themes.

KEY DESIGN THEMES

Pilot sites are serving a diverse population of kith and kin caregivers. Programs are enrolling and serving a much more diverse group of caregivers than the Head Start Bureau envisioned when the grant announcement was written. This is primarily because the lives of Early Head Start families are complicated, with many caregivers involved in the children's lives. Programs have taken the approach of "following the child" into the settings where he or she receives care—including regular, consistent care provided by relatives or family child care providers, sporadic care provided by a series of informal caregivers, care from custodial and noncustodial fathers, and care in foster homes.

To provide services to kith and kin caregivers, pilot sites have applied the same approach they use for providing home visits to Early Head Start families. Most Early Head Start programs selected for the pilot based their designs on what they knew how to do best—they used their home-based services to families as the primary model for providing services to caregivers. Managers and front-line staff are experienced and skilled in providing these services, and many curricular and training resources are available to the pilot home visitors. Using this model has helped families understand and "buy in" to the pilot; because they receive similar services, they can explain the pilot and its value to their caregivers.

In general, caregivers are receptive to the pilot and like the services they receive. Overall, caregivers who participated in the site visit focus groups expressed satisfaction with

the services they are receiving. Many enjoy the emotional support and encouragement their home visitor provides, and they appreciate the ideas and materials they receive as well. Based on discussion in the focus groups, the home-based services and individualized approach offered through the pilot appear to match the needs and interests of the caregivers.

There are trade-offs to using the same or different home visitors to work with parents and caregivers. Programs have taken two main approaches to staffing the pilot—assigning one home visitor to work with both the family and caregiver or assigning different home visitors to work with each party. When one home visitor works with both parties, services are well coordinated, and the home visitor is able to develop an in-depth understanding of the child’s life circumstances. However, because home visitors are mandated by the Head Start Program Performance Standards to complete weekly visits with parents, caregiver visits sometimes become a lower priority when home visitors are pressed for time. In addition, home visitors sometimes find it difficult to avoid getting pulled into conflicts between parents and caregivers. On the other hand, when parent and caregiver visits are conducted by different home visitors, the two home visitors must communicate frequently and coordinate closely to achieve continuity in services provided across the two settings.

KEY SERVICE DELIVERY THEMES

During the first year of implementation, staff focused heavily on building caregiver-parent-home visitor relationships and creating continuity for the child. During site visit interviews, many pilot staff emphasized their view that establishing trusting relationships with kith and kin caregivers and between parents and caregivers would lay an essential foundation for improving the quality of care the child receives and increasing continuity of caregiving across settings. As a result, during early visits, home visitors emphasized building trust with caregivers over influencing caregiving practices.

Home visitors deliver child development information and training by focusing on the child’s individual developmental goals. One third of the pilot sites used the child’s developmental goals established by the parent and Early Head Start home visitor as the primary basis for home visit activities with caregivers. Home visitors in nearly all sites included child-caregiver activities as part of each visit. In addition, home visitors worked with caregivers on learning about stages of development, age-appropriate behavioral expectations, and activities to promote healthy development, but they individualized specific activities according to the needs of the child. By focusing as much as possible on the child’s development during each visit, home visitors feel they are able to make suggestions about caregiving practices and encourage caregivers to do activities “for the good of the child.” Grandparents in particular responded well to this approach.

Individualization of services for caregivers is a hallmark of the pilot programs. As described previously, many pilot home visitors individualized home visit activities according to the needs of the child. They also individualized services to the needs of the caregivers—including the frequency and schedule of home visits, topics covered, and the materials and equipment provided. One program working primarily with fathers met with

fathers at the program office or other locations to address specific education and training needs or to help obtain social services. During focus groups, caregivers expressed appreciation for this flexibility and said it made them feel comfortable participating in the pilot.

Providing equipment, toys, and home safety items makes the pilot attractive to caregivers. During focus groups, caregivers said that the equipment, toys, and materials they received through the pilot made enrollment and continued participation very attractive for them. Many do not have the resources to purchase toys, books, or home safety items. Programs also found these items to be attractive incentives for encouraging participation in group training events.

While most caregivers do not attend group activities, providing incentives and transportation increases their participation. Most programs had difficulty getting caregivers to participate in group training and other events. Because many kith and kin caregivers do not view themselves as child care providers, they often felt they did not need training. Others faced barriers such as lack of transportation or time to attend. Some programs, however—especially those that provided incentives—were able to achieve good participation in group events. In other programs, relative caregivers attended group socializations and field trips organized for Early Head Start families.

Most caregivers are not interested becoming regulated child care providers. Most pilot sites had one or two caregivers who expressed interest in becoming regulated child care providers, but overall few kith and kin caregivers expressed such interest. Programs generally took the approach of assisting caregivers who were interested in connecting with the licensing agency and obtaining the training they needed, but they did not push caregivers who were not interested in pursuing this option.

EARLY IMPLEMENTATION SUCCESSES

During site visit interviews, pilot and community partner staff described four main types of early implementation successes: (1) fostering relationships between parents, caregivers, and home visitors; (2) providing resources to improve the quality of care; (3) delivering pilot services to caregivers; and (4) effecting changes in caregiving practices. At this early stage of implementation, most successes mentioned by pilot staff are activities that set the stage for potential improvements in the quality of care provided rather than actual changes in quality that home visitors have observed. This evaluation is not designed to measure the effects of the pilot program on child care quality. Therefore, we will not be able to determine whether the early successes reported here translate into quality improvements. Nevertheless, identifying program practices and strategies that enable staff to reach out to caregivers and provide them with information and training can be valuable for ongoing program development and more rigorous evaluation in the future.

Fostering Relationships Among Parents, Caregivers, and Home Visitors

- Pilot home visitors have developed trusting relationships with caregivers.
- Pilot participation has improved communication and engendered mutual respect between parents and caregivers.
- The important role that caregivers play in the children's development has been acknowledged.
- Caregivers' social isolation has been reduced, and many are better connected to the community.
- Parents and caregivers receive consistent information about child development and work together on children's developmental goals.
- Fathers are more involved with their children and with program activities.

Providing Resources for Improving the Quality of Care

- Caregivers are receiving information about children's development and developmentally-appropriate practices.
- Caregivers have appropriate home safety equipment and materials for childproofing their homes.
- Caregivers have more age-appropriate toys, books, and developmentally-appropriate activities to do with the children.

Delivering Pilot Services

- Most programs are completing regular home visits.
- At some pilot sites, participation in group activities has been high.
- Coordination with community partners and within Early Head Start programs has increased.
- Services for kith and kin caregivers have become integrated into the Early Head Start program.
- Pilot services benefit all children in the caregivers' homes, including Early Head Start and non-Early Head Start children.
- Some programs reported positive changes in caregiver practices.

EARLY IMPLEMENTATION CHALLENGES

As expected for a new initiative, pilot sites faced a number of unanticipated implementation challenges during the first year of pilot operations. During site visit interviews, pilot staff described five main types of challenges: (1) recruiting and maintaining a full caseload of caregivers, (2) encouraging attendance at group events, (3) dealing with staffing issues, (4) dealing with design issues, and (5) meeting implementation challenges experienced by pilot home visitors.

Recruiting and Maintaining a Full Caseload of Caregivers

- Programs must recruit from a limited pool of Early Head Start home-based families.
- A few programs further limit the pool of eligible families by establishing additional eligibility criteria.
- Recruitment into the pilot is a multistage process.
- Some programs had difficulty gaining caregivers' trust.
- Some programs experienced more turnover in caregivers than expected.

Encouraging Attendance at Group Events

- Attendance at group trainings, group socializations, and support groups for caregivers was lower than expected in two-thirds of the pilot sites.
- Caregivers faced barriers to attending group events, including transportation and lack of time due to caregiving duties and work outside the home.

Dealing with Staffing Issues

- In some programs, tensions arose about coordinating services when multiple staff members began working with the same child and family.
- Some home visitors did not have enough time to conduct home visits as frequently as intended.
- A few programs had difficulty finding qualified staff or experienced turnover when initial staff hired for the pilot did not work out.

Dealing with Design Issues

- Some programs had to make last-minute design changes to meet grant requirements.
- A few programs did not develop a clear design for the pilot until after implementation was under way.

Meeting Implementation Challenges Experienced by Pilot Home Visitors

- Parent-caregiver tensions created challenges for home visitors.
- Caregivers' social service needs distracted from the home visitors' focus on child development during home visits.
- Some caregivers are reluctant to make changes in how they care for the children.

Despite these challenges, programs made significant progress in implementing the Enhanced Home Visiting Pilot during their first year of operation. They hired and trained staff, enrolled families and caregivers, and provided them with regular services. They also identified some implementation challenges and began developing and testing strategies for overcoming them. As the evaluation continues, we will continue exploring the themes identified in this report and identify new themes that emerge as implementation continues and pilot models evolve further. A final report, planned for summer 2006, will examine these themes in detail, exploring the extent to which implementation experiences change over time and the strategies that programs develop for responding to the obstacles they face in recruiting and serving caregivers.

CHAPTER I

INTRODUCTION

Low-income families rely heavily on child care provided by family, friends, and neighbors (“kith and kin” caregivers) for their infants and toddlers (Ehrle, Adams, and Tout 2001). The national evaluation of Early Head Start found that a large proportion of program families used kith and kin care, especially families in home-based programs (Administration for Children and Families 2004). Forty-two percent of families enrolled in home-based options reported using kith and kin care, compared to 17 percent of families enrolled in the center-based options and 37 percent of families enrolled in mixed approach options (Administration for Children and Families 2004). Although state and local agencies are exploring strategies to serve kith and kin caregivers, little is known about how to effectively engage these caregivers and provide services in ways that support their efforts to provide quality care for young children (Anderson et al. 2005; Collins and Carlson 1998; Porter 1998).

Growing recognition of the importance of school readiness—and implementation of the president’s *Good Start, Grow Smart* initiative to prepare young children for school—have prompted policymakers and program administrators to increase their focus on strategies to improve the quality of young children’s out-of-home care. Studies that identify promising program models and service delivery strategies are clearly needed to provide guidance to the early childhood community in its ongoing and future efforts to support kith and kin caregivers.

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

In summer 2004, the Head Start Bureau funded 24 Early Head Start programs to implement the Enhanced Home Visiting Pilot Project, an initiative designed to support the quality of care that kith and kin caregivers provide to infants and toddlers enrolled in home-based Early Head Start programs. The pilot program provides an important opportunity to

learn more about the needs of these caregivers and how to support them. Lessons learned from the pilot can benefit other Early Head Start programs and the broader early childhood education community.

The Head Start Bureau contracted with Mathematica Policy Research, Inc. (MPR), and its subcontractor, the Urban Institute (UI) to conduct a two-year evaluation of the pilot project. The evaluation is focusing on identifying program models, documenting implementation strategies and challenges, learning about promising practices, and assessing the quality of kith and kin child care settings.

This interim report describes the early implementation experiences of the pilot projects. It is based primarily on site visits to participating programs after approximately one year of pilot operation, as well as information collected by programs on the characteristics of children, families, and caregivers enrolled in the pilot. A final report planned for summer 2006 will be based on all data sources used for the evaluation. In the rest of this introductory chapter, we provide an overview of the pilot program and the evaluation.

THE ENHANCED HOME VISITING PILOT PROJECT

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

1. Identifying the needs of kith and kin caregivers and the support they need to provide quality care
2. Increasing the availability of quality infant-toddler child care in the pilot communities by providing training and support to caregivers
3. Providing an enhanced quality of care to Early Head Start children as a result of the support, training, resources, and home visits their caregivers receive
4. Providing children with positive experiences in the enhanced care settings to lay a strong foundation for early learning, improved child outcomes, and school readiness
5. Enhancing relationships, communication, and understanding between programs, parents, and caregivers in support of children’s development

In spring 2003, the Head Start Bureau invited Early Head Start programs that provide services to families through the home-based option to apply for participation in the pilot.¹ Twenty-four programs were selected to participate, and they began operations in summer 2004.² Programs participating in the pilot must continue providing all services that the Head Start Program Performance Standards for home-based programs require. In addition, they are providing training, resources, and support to kith and kin caregivers of enrolled families, tailored to the specific strengths and needs of their communities. All pilot sites must collaborate with community partners, such as community-based home visiting programs or community agencies that offer training to child care providers, in their work with caregivers. Most of the pilot sites planned to provide regular home visits to caregivers, to organize group training and socialization activities, and to offer materials and supplies.

Table I.1 lists the pilot sites, organized by Administration for Children and Families region.³ The table also displays the number of Early Head Start children each program is funded to serve, the number of those enrollment slots designated for the home-based option, and the number designated for the Enhanced Home Visiting Pilot Project. In addition, Appendix A contains a brief profile of each pilot site that summarizes the goals and design of the pilot and describes the site's community partners, staffing structure, methods for recruiting families and caregivers, characteristics of caregivers, and core pilot services.

THE ENHANCED HOME VISITING PILOT PROJECT EVALUATION

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

- Learn about the characteristics and needs of kith and kin caregivers and the families that rely on them for child care

¹ Early Head Start programs that provide services through the home-based option must provide families with weekly home visits lasting at least 90 minutes and at least two group socialization activities per month. Under the home-based option, programs do not provide center-based child care to families either directly or through partnerships with community child care providers.

² One of the 24 sites selected for the pilot subsequently relinquished its Early Head Start grant and withdrew from the pilot.

³ Only 23 of the 24 sites initially selected for the pilot are listed because one program relinquished its Early Head Start grant and withdrew from the pilot.

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

Program	Location	Total EHS Enrollment Slots	Home-Based Enrollment Slots	Pilot Enrollment Slots
ACF Region I				
Children's Friend and Service	Providence, RI	98	98	10
Kennebec Valley Community Action Program	Waterville, ME	64	24	16
Northeast Kingdom Community Action Agency	Newport, VT	72	72	16
ACF Region II				
The Astor Home for Children	Rhinebeck, NY	125	85	20
ACF Region III				
Cen-Clear Child Services, Inc.	Philipsburg, PA	176	176	35
Luzerne County Head Start	Wilkes-Barre, PA	96	96	14
Monongalia County Board of Education	Morgantown, WV	121	75	20
Northern Panhandle Head Start, Inc.	Wheeling, WV	48	48	20
ACF Region IV				
Alabama Council on Human Relations, Inc.	Auburn, AL	152	80	20
Mountain Area Child and Family Center	Asheville, NC	100	46	20
ACF Region V				
Mahube Community Council, Inc.	Detroit Lakes, MN	128	58	50
Hamilton Center, Inc.	Terre Haute, IN	80	44	11
Community Action Wayne/Medina	Wooster, OH	96	66	25
Baraga-Houghton-Keweenaw Child Development Board	Houghton, MI	95	45	25
EightCAP, Inc.	Greenville, MI	198	178	40
ACF Region VI				
Region 10 Education Service Center	Richardson, TX	120	120	24
Hutchinson Public Schools Unified School District #308	Hutchinson, KS	60	54	20
ACF Region VII				
Northwest Nebraska Community Action Council	Chadron, NE	36	36	20
Community Action Agency of Siouxland	Sioux City, IA	85	85	20
ACF Region VIII				
Starpoint First Steps Early Head Start	Canon City, CO	65	55	12
ACF Region IX				
Shasta Head Start Child Development, Inc.	Redding, CA	192	100	20
Maricopa County Head Start Zero to Five	Phoenix, AZ	191	191	14
ACF Region X				
Mt. Hood Community College Child Development and Family Support Program	Gresham, OR	92	84	20
Total		2,490	1,916	492

Source: Site visit interviews conducted in summer and fall 2005.

-
- Identify promising program models for reaching out to caregivers and supporting them in providing good-quality infant-toddler care
 - Identify implementation strategies and challenges
 - Document the quality of care that caregivers participating in the pilot program provide
 - Identify and disseminate lessons learned from the pilot

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

Research Questions

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

1. What are the characteristics of families served by kith and kin caregivers in the pilot program? What are their child care needs and usage patterns?
2. What are the characteristics and needs of kith and kin caregivers participating in the pilot program?
3. What program models are the pilot sites implementing?
4. How is the pilot program being implemented, and what services are sites providing?
5. What community partnerships have sites developed to support the pilot program?
6. What is the quality of care provided by kith and kin caregivers participating in the pilot program?

Data Sources

The pilot evaluation will collect and analyze information from three main sources: (1) interviews and focus groups conducted during two rounds of site visits to the pilot programs, (2) a program recordkeeping system maintained by the pilot sites, and

(3) observational assessments of the quality of the caregiving environments and of interactions between children and caregivers participating in the pilot.

Site Visits. Much of the data needed for the evaluation is being collected during two rounds of site visits to the pilot programs. The first round of visits—to all but one of the 23 of the pilot sites—took place in summer 2005.⁴ Although the number and titles of pilot staff we interviewed varied somewhat across the sites, we interviewed the following types of staff: (1) the Early Head Start director, (2) the pilot coordinator, (3) the pilot home visitors, and (4) community partner staff involved in the pilot. Table I.2 displays the number of each type of respondent we talked to across 23 sites we visited. Site visit protocols are included in Appendix B.

In addition to individual and group interviews with pilot staff, we also attempted to conduct two focus groups during each visit—one with parents enrolled in the pilot and another with caregivers who were receiving pilot services. We were able to conduct the parent focus group in 21 of the 23 sites and the caregiver focus group in 22 sites. On average, four parents participated in each group, ranging from one to nine participants across the sites. An average of five caregivers per site participated, ranging from one to eleven caregivers. While many of these groups were relatively small, in part because of lower than expected enrollment in the pilot in most sites, the focus groups included more than a third of caregivers and more than a quarter of parents enrolled at the time of the site visits.

Table I.2. Type and Number of Site Visit Respondents

Respondents	Number
Grantee Executive Director	3
Early Head Start Director	23
Pilot Coordinator	33
Home Visitor	56
Community Partner Staff	30
Parent	88
Caregiver	107
Total Respondents	340

Source: Site visits to 23 Early Head Start programs conducted in summer and fall 2005.

⁴ One visit was not conducted until October 2005 because the site was delayed in implementing its pilot project.

We also conducted case reviews on a sample of six families and caregivers enrolled in the pilot at each site. During these reviews, we discussed the primary goals of the family and caregiver and the services they have received with home visitors or other staff who work with them. Each review usually lasted about 30 minutes.

In January 2006, we will contact the program director at each site again, by telephone, to update the information we collected during the visit and to learn about any changes that have been made in service delivery. Half of the pilot sites will be selected for a second round of in-depth site visits to be conducted in spring 2006. We will work with the Head Start Bureau to establish criteria for selecting these in-depth study sites.

Program Recordkeeping System. We have designed a program recordkeeping system to collect consistent information about families and caregivers enrolled in the pilot and services provided across the 23 pilot sites. Pilot staff enter information into the system to create three types of records on (1) pilot participants, (2) child care arrangements, and (3) pilot services. Pilot participants include the caregivers, children, and families who are enrolled in the pilot and the home visitors. Child care arrangements tracked in the system are those in which caregivers enrolled in the pilot are caring for Early Head Start children. Pilot services include home visits, group training and support groups, and material support provided to enrolled caregivers. Programs began entering information into the system in July 2005, after OMB clearance was obtained. This report includes preliminary information from the recordkeeping system on the characteristics of children, parents, and caregivers and on the kith and kin child care arrangements.⁵

Observations of In-Home Child Care Settings. During the second round of site visits, we will conduct in-home observations of kith and kin care settings and child-caregiver interactions using the Child Care Assessment Tool for Relatives (CCAT-R; Porter et al. 2005) and the Arnett Caregiver Interaction Scale (Arnett 1989). Following each observation, we will conduct a short, 20-minute interview with the caregiver to determine whether the observer was observing a typical day in the setting and whether the child was behaving as if it were a normal day. The interview will also elicit information about the caregiver's attitudes toward child care, their relationships with the child's parents, and their experiences in balancing child care and home life. We will conduct these observations and interviews with a subsample of eight kith and kin caregivers in each of the 12 in-depth study sites we visit in spring 2006.

Analytic Methods

For this interim report, we analyzed the data collected during the first round of site visits and a preliminary extract of data entered into the program recordkeeping system. Because of the high number of pilot sites in the evaluation, we used a qualitative analysis software package, Atlas.ti (Scientific Software Development 1997), to facilitate organizing

⁵ As of December 2005, 22 of 23 sites had submitted data extracts to MPR. One site had not yet enrolled any families or caregivers and, therefore, did not submit data.

and synthesizing the large amount of data collected during the visits. This software enabled research team members to use a structured coding scheme for organizing and categorizing data that are linked to the primary research questions (Table I.3). Once the site reports were coded, we used Atlas.ti to conduct searches and retrieve data on our research questions and subtopics. We analyzed these data both within and across sites to identify common themes that emerged across respondents and sites, as well as patterns of service delivery, staffing, and other program dimensions.

We also analyzed a preliminary extract of data from the program recordkeeping system covering the initial two to three months of data entered. To provide a snapshot of the characteristics of families, children, and caregivers enrolled in the pilot, we computed descriptive statistics—such as frequencies, means, percentages, and ranges—on characteristics of participants across the sites. Similarly, we examined characteristics of the kith and kin child care arrangements of children enrolled in the pilot by computing descriptive statistics on key characteristics of the arrangements.

The final report for the evaluation will include a more in-depth analysis of these data, as well as information on the types, intensity, and duration of services that caregivers receive through the pilot. It will also include analyses of the in-home quality observations completed using the CCAT-R and Arnett observation tools.

ROADMAP TO THE REPORT

We now turn to presenting interim findings from the evaluation. In Chapter II, we describe programs' initial designs for their pilot projects and the processes they used for developing the designs. The chapter also provides an overview of pilot staffing and the community partners that programs are collaborating with to provide pilot services. Chapter III examines key characteristics of children, families, and caregivers enrolled in the pilot and of the child care arrangements themselves. In Chapter IV, we describe programs' methods for recruiting families and caregivers for the pilot and the services that the pilot sites provide. Chapter V presents early implementation lessons from the pilot project, including programs' views on their early implementation successes and challenges, and a synthesis of key implementation themes that emerged from the first year of the evaluation.

Table I.3. Codes Used to Analyze Qualitative Data Collected During Site Visits, by Research Question

Data Source
Program Director Coordinator Home Visitor(s) Community Partner Parents Caregivers Case Review Summary Site Visitor Reaction Summary
Research Questions
<p>Family Characteristics Question 1: What Are the Characteristics of Families Enrolled in the Pilot?</p> <p>Family Characteristics and Needs Access to Child Care in the Community Child Care Arrangements Reason for Choosing Child Care Arrangement Relationship with Kith and Kin Caregiver Satisfaction with Kith and Kin Care Other Issues Raised by Parents</p> <p>Caregiver Characteristics Question 2: What Are the Characteristics and Needs of Kith and Kin Caregivers?</p> <p>Caregiver Characteristics Motivation for Providing Care Caregiver Typical Day Caregiver Rewards Caregiver Challenges Relationships with Parents Interest in Becoming a Regulated Child Care Provider Amount and Timing of Care Provided Other Issues Raised by Caregivers</p> <p>Program Models Question 3: What Program Models Are the Pilot Sites Implementing?</p> <p>Program Characteristics Goals and Objectives Services Sites Planned to Provide How Models Were Developed Changes in Models and Reasons for Changes Sustainability of Models Sufficiency of Funding Design Lessons</p>

Table I.3 (continued)

Implementation**Question 4: How Is the Pilot Program Being Implemented?**

Recruiting Families
Outreach to Caregivers
Staff Qualifications
Staff Training
Supervision of Pilot Staff
Services to Families
Caregiver Turnover
Caregiver Eligibility
Home Visits to Caregivers
Group Training/Support Groups for Caregivers
Curricula
Materials, Equipment, and Financial Support for Caregivers
Referrals for Caregivers
Strategies for Strengthening Relationships Among Parents, Caregivers, and Staff
Coordination of Services
Receptivity of Caregivers to Pilot Services
Parent Satisfaction with Pilot Services
Caregiver Satisfaction with Pilot Services
Successes of the Pilot
Implementation Challenges
Implementation Lessons
Staffing Lessons
Other

Community Partners**Question 5: What Community Partnerships Have Pilot Sites Developed?**

Types of Community Partners
Partner Recruitment and Selection
Partner Involvement in Model Development
Services Provided by Partners
Sustaining the Partnerships
Partnership Lessons

Child Care Quality**Question 6: What Is the Quality of Care Provided by Kith and Kin Caregivers?**

Staff Opinions About the Quality of Care
Whether Staff Think Quality of Care Has Improved
Changes in Caregiving Practices

CHAPTER II

DESIGN OF THE PILOT PROGRAMS

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

In this chapter, we describe the grantees’ experiences and the processes they followed in developing program models for the Enhanced Home Visiting Pilot, including how they staffed the pilot and the community partnerships they brought together to serve kith and kin caregivers. The chapter begins with an overview of the primary goals established by the pilot programs, and then describes the target populations they planned to serve. Next we describe the design process itself, including the formal and informal needs assessments sites conducted, the services they proposed, and how they involved community partners in the planning process.

The chapter also describes the staffing models developed by the pilot sites, the qualifications of staff who work on the pilot, and the training they received in preparation for their work with caregivers. The chapter concludes with a brief description of the pilot sites’ community partners and the various roles they play in providing pilot services. We describe the processes Early Head Start programs used to select community partners and end with a discussion of the sites’ success in establishing effective partnerships for the pilot.

GOALS SET BY THE PILOT SITES

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

Goals of the Pilot Sites	
	Number of Programs
Improve quality of care	23
Increase consistency of care	10
Improve parent-caregiver relationship	5
Support caregiver needs	12
N = 23 pilot programs	

The overarching goal of the pilot program, as noted by every program director, was to improve the quality of care provided by caregivers to support young children's development. In most sites, addressing this goal involved efforts to improve caregiving practices by sharing child development information and demonstrating play activities designed to stimulate the children's growth. Many sites also planned to address this goal by providing health and safety equipment, age-appropriate toys, and furnishings to caregivers to improve the child care environment. A small number of grantees chose to focus their pilots on a particular aspect of child care quality, such as health and safety, or on a particular aspect of children's development, such as early literacy or physical and mental health.

Increasing the consistency of care between parent and caregiver was identified as a goal guiding pilot efforts in 10 of the 23 programs visited. Programs planned to work toward this goal by encouraging caregivers to adopt practices similar to those used by the parents in meeting the child's needs and stimulating his or her development. Often this goal was prompted by the desire to create more consistency in daily routines for the home-based Early Head Start child. In some cases, it was also motivated by the desire to encourage Early Head Start parents to use certain caregiving practices by reinforcing them among all caregivers in the household. Sites differed in the ways they proposed to accomplish this goal, but all involved efforts to provide consistent child development information to parents and caregivers.

Five sites planned to go a step further, focusing on improving communication and relationships between parents and caregivers as a primary goal of their pilot. For example, one site is serving incarcerated teen parents who in many cases have strained relationships with their own parents. Usually, their parents are also their child's caregiver. A major goal of this pilot program is to prepare the family—child, parent, and relative caregiver—for reunification when the parent is released from the juvenile detention facility. Through individual visits and group activities during the parent's incarceration period and home visits afterward, pilot staff encourage parents and caregivers to rebuild their relationships for the child's benefit.

Providing emotional support and helping caregivers access needed social services was a primary goal reported by over half of the pilot sites. Program directors in these sites noted that relative caregivers are often socially isolated and go unrecognized for the contributions they make to the child's well-being. From these directors' perspective, attention to caregivers' emotional and social service needs are as critical as attention to their caregiving practices in assuring that they are able to provide the best care for the child. One site has focused almost exclusively on this goal, working with residential and nonresidential fathers to help them become more comfortable and skilled in their role as caregivers, to enroll in GED and job training programs, and to access physical and mental health services.

The pilot sites vary in their relative emphasis on improving caregiving practices and addressing caregivers' emotional support and self-sufficiency needs more generally. Over half of the sites are explicitly focused on the dual goals of improving the quality of care and providing emotional support and referrals to address caregiver needs (see Box). The remaining sites, in contrast, have placed most of their emphasis on improving the quality of care provided by kith and kin caregivers, and one site is focused exclusively on this goal. The decision to focus primarily on improving the quality of care was often prompted by programs' concerns that asking home visitors to assist caregivers with personal needs would take time and focus away from the child and away from the pilot's primary goal of improving caregiver knowledge and skills.

Relative Emphasis on Supporting Quality and Addressing Caregiver Needs

	Number of Programs
Dual focus on improving quality and caregiver needs	12
Primary focus on improving quality	11
N = 23 pilot programs	

TARGET POPULATION

The majority of sites reported serving a mix of populations in their Enhanced Home Visiting Pilots, a mix defined in large part by the characteristics of low-income families enrolled in Early Head Start in their communities. In this section, we first describe the types of families pilot sites targeted for enrollment and then describe the types of caregivers they planned to serve.

Types of Families Targeted for Pilot Enrollment

According to the grant announcement, families eligible for enrollment in the pilot needed to be enrolled in Early Head Start, receive services through the home-based option, and use kith and kin care for their Early Head Start child. Beyond these requirements, programs had latitude to define their target population for the pilot. Most sites did not target specific types of families for enrollment; instead they sought to enroll all families that met the eligibility criteria. For the most part, families participating in the pilot reflect the characteristics and needs of the larger population of families enrolled in the site's Early Head Start program.

Some sites, however, targeted specific types of families. These sites were already serving the target population as part of their Early Head Start program and saw the pilot as an opportunity to expand the scope of services available to them. For example, six sites planned to enroll immigrant families in the pilot because these families tended to use relatives to care for their young children (see Box). Several hired bilingual home visitors who would be able to work with Spanish-speaking caregivers. Other sites targeted families in which parents were working or attending college.

Five sites targeted families headed by teen parents. For example, two pilot sites are working almost exclusively with teenage mothers and the child's maternal grandmother. Another targeted teenage mothers and fathers incarcerated in state juvenile detention facilities and the relative caring for the child during the parent's incarceration and probation period. Five sites targeted families involved with the child welfare system; one of these sites is working solely with foster parents and relatives who have been assigned as kinship caregivers by the child welfare agency.

Types of Families Targeted for Pilot Enrollment	
	Number of Programs
Immigrant families	6
Parents working or in college	5
Teenage parents	5
Families involved with child welfare system	5
Non-Early Head Start families	3
N = 23 programs	

Three sites planned to enroll non-Early Head Start families in the pilot. Two of these sites have long waiting lists and viewed the pilot as a way of providing services to more Early Head Start-eligible children. During the grant award process, however, the Head Start Bureau clarified that all families enrolled in the pilot must already be enrolled in Early Head Start. In other words, the pilot was not to be viewed as an expansion opportunity but rather as an enhancement to the services families were already receiving. A third site that provides seamless, birth to 5 services to low-income families through Early Head Start, Head Start, and other funding sources decided to open the pilot to non-Early Head Start families receiving home visiting services. The program director felt that opening enrollment to all families using kinship and kin care, regardless of the child's enrollment in Early Head Start, was more in keeping with the agency's practice of seamless service delivery. Services for the non-Early Head Start families and caregivers are funded by other sources.

Types of Caregivers Targeted for Pilot Enrollment

As stated previously, most sites did not target specific populations of families for pilot enrollment; instead, they recruited families that met the eligibility criteria and then worked with the caregivers they were using. As described in more detail in Chapter III, for the majority of pilot sites this meant working primarily with grandmothers or other female relatives who cared for the Early Head Start child (see Box next page). Some of the relative caregivers are the children's primary caregivers because the biological parents are unable to

care for the child; in some cases, the relative caregiver has obtained or is in the process of obtaining legal guardianship as well.

The pilot sites were given some degree of latitude in how they chose to define kith and kin caregivers for the purpose of pilot eligibility. The federal grant announcement stated that programs targeted to “relatives and neighbors who are caring for Early Head Start/Migrant infants and toddlers” were eligible but did not specify further what types of caregivers could be enrolled. Some sites decided up front to define kith and kin caregiver broadly, including both regulated and unregulated in-home child care arrangements. Three planned to enroll a mix of relative caregivers and regulated family child care providers. For example, some Early Head Start parents in one rural site do not have family living in the area and as a result rely on friends and neighbors who are licensed family child care providers to care for their child.

Types of Caregivers Targeted for Enrollment	
	Number of Programs
Mostly grandparents or other relatives	18
Mixture of relatives and regulated family child care providers	3
Mostly fathers	1
Foster parents and kinship caregivers	1
N = 23 programs	

Two sites planned to serve very specific groups of caregivers. One site is working almost exclusively with residential and nonresidential fathers as the kith and kin caregivers, and one site is working exclusively with foster parents and relatives assigned as kinship caregivers by the child welfare system.

Expanding Eligibility for the Pilot

During site visit interviews, staff in half of the pilot sites—including program directors, pilot coordinators, and home visitors—expressed a desire to extend pilot eligibility to families beyond those enrolled in the Early Head Start home-based option. Some community partners, parents, and caregivers recommended expanding eligibility as well. This issue came up, in part, because most programs had difficulty recruiting sufficient numbers of families (discussed in more detail in Chapters IV and V): expanding eligibility might alleviate recruitment problems. For example, staff in two sites said that some families served through the center-based option also used kith and kin child care and could benefit from pilot services. Staff wanted to extend pilot services to these families, and a third program reported that it was already doing so (see Box next page).¹

¹ At a grantee meeting held in June 2005, Head Start Bureau staff clarified that families enrolled in the home-based option at the time of pilot enrollment could remain in the pilot if they transitioned to the center-based option, as long as the family continued to use kith and kin child care.

The desire of staff to expand eligibility also came up in the context of transitioning children and families from Early Head Start to Head Start. Staff in seven sites said they wanted to continue working with caregivers once the children they cared for moved into the Head Start program. Even when the children received center-based Head Start services, many families continued to use kith and kin child care, according to the staff. Home visitors, in particular, felt awkward about dropping caregivers when the children continued to receive services from the grantee agency. One site operating a seamless Early Head Start/Head Start program dealt with this issue by gradually reducing the scope of services for caregivers of children who transitioned to Head Start, from home visits and group activities to monthly newsletters and invitations to parent events. Staff in other sites have not yet established a process for gradually limiting pilot services to caregivers when children age out of Early Head Start and said they were unsure of how they will do so when the need arises. As stated previously, another site is using alternative funding sources to pay for pilot services for Head Start and non-Early Head Start children. Finally, one program already operates a similar kith and kin child care initiative for Head Start families and thus could continue services for transitioning families if needed.

Recommendations for Expanding Pilot Eligibility	
	Number of Programs
Include families in the center-based option	3
Include Head Start families	7
Include non-Early Head Start families who are income-eligible	8
N = 23 programs	
Note: Some sites made more than one type of recommendation.	

In eight sites, staff said they wanted to extend pilot eligibility to non-Early Head Start children and families who were income-eligible for the program. As stated previously, several programs initially planned to use pilot funds to serve children and families on their waiting lists or non-Early Head Start families served by their agency through other funding sources. In addition, community partners in some sites raised this issue because they would like to refer families and caregivers they serve to the pilot. Because the Early Head Start programs are fully enrolled and have long waiting lists, however, programs often are not able to enroll referred families and caregivers, even if they are eligible.

DESIGN PROCESS AND SERVICES PROPOSED

During site visit interviews, program directors in half of the pilot sites said they viewed the Enhanced Home Visiting Pilot as a natural extension of the services they were already providing or wanted to provide, which for them was a primary reason for applying for the grant. For example, one Head Start program had tried in the past to establish partnerships with child care centers and family child care homes to improve the quality of care used by Head Start families. When the grant announcement was released, they viewed the pilot as an opportunity to continue pursuing this goal with kin and kin caregivers of Early Head Start children. Another had already been providing home visits to kith and kin caregivers of children enrolled in Head Start since 2001; staff were eager to apply the lessons learned from

that initiative to Early Head Start. Yet another site viewed the pilot as a welcome opportunity to expand its Early Head Start initiative for foster parents from a single county to its entire four-county service area. Similarly, a program already operating an Early Head Start initiative for incarcerated teen mothers and relative caregivers viewed the pilot as a means of expanding the initiative to include incarcerated teen fathers as well. All of these sites, because of their prior work, considered themselves ready to implement a home visiting program for kith and kin caregivers and were eager to take on the challenge.

Three-quarters of the pilot sites used some combination of a formal needs assessment, consultation with community partners, and informal input from staff and Policy Council members to design their Enhanced Home Visiting Pilots. The remaining sites relied either on family surveys, input from home visiting staff, or discussions with community partners to determine who should be targeted for enrollment and what services should be provided. Only one pilot site did not begin a formal design process until after funding was received. Sites that based their pilot design on a prior or ongoing initiative were no less likely than other sites to follow a formal design process of community needs assessment, community partner involvement, and informal input from staff, parents, and families.

All of the pilot sites planned to conduct home visits with kith and kin caregivers, although the anticipated frequency and intensity of visits varied (see Box). The proposed intensity of home visits ranged from weekly, 90-minute sessions with the caregiver and child to an initial home visit followed by monthly contact with the caregiver via phone, newsletter, or the parent's home visit. In keeping with pilot goals, five sites also planned specific strategies for coordinating lesson plans for parents and caregivers, so that each would be working on the same developmental goals and activities with the child.

Services that Pilot Sites Planned to Provide

	Number of Programs
Home visits	23
Group activities	22
Materials and equipment	21
N = 23 programs	

All but one site proposed offering some type of group activity for caregivers. Again, these group activities varied in frequency and intensity, from monthly support group trainings lasting three to four hours to invitations to attend the monthly group socialization events for Early Head Start families. To encourage participation, eight sites planned to provide incentives—either material items, gift certificates, or small cash stipends. One site proposed a tiered incentive system, in which caregivers would receive gift certificates to toy and department stores each time they participated in a group activity, supplemented by a \$150 stipend each time they completed 18 hours of home visits and group training workshops.

Finally, all but two sites planned to provide materials and equipment for caregivers to use in caring for children, either as gifts or loans. The most commonly proposed items to be given to caregivers were health and safety items such as smoke detectors and outlet plugs.

The most commonly proposed loaned items were toys and books. One site planned to give caregivers \$300 worth of educational toys, books, and safety equipment at the beginning of enrollment and then again in the second year if they continued to participate in the pilot.

Overall, the pilot sites proposed a comprehensive package of training, resources, and services for kith and kin caregivers, but the scope and intensity varied greatly from one site to another. In Chapter IV we describe in greater detail the types of trainings, resources, and services that were actually provided and how the implementation of services differed from what was proposed.

DESIGN CHALLENGES

Program directors in nine of the pilot sites reported no difficulties in designing their Enhanced Home Visiting Pilots. As one program director put it, “We knew what we wanted.” As would be expected, sites that based their pilot on experiences implementing similar initiatives faced fewer design challenges. Fourteen sites, however, experienced varying degrees of difficulty in designing their pilots and getting them launched. One site was in midst of implementing its Early Head Start program and found it challenging to take on another new initiative at the same time. Two other sites were delayed by difficulties in identifying and hiring qualified staff.

Eleven sites had difficulty during the design phase because they initially misinterpreted the federal grant announcement. For example, two sites interpreted the announcement as an expansion opportunity to serve a larger number of Early Head Start families. Two other sites interpreted the announcement as an opportunity to serve caregivers of children enrolled in a community partner’s home visiting program. Another site thought it could provide some services to caregivers in lieu of services to parents and planned to alternate home visits between parents and caregivers. One site thought that staff from the community partner had to provide services to caregivers; however, when program managers learned that their staff could provide these services, the program chose to redesign the staffing structure. During the grant review and award process, the Head Start Bureau clarified the grant requirements and requested that these sites redesign their pilots accordingly. While most sites were able to accomplish this with little difficulty, a few struggled to devise an alternative approach given the staff and budget available for the pilot. In fact, four of the sites considered returning the pilot funding because of difficulties they encountered during the redesign process, but in the end they identified ways to reassign existing staff or reduce the scope of proposed pilot services to fit the grant amount awarded.

As a result of these difficulties, several program directors said they would have liked more clarity in the grant announcement about who should be considered a kith and kin caregiver, the extent to which Head Start Program Performance Standards apply to the pilot, and the frequency and intensity of services that should be provided to caregivers. In addition, a few directors said they would have liked more technical assistance during the grant proposal process, especially in the areas of staffing and budgeting.

Other program directors said that the technical assistance they received from ZERO TO THREE was helpful. Some praised the listserv in particular as a useful tool for sharing ideas and learning from the experiences of other pilot sites. Staff also found the grantee orientation meeting helpful in providing opportunities to share recruitment and implementation strategies with other pilot grantees.

STAFFING FOR THE ENHANCED HOME VISITING PILOT

In many ways, the success of the Enhanced Home Visiting Pilot hinges on the programs' ability to attract and retain home visitors that caregivers will trust, confide in, and look to for knowledge and expertise. Finding the right staff to fill this role is not a simple task. In the words of one program director, "It's not for everyone. It takes a certain kind of person who can deliver the message in a non-threatening way, a person who believes in the mission...." This section describes the staffing models developed by the pilot sites. We begin with an overview of the staffing structures sites developed and the qualifications of staff working on the pilot. We then describe the pre-service and in-service training pilot staff received. We end the section by discussing levels of staff turnover experienced by pilot sites during their first year of implementation.

Staffing Structure

In the majority of pilot sites, one or two management staff served as pilot coordinators, overseeing recruitment and service delivery and supervising the pilot staff. Below, we describe models for staffing pilot home visits, approaches to supervising pilot staff, and strategies for coordinating services for families and caregivers.

Staffing for Pilot Home Visits. All of the pilot sites have assigned one or more staff to conduct caregiver home visits. The sites took one of three main approaches to assigning home visitors to caregivers: (1) a dual-home visitor model in which a pilot home visitor worked with the caregiver and an Early Head Start home visitor worked with the family, (2) a single-home visitor model in which a single home visitor provided services to both the caregiver and family, and (3) a community partner model in which community partner staff conducted caregiver visits and Early Head Start home visitors worked with families.

Fourteen sites have implemented the dual-home visitor approach (see Box). In these sites, one or two pilot home visitors typically provide all of the caregiver home visits; most of these staff work full time or nearly full time on the pilot. In some programs, such as the one that targeted foster parents as caregivers, it was important that different staff be assigned to the caregiver and biological parent to maintain confidentiality of the foster parents' and biological parents' situations. Other sites

Approaches to Assigning Home Visitors to Caregivers Enrolled in the Pilot	
	Number of Programs
Dual-home visitor model	14
Single-home visitor model	7
Community partner model	2
N = 23 programs	

chose this staffing model because of concerns that home visitors would be overburdened if they were expected to provide home visits to both caregivers and parents. One site began implementation using the same home visitor for caregivers and families but quickly found that the increased caseload was too difficult for staff to manage. After several months' effort to make this staffing model succeed, the site hired a full-time home visitor to work exclusively with pilot caregivers.

Most sites implementing the dual-home visitor model planned for caseloads of about 10 caregivers per home visitor; because enrollment has been lower than planned, some home visitors have caseloads of six or fewer caregivers. Two sites implementing this model have larger caseloads of 30 to 40 caregivers per home visitor; however, the planned intensity of home visiting services is much lower compared to the other dual-home visitor sites.

Seven sites purposely chose a single-home visitor staffing model, in which the same home visitor worked with both parents and caregivers, either as a joint home visit (if the caregiver and family lived in the same home) or during separate visits. The number of home visitors involved in the pilot in these sites ranged from two to ten. Programs chose this staffing model based on the belief that families and caregivers would be more receptive to enrolling in the pilot if they already had a relationship with the home visitor assigned to them. Staff also thought that this staffing arrangement would facilitate coordination of services and increase consistency in caregiving between parents and caregivers.

In general, home visitors in these sites were receptive to adding caregivers to their caseloads. Distributing the pilot caseload across multiple home visitors reduced the burden of additional work; some sites weighted pilot families as two cases when distributing caseloads to ensure an even workload across home visitors. In addition, some of these sites used pilot funds to hire an additional home visitor to accommodate the increased workload. Typically, each home visitor was responsible for visiting two to four caregivers.

Two sites are relying solely on their community partners to provide home visitors for the pilot. In both cases, the community partners were programs operating under the larger umbrella organization that serves as the Early Head Start grantee. For example, one site chose to collaborate with the Parents As Teachers (PAT) program administered through its grantee. This program had been providing home visiting and other services to families in the community for over a decade and seemed well-suited to play a key role in the pilot. Moreover, the Early Head Start and PAT programs shared space and had collaborated previously on another initiative.

Approaches to Supervising Pilot Staff. Most Early Head Start programs participating in the pilot provided weekly or monthly group supervision meetings with all home visitors and weekly or monthly individual supervision meetings between the supervisor and home visitor, as well as periodic reviews of services provided to individual families. In some sites, supervision also included periodic in-field observations of home visits. The amount of supervision time that focused specifically on pilot activities and services, however, varied widely across programs. In some sites, discussion of the pilot was limited to monthly staff meetings and occasional case reviews. In other sites, supervision focused on the pilot was more intensive; home visitors and supervisors met regularly, both one-on-one and as a

group, to discuss the services they were providing to caregivers. The intensity of focus on pilot activities related to programs' approaches to supervision, as described below.

Programs took several different approaches to supervising home visitors who worked on the pilot; to some extent, these decisions were driven by the approach they took to assigning home visitors to caregivers (dual, single, or community partner models). More than half of the sites assigned one supervisor to all of the program's home visitors (see Box). All seven sites using the single-home visitor model took this approach, as well as five of the sites using a dual-home visitor model. Typically, supervision of home visitors' work with caregivers was folded into the overall supervision that home visitors

Approaches to Supervising Pilot Staff	
	Number of Programs
One supervisor for all home visitors	12
Different supervisors for Early Head Start and pilot home visitors	8
Community partner supervises pilot home visitors	2
Home visitor supervisors provide pilot home visits	1
N = 23 programs	

received, and specific focus on the pilot was somewhat limited. For example, supervisors and home visitors might discuss the pilot primarily during monthly staff meetings or during occasional reviews of services provided to individual families.

Eight sites assigned different supervisors to pilot home visitors who worked with caregivers and Early Head Start home visitors who worked with families. In these sites, supervision of work on the pilot was more extensive. Supervisors and home visitors met regularly to discuss services for particular caregivers. In the two sites that used community partner staff to conduct caregiver home visits, supervision was also provided by the community partner. Finally, one site assigned the staff members who supervised the Early Head Start home visitors to serve as the pilot home visitors. These staff were highly skilled and already familiar with the pilot families.

Approaches to Coordinating Services for Parents and Caregivers. A primary goal of the pilot is to increase consistency in caregiving between parents and caregivers. To accomplish this goal, pilot sites need to ensure coordination among staff working with the family and caregiver. As stated previously, some sites are accomplishing this coordination by assigning one home visitor to work with both the parent and caregiver. In sites using a dual-home visitor model, communication and coordination is accomplished in several ways. Pilot home visitors in some sites have weekly or monthly team meetings with Early Head Start staff to keep each other informed about family needs and goals and to coordinate strategies for addressing child and family issues that arise. In other sites, home visitors share goal sheets, developmental screening results, and service plans to coordinate their work with the child, parents, and caregivers during home visits. Information sharing is often facilitated by shared office space for the Early Head Start and pilot home visitors. In at least two sites, staff have conducted joint home visits with the parents and caregivers to facilitate coordination and consistency with the child. Moreover, during site visit interviews, many

pilot home visitors in the dual-approach sites stated that they coordinate lesson plans with Early Head Start staff so that the parent and caregiver are receiving the same information and doing similar child-focused activities during the home visits.

Most of the home visitors reported that communication and coordination are working well in their programs. In about half of sites, however, pilot home visitors experienced some tension and resistance from Early Head Start home visitors during the early months of implementation. Some home visitors did not feel comfortable with having a new staff person involved with “their families.” In some cases, the roles for each home visitor and guidelines about sharing information on families were not initially clear. In most programs, tensions eased once staff discussed their concerns and clarified how they would work together on behalf of the families and children. Throughout the first year of implementation, most sites have continued developing systems for communicating effectively and coordinating their work.

In a few sites, however, coordination continues to be challenge. In one program using a community partner staffing model, questions remain about how to coordinate their work while maintaining the confidentiality of family and caregiver information. At the time of the site visit, regular cross-agency team meetings had been implemented to improve coordination of services. Staff at another reported that they were considering changing to a single-home visitor staffing model because of ongoing coordination challenges among home visitors.

Staff Qualifications

For the most part, the pilot sites have been able to draw on a highly qualified pool of people to serve as home visitors for the pilot. The majority of sites had little difficulty initially identifying and hiring qualified home visitors for the pilot. In some cases, qualified staff within the agency chose to transfer positions to work on the pilot; in other cases, qualified people from outside the agency applied and were hired for home visitor positions.

The majority of home visitors have an associate’s or bachelor’s degree in early childhood education, elementary education, child development, social work, or nursing; some are pursuing a bachelor’s or master’s degree part-time while working on the pilot. A few home visitors who do not have two- or four-year degrees have a Child Development Associate (CDA) credential. The majority of home visitors have worked in early childhood or home visiting programs, with years of experience ranging from one to eighteen years in early childhood education and one to sixteen years as home visitors. Two-thirds have prior experience working in Early Head Start or Head Start. In two of the three sites targeting a mix of relative caregivers and licensed family child care providers, at least one home visitor has experience as a licensed family child care provider herself. However, only one home visitor across all of the pilot sites reported having prior experience working with kith and kin caregivers.

During site visit interviews, program directors mentioned several characteristics they looked for when staffing the pilot. They felt that prior experience as a home visitor was

important; they also wanted staff who were flexible, persistent, and not easily flustered by what they might encounter in caregivers' homes. Some directors stressed the importance of hiring someone whom caregivers would accept as a peer, such as a grandmother or someone with life experiences similar to those of the caregiver. For example, one site chose to assign an assistant Head Start teacher to the pilot because of the skill she displayed in interacting with families at the Head Start center. Moreover, this home visitor is from the local community, a former Head Start parent herself, and adept at locating needed resources and sharing child development information in a supportive, non-threatening way.

Staff Training

A variety of pre-service and in-service trainings were offered to home visitors in preparation for work with caregivers, but the scope and intensity of training experiences received varied widely across the pilot sites (see Box). In nearly half of the sites, home visitors participated in formal training workshops for certification on PAT, WestEd's Program for Infant/Toddler Caregivers (PITC), or other curricula. In the site that targeted fathers for enrollment, staff attended a fatherhood conference and received training on several fatherhood curricula. Pilot staff at some sites, especially those who were new to Early Head Start, also shadowed the

Pilot Home Visitor Training	
	Number of Programs
Formal curricula training	10
Shadowing home visitors	6
National and state conferences	6
Early Head Start in-service trainings	10
Orientation or self-guided reading only	5
No specific training for pilot	3
N = 23 programs	
Note: Some sites provided more than one type of training.	

Early Head Start home visitors as part of their pre-service training. These experiences were often augmented by an orientation to the Enhanced Home Visiting Pilot provided by the pilot coordinator and monthly in-service trainings for all Early Head Start staff on topics such as CPR, first aid, and nutrition. In seven sites, pre-service training for pilot home visitors consisted primarily of orientation to the pilot and self-directed readings on kith and kin care. Home visitors in some of these sites, including the program that assigned supervisors as pilot home visitors, were already experienced in providing home visits to Early Head Start families.

The types of training that home visitors found most useful for their work with kith and kin caregivers varied from site to site and was somewhat dependent on the extent of their prior experience as Early Head Start home visitors and the type of training they received for the pilot. For example, in sites that included shadowing or discussions with other program home visitors, pilot staff found this aspect of their preparation to be by far the most useful; this was especially true for staff who were new to home visiting. In other sites, home visitors found training on specific curricula especially useful for solidifying their knowledge

about early childhood development so they could more effectively share this information with caregivers. In one site, pilot staff participated in several meetings with Head Start home visitors who provide services to kith and kin caregivers. Although the pilot staff were already highly experienced parent home visitors, they found the discussions on how to recruit and work with kith and kin caregivers to be especially helpful.

Home visitors identified several areas in which, in hindsight, they would have benefited from receiving more training during the pilot's first year. Across all sites, the most commonly requested training topics included language development, child health issues, behavior management strategies, the impact of prenatal drug exposure, adult literacy, conflict mediation, and availability of community resources. Some home visitors also requested more training on family child care licensing requirements. Home visitors who received minimal pre-service and in-service training were the most likely to express the need for more general training on child development and on how to work with kith and kin caregivers.

Staff Turnover

More than half of the pilot sites experienced no turnover in home visitors during their first year of implementation. Moreover, in most of the sites where home visitors left their positions, supervisors were able to hire qualified replacements with little disruption in pilot services. In three sites, however, staff turnover resulted in difficulties with implementation. For example, in one, the home visitor was fired after the first few months of implementation and temporarily replaced by another staff member who oversees another program operated by the agency. At the time of the site visit, the program still did not have a plan for permanently filling the home visitor position. Because the temporary staff person could not devote her full attention to the pilot, implementation was hampered. In another site, the original home visitor was not able to build rapport with families and caregivers. Finding a replacement for this position took several months; during this period, services for caregivers were interrupted. A third site has been plagued by staff turnover since beginning its pilot program, with several home visitors and the pilot coordinator leaving the agency during the first year. At the time of our site visit, the pilot coordinator's position had not been filled because of difficulty finding a replacement with the required experience and credentials. An interim coordinator is temporarily filling this role.

COMMUNITY PARTNERSHIPS

The Head Start Bureau required all of the sites to involve a community partner in their pilot programs, acknowledging that fully meeting the needs of kith and kin caregivers requires drawing and building upon existing expertise and resources from other community agencies. All of the sites are working with at least one community partner to provide training, resources, and services to caregivers; more than a third are working with multiple partners. In six sites, at least one partner is part of the larger umbrella agency that serves as the Early Head Start grantee. As stated previously, in two of these intra-agency partnership sites, the community partner provides all home visits and other services to caregivers.

In this section, we describe the types of community partners involved in the pilot and the services they provide to caregivers. We then describe the process Early Head Start programs used in selecting community partners and end with a discussion of the sites' success in establishing effective partnerships for the Enhanced Home Visiting Pilot.

Types of Community Partners and Services Provided

Across all 23 sites, the most common community partnership is with local child care resource and referral agencies (CCR&Rs) (see Box). Typically, these agencies collaborate with the pilot on providing group training for caregivers, either by offering training specifically for pilot caregivers or inviting them to other training workshops they offer to licensed and unlicensed child care providers in the community. In three sites, the CCR&Rs provide caregivers with access to a lending library of toys and children's books; in one site, the CCR&R operates a mobile lending library with toys and safety equipment for pilot caregivers. Several sites planned to do much of their caregiver recruitment through referrals from CCR&Rs. However, these referral arrangements did not prove fruitful because few eligible caregivers were identified. Moreover, as discussed in more detail in Chapter IV, when eligible caregivers and families were referred, they were usually placed on the Early Head Start waiting list because the program was already fully enrolled.

Community Partners Involved in the Pilot	
	Number of Programs
Child care resource and referral agency	11
Family support and home visiting programs	7
State and local child care initiatives	4
Health care providers	4
Part C providers	3
Child welfare agency	3
Even Start	3
Mental health care provider	2
County social services agency	2
Cooperative extension service	2
Public school district	2
State university	1
Public library system	1
Department of Juvenile Corrections	1
Literacy council	1
N = 23 programs	
Note: Some programs reported more than one partner.	

Family support programs comprise the second most common type of community partner. These programs provide a variety of services to families with young children, including home visits, parenting classes, play groups, and parent support groups. In three sites, the family support program is the pilot's primary partner. In most of these sites, the family support program's role is to provide play groups or cosponsor group socialization events for pilot caregivers, children, and their families. Two programs offer support groups for relative caregivers. In one site, the family support program provides all staffing and services for the pilot, including home visiting, support group trainings, socializations, and materials and equipment.

A variety of other agencies are collaborating with Early Head Start programs to provide pilot services. Three sites have developed partnerships with child welfare agencies because of the nature of the families enrolled in the pilot—for example, incarcerated teenage parents, foster parents, or kinship caregivers. In two sites, the child welfare agency’s primary role is to provide referrals for pilot enrollment and coordinate child protective services with services provided by Early Head Start. The site working with incarcerated teenage parents has also developed a strong partnership with the state’s Department of Juvenile Corrections, which provides access to the incarcerated parents, referrals for enrollment, and space at the correctional facility for pilot activities. Even Start programs typically cosponsor group socialization events with the pilot. Several other types of partners, such as local health care providers and child care organizations, provide training for the pilot; others, such as mental health care providers, Part C providers, and a literacy council, will accept referrals.

Selecting Community Partners

Selecting appropriate community partners who share a similar vision and commitment to service delivery is crucial for any program’s success. This may be especially true for an initiative like the Enhanced Home Visiting Pilot because so little is known about how to effectively deliver services to kith and kin caregivers. Building strong partnerships—defining roles and expectations and working through differences—can be a complex and time-consuming task.

Given these challenges, it is not surprising that the vast majority of pilot sites selected community partners with whom they already had relationships, either because they are part of the same umbrella organization or because they have a history of collaborating on other initiatives. For example, one site looked to the CCR&R within its umbrella organization to provide the group trainings for kith and kin caregivers, recognizing that the community partner had greater expertise in this area. Similarly, more half of the pilot sites drew on already established partnerships with other community agencies, such as Part C providers, Even Start programs, and other service providers who could accept or make referrals to the pilot.

None of the sites used a formal process for identifying and inviting community partners to be involved in the pilot; instead, a more informal process was used. In most cases the Early Head Start director contacted potential community partners about the pilot, discussed what their agencies might provide, and then included them in the grant application. Often the community partner provided a letter of commitment for the grant application but was not involved in writing it. In some cases, formal partnership agreements were drawn up specifically for the pilot; in others, the sites relied on formal partnership agreements already in place with the Early Head Start or Head Start program. During site visit interviews, one program director expressed regret that a more formal process for identifying and inviting community partners to participate in the pilot was not followed, because the CCR&R was not involved in the pilot’s first year. However, during early implementation this site became aware of the need to include the CCR&R and planned to do so in the pilot’s second year.

In most cases, community partners were identified for the pilot before the grant application was submitted. In at least two sites, however, new partnerships have been forged with community agencies because of program needs that emerged during the first year of implementation. For example, one site had initially planned to provide all of the support group trainings for caregivers in-house, using Early Head Start staff and occasional outside speakers to cover various topics. After seven months of low caregiver attendance, the site decided to solicit help from the local CCR&R, which had been implementing kith and kin caregiver support groups since 1999. The two agencies have since drawn up a partnership agreement outlining how they will provide support groups for pilot caregivers, with specific strategies for caregiver outreach, incentives for attendance, and plans for caregiver transportation and child care.

Strength of the Community Partnerships

The Enhanced Home Visiting Pilot sites faced a major task of forging new partnerships or reworking prior partnerships within a short period of time to provide services to kith and kin caregivers. Initially, some sites may have been more primed than others to establish strong partnerships, so we would expect variation in the successes achieved in collaborating and integrating services with other community agencies. There are several ways of assessing the strength of community partnerships in the Enhanced Home Visiting Pilot. One method is to rely directly on assessments made by the Early Head Start program directors and community partner staff themselves. Based on these criteria, 18 out of the 22 sites considered their partnerships to be going well by the end of the pilot's first year.

Another method is to look more closely at various criteria that suggest a strong partnership is in place. To assess the strength of the pilot sites' partnerships, we reviewed all partnership information provided during interviews with the program director and community partners for evidence that the partnerships met four key criteria: (1) a history of collaboration (2) involvement in the design process (3) formal partnership agreements, and (4) active involvement in implementation, including evidence of effective communication and coordination. Based on this information we classified the partnerships as follows:

- **Strong partnerships.** At least one community partner is actively involved in pilot implementation, has a formal partnership agreement with the pilot or was involved in the pilot's design, and has a history of collaboration with Early Head Start or is part of the same umbrella organization.
- **Evolving partnerships.** At least one partnership meets one of the three criteria for a strong partnership, and the site had clear plans for strengthening existing partnerships or adding new partners in the coming year.
- **Limited partnerships.** Community partners are not actively involved in pilot implementation, do not have formal partnership agreements with the pilot and were not involved in the design process, and have no history of collaboration or are not part of the same umbrella organization.

Based on these criteria, more than two-thirds of the sites were classified as having strong or evolving partnerships (see Box). Sites with strong partnerships had a shared vision and clearly defined roles from the start of implementation, or they were able to define their vision and roles early on in the pilot's first year. For example, one site chose to collaborate with the CCR&R in its community. The two agencies had a long-standing history of collaboration on various Head Start-child care initiatives and saw the pilot as an opportunity to continue working together to improve child care quality. The two organizations

developed the grant proposal together and secured state funding to purchase a van for a mobile lending library. While the partnership experienced some delays in implementation, by early 2005 they began scheduling home visits with pilot caregivers to do home safety checks, providing health and safety information, and arranging for caregivers to receive health and safety equipment.

Strength of Community Partnerships Established for the Pilot	
	Number of Programs
Strong partnerships	8
Evolving partnerships	8
Limited partnerships	7
N = 23 programs	

Sites with evolving partnerships represent a more varied group, but are all defined by efforts to strengthen existing partnerships or disband ineffective partnerships and develop new ones. One example is a partnership with a child welfare agency. Initially, all necessary ingredients appeared to be in place—a history of collaboration and clearly defined roles that emerged from prior joint efforts to serve to families. When the grant announcement was released, the two agency directors agreed to expand their current collaboration. Once the pilot began, the site experienced difficulty in gaining full cooperation from child welfare agency staff. However, Early Head Start staff have been proactive in nurturing relationships with child welfare staff, and the situation has improved. Some differences in program vision have not yet been fully addressed, but pilot staff are continuing efforts to make the partnership work.

Sites with limited partnerships had far less success in working through the challenges of commitment and coordination, and in most cases the partners have never been actively involved in pilot implementation. For example, one pilot site formed a partnership with the local CCR&R, primarily to provide training and refer caregivers to the pilot. To all involved, the partnership seemed like a good fit. The two organizations had worked together in the past, and the CCR&R was involved in discussions during the pilot design phase. At the time of the site visit, however, this partnership had not yielded referrals to the pilot and plans for group trainings had not gotten off the ground.

In this chapter, we have described the critical steps taken by the Early Head Start programs in developing their Enhanced Home Visiting Pilots—including the goals they hoped to achieve, the target populations they identified, the design processes they followed, the staffing structures they put in place, and the community partnerships they forged to provide pilot services. In the next chapter, we describe the characteristics of the families, children, and caregivers who have actually enrolled in the pilot.

CHAPTER III

CHARACTERISTICS OF CHILDREN, FAMILIES, AND CAREGIVERS

Kith and kin care represents as much as half of all child care arrangements used by working parents with children under age 5 (Brown-Lyons et al. 2001). While families at all income levels rely on kith and kin care to some degree, low-income families do so heavily (Ehrle et al. 2001; Casper 1997). Most kith and kin caregivers are related to children they care for, but their ages and education levels vary widely (Anderson et al. 2003). Given the large proportion of families that use kith and kin child care, understanding the characteristics of these families and their caregivers is an important precursor to developing effective outreach strategies and identifying the mix of services they need.

In this chapter, we describe the characteristics and needs of families and caregivers participating in the Enhanced Home Visiting Pilot Project, as well as the kith and kin child care arrangements themselves. We begin by describing the children and parents enrolled in the pilot and the families' child care needs. We then explore the characteristics of enrolled caregivers, their training and support needs, their interest in becoming licensed, and their experiences as caregivers. We end with a description of the child care arrangements that are the subject of the pilot. The information presented in this chapter comes primarily from the program recordkeeping system developed for the evaluation (described in Chapter I), focus groups with parents and caregivers, and, to a lesser extent, site visit interviews with pilot staff.

CHARACTERISTICS OF PILOT FAMILIES AND CHILDREN

To be eligible for the pilot, families must be enrolled in home-based Early Head Start and be using kith and kin care. Consequently, all the pilot families have incomes below poverty and at least one child under age 3. In this section, we describe in detail the Early Head Start families enrolled in the pilot, including their demographic characteristics, their child care needs, and their reasons for using kith and kin child care.

Demographic Characteristics of Children and Families

Preliminary data on characteristics of children in the pilot indicates that children were 17 months old, on average, when their families enrolled; nearly one-third were 24 months old or older (Table III.1).¹ Nearly two-thirds were white, a considerably higher proportion compared with the total population of Head Start children, which is only 27 percent white (Head Start Bureau 2005). This difference in the racial makeup of the pilot and Head Start caseloads may be due in part to the demographic characteristics both of the communities in which pilot sites are located and of the families in these sites that are enrolled in the home-based option.

All Head Start and Early Head Start programs must reserve at least 10 percent of enrollment slots for children with disabilities, but the Head Start national average is actually 13 percent (Head Start Bureau 2005). The percentage in pilot programs is even higher: 16 percent of children have a suspected or identified disability or delay. This could reflect difficulties families have finding regulated child care for children with disabilities or parents' desire to place such vulnerable children in the care of a trusted relative or friend. Of those children with a disability or delay, more than half have a speech delay; the others have a range of diagnoses. Almost all (94 percent) have been referred for early intervention services, and 70 percent have been enrolled in early intervention. The difference between the proportion referred and the proportion enrolled probably reflects the time lag between referral, assessment, and enrollment for services.

In nearly 90 percent of the pilot families, the Early Head Start child's primary caregiver was a parent or stepparent (Table III.2) and 5 percent were grandparents. Another 5 percent were nonrelatives, either foster parents or other legal guardians. On average, primary caregivers were 26 years old when they enrolled in Early Head Start; 22 percent were teen parents. Less than half were married or living with a "significant other." As with the children, a large proportion (more than 70 percent) of primary caregivers were white. Ten percent spoke Spanish as their primary language, and 2 percent spoke a language other than English or Spanish. Of those caregivers whose primary language was a language other than English, 6 percent did not speak English well or did not speak English at all.

At the time of pilot enrollment, more than half the primary caregivers were employed either full- or part-time; another 9 percent were looking for work. Nearly 14 percent were in school or training. In terms of education, almost three-quarters had a GED, a high school diploma, or a higher degree.

¹ As noted in Chapter I, the program record-keeping data presented in this report are based on data extracts from 22 of the 23 pilot sites. One pilot site had not yet enrolled any families or caregivers in the pilot as of December 2005.

Table III.1. Demographic Characteristics of Children Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Children
Child's Age at Enrollment in Early Head Start	
0 to 11 months	46
12 to 23 months	22
24 months or older	18
Child's Age at Enrollment in the Enhanced Home Visiting Pilot	
0 to 11 months	33
12 to 23 months	30
24 months or older	32
Child's Gender	
Female	49
Male	51
Child's Race	
American Indian or Alaskan Native	5
Asian	2
Black or African American	11
Hispanic or Latino	17
Native Hawaiian or Other Pacific Islander	<1
White	65
Child Has a Suspected or Identified Disability or Delay	16
Of Those with a Disability, Category of Disability or Developmental Delay	
Visual impairment	2
Hearing impairment	2
Orthopedic	9
Speech	48
Mental retardation	2
Emotional-behavioral	2
Learning disability	6
Autism	3
Other disability	27
Child has been referred to early intervention services	94
Child is enrolled in early intervention services	70

Source: Enhanced Home Visiting Recordkeeping System. Missing data range from 0 to 42 across items.

Note: N = 423.

Table III.2. Demographic Characteristics of Primary Caregivers for Children Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Primary Caregivers
Primary Caregiver's Age at Enrollment in Early Head Start	
Under age 20	22
20 to 29	55
30 to 39	15
40 or over	9
Primary Caregiver's Relationship to the Child	
Parent or stepparent	89
Grandparent	5
Other relative	1
Other nonrelative	5
Primary Caregiver's Gender	
Female	95
Male	5
Primary Caregiver's Marital Status	
Single	43
Married	36
Living with significant other	14
Separated	2
Divorced	5
Widowed	1
Primary Caregiver's Race	
American Indian or Alaskan Native	4
Asian	2
Black or African American	7
Hispanic or Latino	14
Native Hawaiian or Other Pacific Islander	<1
White	73
Primary Language Spoken at Home	
English	89
Spanish	10
Other	2
Primary Caregiver's Occupational Status	
Employed full time	29
Employed part time	25
In school, high school, or GED	8
Trade or business school	<1
In college	5
In graduate school	<1
Looking for work	9

Table III.2 (continued)

	Percentage of Primary Caregivers
Retired	<1
Homemaker	19
Disabled	2
Other	2
Primary Caregiver's Highest Level of Education	
Less than high school	10
Some high school	20
High school diploma/GED	46
Some college	18
Two-year college degree	5
Four-year college degree	2
Primary caregiver's reason for accessing child care	
Employment	41
Training/education	13
Both employment and training/education	9
Respite	12
Other	24

Source: Enhanced Home Visiting Recordkeeping System. Missing records range from 26 to 59 across all items except primary caregiver's age. For this item, 122 records are missing.

Note: N = 423.

Families' Child Care Needs and Access to Care

According to program recordkeeping system data, nearly two-thirds of the primary caregivers were using kith and kin child care so they could work, attend school, or both (Table III.2). Another 12 percent cited respite as their primary reason. Early Head Start families may use kith and kin care simply because they lack access to regulated child care. Research shows that the supply of regulated infant-toddler care is limited in many communities, especially for low-income families (Paulsell et al. 2003). To understand better the potential constraints on parents' child care choices in the pilot communities, during site visits we asked pilot and community partner staff about the availability of regulated infant-toddler child care in their communities.

Supply of Regulated Infant-Toddler Care. In all but two of the pilot sites, staff reported that the supply of licensed infant-toddler child care was low, especially for low-income families. In some of the rural sites, staff reported that only one child care center in the entire county accepted infants and toddlers; many others reported long waiting lists. For example, in one site, the program director described the supply of child care in the community as "a real mess," adding that Early Head Start had hundreds of children on its waiting list. Staff in another small community, which has only three child care centers, reported a two-year wait for infant-toddler care. Similarly, staff in another site estimated that licensed child care slots met only 25 to 30 percent of the demand for care in their community. Moreover, consistent with national patterns, pilot staff also reported that the supply of center-based care available during nontraditional hours was very limited (Ross and Paulsell 1998). Transportation posed a further barrier to accessing child care for some pilot families. And in many sites, staff cited the high cost of providing infant-toddler care, partially as a result of the low child-staff ratios required by licensing regulations, as one reason for the limited supply.

One urban site was an exception to the overall pattern of limited supply. In this site, the program director reported that there are two infant-toddler slots available in the community for every child who needs care. Furthermore, staff explained that there had been an "explosion" of child care slots available in the past five years. Staff speculated that the reason for this increase was greater demand, coupled with the relative ease and low cost of becoming a licensed provider in the state, since there are few regulatory requirements for family child care providers.

Cost of Infant-Toddler Child Care. The high cost of regulated infant-toddler child care was another barrier for the families in the pilot communities. For example, staff reported that the cost of licensed infant-toddler care in one rural site averaged \$100 to \$125 per week; in other site, staff reported a cost of nearly \$700 a month.

Overall, pilot staff reported that families' access to child care subsidies was also limited. In some communities, waiting lists for child care subsidies existed. In addition, most states required parents to work full-time to be eligible for a subsidy; according to program recordkeeping data, only a third of parents enrolled in the pilot met this criterion. Parents who worked part-time or were in school may not have been eligible. For example, staff in

one site reported that recent cuts in subsidies resulted in eligibility limits that precluded teen parents attending school from being eligible. Similarly, parents attending college or, in another site, parents working less than 30 hours per week were not eligible. In a few sites, staff reported that some pilot families, because of their immigration status, were not eligible for subsidies.

Even when parents obtained a child care subsidy, pilot staff said that some families, as a result of illness, irregular work attendance, job loss, or reductions in work hours, had difficulty sustaining their eligibility. One site explained that formal centers are usually not flexible enough to deal with frequent disruptions in service. In addition to losing their subsidies, some pilots reported that required copayments were sometimes too high for parents to afford.

Parents' Reasons for Using Kith and Kin Child Care

During site visit focus groups, we asked parents why they decided to use kith and kin child care and whether they had considered other arrangements. Parents discussed a variety of reasons for using their kith and kin caregiver—such as trust, convenience, low cost, and shared culture and values—that are consistent with prior research on parents' child care decisions (Emlen 1999; Larner and Phillips 1994; Mitchell, Cooperstein, and Larner 1992; Porter 1991) (see Box). Few parents said they had considered other arrangements; however, as discussed in the previous section, families enrolled in the pilot may not have had access to other child care options.

In more than half the sites, at least one parent reported using kith and kin child care because the caregiver was available; these parents felt that the caregiver was the “natural choice” for them. In many families, the kith and kin caregiver was living in the same household as the parent and child or had been helping to care for the child since birth (see Box). Trust was also mentioned by at least one parent in more than half the sites. Some parents expressed general distrust of child care centers and strangers, and said that for this reason they preferred relatives, especially their own mothers, to care for their infants and toddlers. Convenience was also a factor for parents in deciding to use kith and kin care, especially when the caregiver and parent lived in the same home.

Parents' Reasons for Using Kith and Kin Child Care

	Number of Programs
Availability	12
Trust	12
Low or no cost	4
Convenience	3
Wanted child to be with grandparent	2
Shared culture	1

N = Parent focus groups conducted in 20 programs

Parent Quotes on Reasons for Using Kith and Kin Child Care

Availability

“I used to live with my parents, and my grandma lived in the same house. So she started taking care of [my daughter], and when we moved, she continued to take care of her. I had to go back to work right after my daughter was born. Because I'm a single parent, I needed someone. She just volunteered to help out.”

Trust

“I don't trust too many people with my kids. The only people I trust are my mom or his mom, or my sister. She's good with kids, too. But I prefer my mom.”

“With this arrangement, I can just go to work and come home and there are no pick-ups,” explained one parent. Other parents needed only part-time care or care during nonstandard hours or shifting schedules; in these situations, relatives were much more flexible than regulated child care providers. In one family, the mother and the caregiver (the mother’s sister) shared caregiving so that the mother could work part-time during the day and the sister could work evening shifts at a fast food restaurant. In four sites, parents reported that they sought out an unrelated family child care provider because they did not have family or friends available to care for their child or because they wanted their children to socialize with other children while in care.

CHARACTERISTICS OF KITH AND KIN CAREGIVERS

To be eligible for the pilot, caregivers must be providing care for at least one child enrolled in Early Head Start; there are no other requirements. Across the pilot sites, the caregivers enrolled in the pilot are quite diverse, both in terms of their relationships to the children and their demographic characteristics. In this section, we describe the caregivers in detail, including their demographic characteristics, their strengths and caregiving challenges, their training and support needs, and their interest in becoming licensed.

Demographic Characteristics of Kith and Kin Caregivers

Data on characteristics of kith and kin caregivers enrolled in the pilot indicates that more than half are the children’s grandparents (Table III.3). Another 21 percent are relatives, including nonresidential parents, residential fathers, aunts, and uncles. About 26 percent of the caregivers are not related to the children; they are family friends, neighbors, foster parents, or family child care providers with no prior relationship to the family.

The average age of the caregivers is 43—three-quarters are 30 to 59 years old. Ten percent are 60 or older and 1 percent of the caregivers are 70 or older. Over 80 percent are women, almost two-thirds are married or living with a “significant other,” and like the pilot parents and children, most of these caregivers are white. Also, English is not the primary language for 12 percent of the caregivers. More than 7 percent do not speak English well or at all. Their education levels also vary widely. About one-third have some college experience, slightly more than one-third have a high school degree or GED, and nearly one-third have less than a high school education.

Most caregivers have some experience caring for young children. More than 80 percent have at least one year of experience. In addition, one-third have attended at least one training workshop on child development, and one-third have experience working in a child care or Head Start program. Twelve percent are licensed or registered child care providers; another 7 percent have another type of license, most likely as a foster care parent.

Table III.3. Demographic Characteristics of Caregivers Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Caregivers
Caregiver's Relationship to the Early Head Start Child	
Nonresidential parent	2
Residential father ^a	5
Grandparent	54
Aunt/uncle	9
Other relative	5
Family friend	8
Neighbor	2
Other relationship	6
No prior relationship	10
Caregiver's Age at Enrollment in Enhanced Home Visiting	
Under age 20	2
20 to 29	14
30 to 39	20
40 or 49	36
50 to 59	18
60 to 69	9
70 or older	1
Caregiver's Gender	
Female	83
Male	17
Caregiver's Marital Status	
Single	22
Married	55
Living with significant other	7
Separated	2
Divorced	9
Widowed	4
Caregiver's Race	
American Indian or Alaskan Native	4
Asian	2
Black or African American	7
Hispanic or Latino	13
Native Hawaiian or Other Pacific Islander	0
White	75
Primary Language Spoken at Caregiver's Home	
English	88
Spanish	10
Other	2
Primary Caregiver's Highest Level of Education	
Less than high school	7
Some high school	22
High school diploma/GED	39
Some college	18
Two-year college degree	7
Four-year college degree	5
Some graduate school	1

Table III.3 (continued)

	Percentage of Caregivers
Caregiver Has Education or Training in Child Development	31
Caregiver Has Experience Working in a Child Care Program	24
Caregiver's Years of Experience Caring for Other People's Children	
Less than 1	19
1 to 3	24
4 to 6	18
7 to 10	10
More than 10	30
Caregiver's Licensing Status	
Licensed family child care home	6
Registered home child care provider	6
Exempt from licensing or registration	44
Other licensing status	7
Licensing status unknown	38
Total Hours of Care Provided for Pilot Child in a Typical Week	
1 to 10	24
11 to 20	20
21 to 30	15
31 to 40	14
More than 40	27
Caregiver Has a Regular Assistant	39
Assistant's Gender	
Female	50
Male	50
Assistant's Age	
17 or younger	10
18 to 60	80
Over 60	8
Assistant's Relationship to Caregiver	
Spouse/significant other	48
Assistant's own child	16
Paid assistant	5
Other relative	28
Other nonrelative	2

Source: Enhanced Home Visiting Recordkeeping System. Missing records range from 13 to 75 across all items except caregiver's age at enrollment. For that item, 158 records are missing.

Note: N = 394.

^aOne pilot program served both nonresidential and residential fathers. The caregivers in this category represent the residential fathers served by this program.

Three-fourths care for children for more than 10 hours a week, and more than half do so for more than 20 hours a week. More than one-third have a regular assistant who helps them provide care. Most are between the ages of 18 and 60, and half are male. More than 90 percent are relatives of the caregiver, such as a spouse or child.

Caregiver Strengths

During site visit interviews, we asked pilot staff about their views on the strengths of the caregivers they serve through the pilot. Overwhelmingly, staff thought that the most significant strengths were the love and affection the caregivers, especially the grandparents, demonstrate toward the children. For example, one home visitor said about a particular caregiver, “The sun rises and sets on her grandbaby.”

Another strength noted by pilot staff in many sites was the caregivers’ willingness to learn from the home visitor about the child’s development and new approaches to childrearing and behavior management (see Box). Some home visitors also noted that many grandparents were eager for a “refresher course” in childrearing, since many had not cared for an infant or toddler in many years. Caregivers typically sought help with such issues as managing difficult behaviors, temper tantrums, toilet training, and sleeping and eating habits.

Quotes from Pilot Staff About Caregivers’ Strengths

“The grandmothers let us in their home to benefit their grandchild. They know it is going to benefit the child developmentally and educationally to let us in, and they are willing to participate and do the activities. . . . They get down on the floor and do it with [the child and home visitor]. The willingness and the enthusiasm that they show towards their grandchild is amazing.”

Finally, some pilot staff cited as a significant strength the caregivers’ very willingness to help the parent with child care. Many of the caregivers were able to provide care during flexible and nonstandard working hours, even on weekends and sometimes overnight. Few parents could have found a regulated child care provider willing to provide such flexibility.

Caregiver Challenges and Needs for Training and Support

During focus groups, we asked caregivers about the challenges they faced in caring for the Early Head Start children. Many cited managing children’s behavior, as well as a range of issues related to toddlers, such as temper tantrums, children hitting one another, toilet training, and “picky” eating habits. Older caregivers spoke about feeling overwhelmed at times; some said they had a hard time “keeping up” with the children. A few also said that caring for children with special needs was challenging (see Box next page).

Another challenge discussed during caregiver focus groups was inconsistency or disagreement between caregivers and parents about how to handle different types of child behavior. Especially for caregivers, allowing the parents to take the lead in decisions about various behavior management issues and not undercutting their authority as parents was difficult. As one grandmother put it, “You are the grandmother and they are the parent, period.” This situation was sometimes exacerbated when the parents were teenagers; some

felt they had two sets of children to raise and expressed some resentment about the situation (see Box).

Caregivers' Training and Support Needs. During site visits, we also asked pilot staff about their views on the types of training and support caregivers need. Most cited the need for information on child development, behavior management, and home safety. Especially for older caregivers, pilot home visitors cited the need for "updated" information about childrearing practices and behavior management; strategies considered acceptable by a previous generation are no longer considered developmentally-appropriate.

Pilot staff also cited emotional support as another pressing need of many caregivers. They explained that some caregivers are isolated and just need someone to talk to about the challenges they face. In one site that targets foster parents as caregivers, staff said that many caregivers need extra support to cope with their frustrations related to the child welfare system. Other home visitors said that many caregivers have poor self-esteem and do not receive sufficient recognition for the work they do in caring for the children.

Home visitors also said that many caregivers need developmentally-appropriate equipment and materials, such as child-sized furniture, toys, and books. Often they also need health and safety equipment, such as first aid kits and materials for childproofing their residences. In sites that sought to address caregivers' personal needs, home visitors cited financial support, transportation, housing, employment, and mental health services.

Caregivers' Interest in Becoming Licensed Child Care Providers

Across all the pilot sites, few unregulated kith and kin caregivers expressed interest in becoming licensed. Their reasons varied, but most viewed themselves not as "child care providers," but simply as grandparents caring for their own families. Many cared for only one or two children and were not interested in caring for children outside the family. According to home visitors, some caregivers had too many other commitments, such as employment outside the home, in addition to caregiving duties, to work on meeting licensing requirements. Some had health problems that precluded their viewing child care as a potential career option. Despite an overall lack of interest, at least one caregiver in more than half the sites expressed some interest in licensing; services provided to help these caregivers with the licensing process are described in Chapter IV.

In addition to lack of interest, pilot staff said that many caregivers faced significant barriers to meeting licensing requirements. In some cases, caregivers or others living in their

Caregiver Quotes About the Challenges They Face

Caring for a Child with Special Needs

"He's two and a half, and there are certain things that you expect a two-and-a-half-year-old to do, but he's not there yet. . . . That's hard because you think he should be able to do it but he can't. . . . That's my hardest thing, being patient with him."

Caring for the Child of a Teen Parent

"I thought it was kind of unfair because, I mean I love my grandson right to pieces, and I wouldn't change him for the world. But I told [the home visitor], 'I didn't make him. I didn't ask for that extra financial responsibility. I have four kids of my own that I have to support.'"

homes had criminal records that would bar them from becoming licensed. In other cases, caregivers' homes were too small or would need extensive repair work to meet health and safety codes. For example, one caregiver initially expressed interest in licensing; however, her home was located on a busy street and did not have a fence. At the time of the site visit, the home visitor was searching for resources in the community for building the fence she would need to meet licensing standards, as the caregiver could not afford to pay for a fence on her own. Finally, immigration status prevented a few caregivers from pursuing licensing.

CHILD CARE ARRANGEMENTS

This section describes in detail the kith and kin child care arrangements that are the subject of the pilot. We provide information about hours and location of care, typical schedules and activities, and parents' views on the arrangements.

Characteristics of the Child Care Arrangements

According to preliminary program recordkeeping data, more than half the Early Head Start children are in the kith and kin child care setting for at least 20 hours a week (Table III.4). More than a quarter are in care for more than 40 hours a week. In nearly 80 percent of the arrangements, care is usually provided during weekday daytime hours. In the other 20 percent, care is provided primarily during the evening or early morning or on weekends. Less than 1 percent of programs reported arrangements in which care is provided primarily overnight, but in focus groups, caregivers reported sometimes providing overnight care. In nearly 80 percent of these arrangements, care is provided in the caregiver's home; in 15 percent, the child and caregiver already live in the same home. In another 16 percent, care is provided primarily in the child's home. About one-third of the caregivers receive compensation for this child care arrangement; only 13 percent receive a subsidy.

Pilot staff also recorded parents' reasons for using this particular arrangement for their young child. Responses are similar to reasons for using kith and kin care discussed by parents in focus groups (presented earlier in this chapter). Nearly 60 percent reported using the arrangement because they trusted the caregiver, and another 18 percent used the arrangement because the caregiver was a relative.

Typical Activities During Care

In the focus groups, caregivers described a variety of activities they do with the children. In general, most mentioned routine care activities, such as making meals and bathing and dressing the child. Other commonly discussed activities were playing, reading, going outside to play or for walks, and letting the child watch television. In terms of schedules, family care providers caring for multiple children tended to describe set schedules of routine care and play activities they followed with the children every day. In contrast, relatives did not tend to schedule structured activities beyond sleeping and eating. While they engaged the children in many of the same activities as family child care providers, their days were less

Table III.4. Characteristics of Care Arrangements Covered by the Enhanced Home Visiting Pilot

	Percentage of Arrangements
Number of Hours Child Is in Care During a Typical Week	
1 to 10	27
11 to 20	19
21 to 30	12
31 to 40	12
More than 40	30
Times When Caregiver Regularly Cares for the Child	
Weekday daytime	79
Early mornings	4
Evenings	16
Weekends	1
Overnight	<1
Location Where Care Is Provided	
Caregiver's home	64
Child's home	16
Both child's and caregiver's home	15
Multiple locations	5
Primary Caregiver Receives Compensation for Providing Care	29
Primary Caregiver Receives a Child Care Subsidy for this Child	13
Parent's Primary Reason for Using this Arrangement	
Trust in the caregiver	59
Flexible hours	6
Affordability	3
Individual attention, child-to-adult ratio	1
Shared language/cultural values	1
Caregiver is a relative	18
Other	12

Source: Enhanced Home Visiting Recordkeeping System. The number of missing records ranges from 38 to 49 across all items except caregiver compensation. For that item, 102 records are missing.

Note: N = 435.

structured (see Box). Some caregivers who provide care on a more erratic basis said they could not describe a typical day, because it varied so much. Nevertheless, they also talked about providing routine care such as feeding, dressing, bathing, and generally “filling in” for the parent when needed.

Finally, several caregivers described doing shifts of caregiving either before or after their work shifts outside the home. For example, one grandmother described how her daughter and grandson meet her at work. She then takes her grandson back to her home, feeds him, plays outside, recites letters and numbers, and then gets him ready for bed.

Parents’ Views on Their Child Care Arrangements

Across the sites we visited, most parents reported overall satisfaction with their kin and kin child care arrangements; few mentioned things they disliked or changes they would make. This finding is consistent with prior research on parent satisfaction with child care; parents typically say they are satisfied with the arrangements they use, perhaps because they feel they are using the best arrangement available to them given the constraints they face (Emlen 1999; Phillips 1995). In the rest of this section, we describe aspects of the arrangements that parents said they liked and disliked.

Aspects of Care Arrangements that Parents Liked.

Many aspects of child care arrangements that parents liked reflect their reasons for choosing the arrangements in the first place. For example, trust was a major reason that parents chose their caregivers, and it is the most commonly cited aspect of the arrangement that parents like (see Box). Parents feel that they can trust their caregivers to take good care of their children, and that their children are safe with the caregivers. Many parents emphasized that they feel particularly safe leaving their child with a family member. One parent explained, “The safety factor, that we know our child’s going to be safe. In today’s society, any place that they’re safe is a good place. We trust family.”

Caregivers’ Descriptions of a Typical Day

Family Child Care Provider

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

Grandmother

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

Aspects of Care Arrangements That Parents Liked

Trust
 Caregiver’s love for the child
 Child familiar with caregiver
 Shared family culture
 Consistency with parent’s rules and routines
 Reliability
 Convenience
 Child is learning

Parents also liked how much the caregivers love their children. One parent noted, “[The caregiver] is a big part of [my daughter’s] life. She’s good with her. She reads to her, pays attention to her; you can tell that she likes being with her.” Similarly, parents said they liked the bond that the caregivers had with the children. For example, one parent said, “[My daughter] is so familiar with her [caregiver] that they even have their own kind of language. They understand each other, and they’re really good together.”

Other parents said that they liked the fact that their relative caregiver was familiar with the child’s needs and the values parents wanted to pass on to the child. One mom explained, “Some babysitters don’t stay in contact unless you need them that day. My mom, I talk to her every day. I tell her if the baby’s not feeling good. . . . She knows the whole situation.” A father also explained that in his house the parents and grandparents support each other’s rules. He noted, “They know how I stand on things, ’cause we live right with them. If I tell ’em no, my parents don’t go behind my back, and if they tell ’em no, it goes the same way. They know what they’re allowed to do, and what they’re not allowed to do.”

Several of the parents across sites mentioned that they like how reliable and flexible their caregiver is and appreciate the caregiver’s willingness to pitch in when needed or adapt to schedule changes. One parent explained, “I think I am blessed to have my mom help me. You don’t have a lot of absences from work, because even if [the baby] is sick, my mom will still take him. She is very reliable.”

A few of the parents said they liked the fact that their child learns a lot with the caregiver. As one mom put it, “With my provider, the first impression I had of her is that she had a schedule and it wasn’t TV. . . . They have learned so many songs, my kids know their colors, they do flash cards. They have really learned a lot with her. She is just like having preschool every single day. . . . She does a lot of educational activities. I have been so blessed. She is wonderful. . . . She really does a very good job.” Parents also appreciate that the caregiver helps their child reach developmental goals such as toilet training, walking, and crawling.

Aspects of Care Arrangements that Parents Would Change. Very few of the parents mentioned aspects of the child care arrangement they would like to change. In fact, in several focus groups, the parents all said they would make no changes. Nevertheless, a few said they would like the caregiver to use behavior management strategies and limits that are consistent with those established by the parent. A few felt that their caregiver was too permissive with—and thus “spoiling”—the child.

In addition, a few parents said they would like their caregiver to be more available, particularly on evenings and weekends. For example, one mom expressed her frustration with the fact that her caregiver is pregnant and has reduced the hours she is available to care for the child. She would prefer to have a caregiver who is available during nonstandard hours, since her job requires her to work odd hours and weekends. She would also like to use one caregiver rather than different caregivers for weekday and weekend care.

A few parents also raised concerns about the caregiver’s age and physical ability to provide good-quality care. For example, one mother said about her caregiver, “She already raised us all and she’s tired. It will be better for our relationship if she doesn’t do this

anymore.” Furthermore, a few parents were concerned that their child was watching too much television with the caregiver. “But that’s all they do is watch TV all the time. I always tell them they need to do more,” explained one parent.

CHAPTER IV

DELIVERY OF SERVICES DURING THE FIRST YEAR OF IMPLEMENTATION

In Chapter II, we discussed the services the Enhanced Home Visitor Pilot programs initially planned to provide. In this chapter, we discuss the services that were actually provided by programs during the first year of pilot implementation. Overall, the pilot programs made significant progress in carrying out their plans for working with kith and kin caregivers. By the end of the first year, 22 of the 23 programs we visited had enrolled kith and kin caregivers in the pilot and had implemented most of the services they set out to provide. Programs have also faced some challenges, such as difficulties recruiting participants and low attendance at group activities. However, many reported developing new ideas and approaches to address these challenges.

This chapter provides a detailed description of the services offered to caregivers, including their intensity, format, and content. We begin the chapter with a discussion of strategies used to recruit and enroll families and caregivers into the pilot. Next, we discuss the services offered through the pilot—including home visits, group activities, and provision of materials and equipment. We also explore the strategies programs used to strengthen relationships between caregivers, parents, and staff. Throughout the chapter, we highlight the differences in service provision that stem from variation in staffing structures and other differences across programs. We conclude the chapter by discussing caregivers' and families' satisfaction with the services they have received through the pilot and their recommendations for improvement.

RECRUITMENT

During site visit interviews, program staff described a three-stage process of recruitment for the pilot: (1) identifying eligible families, (2) recruiting interested families, and (3) recruiting and enrolling kith and kin caregivers. In this section, we discuss these three stages of recruitment as well as the parents' and caregivers' motivations for enrolling in the pilot.

As described in more detail in Chapter V, all 22 pilot sites we visited had difficulty recruiting sufficient numbers of families and caregivers. Although program staff envisaged some recruitment challenges, in many sites the challenges were more difficult to overcome

than they anticipated. For example, programs expected some turnover in caregivers, but they did not expect to have difficulty identifying sufficient numbers of families that use kith and kin caregivers and were willing to participate. During site visit interviews, program staff described changes they made to the recruitment process based on these early experiences and the strategies they found to be most effective. We note these throughout the section.

Strategies for Identifying Eligible Families

To be eligible for the pilot, families must be enrolled in the Early Head Start home-based option and use kith and kin child care. For all programs, therefore, the first step for recruitment was to inform home-based families about the pilot and identify which ones used kith and kin caregivers. Programs used five main strategies to identify eligible families: (1) soliciting referrals from Early Head Start staff, (2) developing outreach materials and advertising the pilot, (3) identifying eligible families at Early Head Start enrollment, (4) soliciting referrals from community partners, and (5) soliciting referrals from kith and kin caregivers (see Box).

In nearly all programs, Early Head Start staff, especially home visitors, identified eligible families in their caseloads and referred them to the pilot. Many home visitors were familiar with the child care arrangements of families in their caseloads; others asked families about their use of kith and kin care during regular visits. In some programs, center-based staff also identified and referred pilot-eligible families when they knew the families and were aware of their child care arrangements.

During site visit interviews, programs reported that having Early Head Start staff identify eligible families was the most successful recruitment strategy. Program directors stressed the importance of making sure that all staff understood the pilot and its goals and “bought into” its benefits for children and families. Once this was accomplished, staff were more likely to identify and refer eligible families.

Almost half of the pilot programs also developed and distributed outreach materials such as brochures and posters to advertise the pilot. Staff displayed posters in Early Head Start centers and distributed brochures at socialization events and Policy Council and parent meetings to raise families’ awareness of the pilot. Programs also mailed letters to Early Head Start families describing the pilot and encouraging them to contact pilot staff to enroll. In addition, pilot staff made presentations about the pilot at Policy Council and parent meetings and other program events to encourage enrollment.

Strategies for Identifying Eligible Families	
	Number of Programs
Referrals from Early Head Start staff	20
Advertisement/outreach materials	10
Identification at Early Head Start enrollment	9
Referrals from community partners	7
Referrals from caregivers	3
N = 22 programs	
Note: Some programs used more than one strategy.	

These two primary strategies—soliciting referrals from staff and advertising among program families—proved to be useful first steps in identifying potential enrollees. In many programs, however, these strategies did not yield sufficient numbers of families to meet enrollment targets, either because families using kith and kin care had left the program, families no longer needed child care, fewer families than expected had stable kith and kin arrangements, or some families and caregivers were reluctant to enroll.

In response, programs developed strategies for identifying potentially eligible families beyond those already enrolled in Early Head Start. For example, nine programs began identifying families using kith and kin care during the Early Head Start enrollment process, either by adding new sections about child care use to enrollment forms or by asking families about their child care arrangements. Others contacted families on their waiting list to determine which ones used kith and kin care and prioritized them for enrollment when Early Head Start slots opened up. Sites generally reported that this strategy was helpful for boosting pilot enrollment.

Seven programs solicited referrals to the pilot from community partners. Overall, programs did not find this strategy effective. Some families referred by partners were not income-eligible for Early Head Start; if they were eligible, they had to be placed on the waiting list because Early Head Start programs were typically fully enrolled. For example, one community partner did a mass mailing to families with children ages birth to 3, but all families who expressed interest ended up on the Early Head Start waiting list. During site visit interviews, several community partners expressed frustration about their inability to get families and caregivers into the pilot (see Box).

Two programs, however, relied solely on community partners due to the special populations they targeted; one targeted families headed by incarcerated teens, and the other targeted foster parents as caregivers. Referrals to these pilot programs came from the Department of Juvenile Corrections and the foster care agency, respectively. To generate sufficient referrals from these agencies, pilot staff worked on sustaining close communication about the pilot with staff from the referring agencies.

A final strategy programs tried for identifying eligible families was soliciting referrals from the kith and kin caregivers themselves. These referrals typically occurred when a caregiver enrolled in the pilot stopped caring for the Early Head Start child (or the child transitioned to Head Start) but wanted to continue participating in the pilot. A few programs reported that caregivers referred families of other children in their care to the program. This approach, however, had the same drawbacks as referrals from partners: unless the Early Head Start program had an opening, the referred family would be placed on a long waiting list.

Community Partner Quote About Making Referrals to the Pilot

“I have lots of grandparents raising children, but I can’t get them into the pilot. So they’re out there in limbo. I can’t get them into the enhancement program because they have to be in Early Head Start, and we can’t get them into Early Head Start so they can’t go into the pilot. So it’s very frustrating, because I have all these beautiful brochures and flyers that I pass out in my center, but I feel bad because I know they can’t get in.”

Strategies for Recruiting Families

Once eligible families were identified, programs used several strategies to recruit them. In programs that used a single-home visitor staffing model (described in Chapter II), the home visitor simply presented the pilot to the family during a regular home visit. In programs that used a dual-home visitor staffing model, the family's home visitor would describe the pilot during a home visit; if the family was interested, the pilot home visitor would follow up. In many cases, the next step would be that the pilot home visitor accompany the Early Head Start home visitor on a visit to discuss the pilot in more detail and to enroll the family. Other times, however, the pilot home visitor contacted the family independently. During site visit interviews, home visitors explained that they decided how to approach parents based on whether they knew the family from other program events and the family's level of interest in the pilot. If they did not know the family well or thought the other home visitor's presence might encourage the family to enroll, they conducted a joint visit. In programs using a community partner staffing model, pilot home visitors usually contacted families on their own.

During the visit, pilot staff informed families about the goals of the pilot and the services that could be provided. For example, home visitors sometimes brought educational materials and toys to the visit and explained how they would use these materials to work with the child and caregiver on developmental goals. They also described to families the types of safety equipment they would distribute to caregivers. In addition, they described the training opportunities that would be available to the caregiver, and, in sites that offered incentives, they described incentives that caregivers could earn. Some said they preferred to focus their recruiting visits more on the objectives of the pilot and its potential benefits for the child rather than on the tangible benefits to caregivers.

Strategies for Recruiting Caregivers

Apart from rare exceptions, all programs required that families give approval before a caregiver was contacted. Once families gave approval, program staff relied on three main strategies for approaching caregivers about the pilot: (1) families approached caregivers, (2) Early Head Start home visitors approached caregivers, or (3) pilot home visitors approached caregivers. Many home visitors said they preferred that families approach caregivers first, because families were able to vouch for the Early Head Start program and share their positive experiences with caregivers. However, if the caregiver and family lived in the same home or the home visitor already knew the caregiver, this step was generally not necessary. A few programs described other situations in which pilot staff contacted caregivers directly. For example, staff from the program that serves incarcerated teens reported contacting the caregivers directly once the teens gave permission. In addition, a few programs enrolled noncustodial fathers and sometimes discussed the pilot with them before obtaining approval from the children's mothers.

When pilot staff contacted caregivers for the first time, they attempted to schedule an initial home visit because they found that in-person contact was the most successful means of convincing them to enroll. If a caregiver expressed reluctance, home visitors sometimes suggested that the caregiver agree to an initial visit or two and then decide about enrolling.

In addition, home visitors asked families to continue encouraging the caregiver to enroll and emphasizing the pilot's benefits. When caregivers did not agree to enroll, the home visitors would sometimes approach them again at a later time.

During the initial contact, pilot staff focused on how the pilot could benefit the child and caregiver and the services that were available through the pilot. Some home visitors said they also stressed that services and participation requirements were flexible and would be tailored to the caregiver's needs and interests. Others described how they tried to engage the child during the visit and demonstrate techniques the caregiver could use to help the child achieve a developmental goal. Programs that served foster parents or caregivers in the process of becoming licensed frequently explained how the training sessions offered through the pilot could be counted towards required training hours for licensing. One home visitor said she even drove a caregiver to a medical appointment during her first home visit to demonstrate how the pilot could benefit her.

In sites that provide materials and incentives, home visitors often emphasized the equipment, gift certificates, and other items they could provide as a selling point for the program. For example, one home visitor explained that she would try to identify a need the caregiver had, such as a high chair, and then explain how she could help the caregiver obtain that equipment through the pilot. Other home visitors stressed incentives such as stipends for attending trainings and the books and toys distributed at each home visit.

Families' and Caregivers' Motivations for Enrollment

During focus groups with parents and caregivers, we asked participants what attracted them to the pilot. Understanding their motivations for enrolling can help the pilot sites and staff of similar initiatives to make enrollment attractive to families and caregivers.

At least one parent in six of the sites said that his or her primary motivation was that the pilot would be beneficial for the caregiver—because the home visitor would provide support, someone to talk to, activity ideas, or information (see Box next page). In three programs, parents said that access to free equipment and materials attracted them. A few others said that they enrolled because they thought the pilot would benefit the child, because they trusted Early Head Start, or because they were ordered by the family court to enroll.

Caregivers described similar motivations. The most frequently cited reason (mentioned by at least one caregiver in eight sites), however, was that the pilot would benefit the child. In particular, grandparents and other relative caregivers expressed a willingness to participate “for the child's sake”—in other words, because they thought pilot services would support the child's healthy development. Caregivers in four sites said they were attracted by the equipment and materials or by the information they could obtain on childrearing techniques. For example, one grandmother said, “I thought it sounded pretty good. To me, no matter how much education you have on this stuff, you can always learn more.”

Other caregivers explained that their motivation to enroll was based on the connection with pilot staff or the program itself. For example, several cited their families' relationships with Early Head Start and positive experiences with their home visitors as reasons to enroll. One grandmother said she was enticed by the opportunity to regain a connection to Head Start; her own child, now 18 years old, had been enrolled in Head Start as a young child. In four sites, caregivers said that the opportunity to receive support and encouragement from the home visitor on a regular basis motivated them to join the pilot. In a site that enrolled fathers, one father said he enrolled in the pilot in part to "have someone to talk to about stuff."

During interviews with home visitors, we asked about their perceptions of family and caregiver motivations for enrolling in the pilot. While they cited reasons similar to those expressed by the parents and caregivers themselves, they ranked the importance of each motivation somewhat differently. For example, home visitors in more than half of the sites thought that participants' primary motivation was access to materials and equipment, followed by support for the caregiver and benefits for the child.

Family and Caregiver Reasons for Enrolling in the Pilot

	Number of Programs
Reasons reported by parents	
Beneficial for the caregiver	6
Access to free equipment and materials	3
Beneficial for the child	3
Trust in Early Head Start	2
Parent ordered to participate by court	1
Reasons reported by caregivers	
Beneficial for the child	8
Access to free equipment and materials	4
Access to new information on childrearing	4
Trust in Early Head Start/Head Start	4
Emotional support	4
Help in obtaining licensure	2
Reasons reported by home visitors	
Access to free equipment and materials	13
Emotional support	8
Beneficial for the child	6
Trust in Early Head Start	3
Training hours count toward licensing	3

N = 14 parent and 17 caregiver focus groups in which reasons for enrolling were discussed; 18 home visitor interviews in which perceptions of caregiver and family motivations for enrolling were discussed.

SERVICES PROVIDED THROUGH THE PILOT

In general, the pilot programs reported that they did not provide additional services to families enrolled in the pilot beyond those that all Early Head Start families received. Instead, nearly all of the programs' basic services were directed to the kith and kin caregivers. In this section, we describe the services that pilot sites provided to the caregivers during the first year of implementation. The pilot programs delivered services through the following four approaches: (1) conducting home visits, (2) offering group activities, (3) distributing or loaning materials and equipment, and (4) making referrals. Although few caregivers expressed interest in licensing, pilot sites also helped some caregivers pursue licensing. In addition, nearly all programs developed strategies to strengthen relationships between parents and caregivers.

Home Visits to Caregivers

All programs offered home visits to caregivers, although the visits varied in frequency, duration, and content. The specific approaches programs took to home visits differed according to their goals for the pilot and their staffing approaches. Some programs made working on children's developmental goals, primarily through caregiver-child activities, the central focus of their visits. Others spent more time providing information to caregivers, and some placed more emphasis on meeting caregivers' emotional and social service needs. Here we describe the frequency and duration of caregiver visits, the content of initial visits, the content of typical visits, curricula used for the home visits, types of information typically requested by caregivers, and ways in which home visitors included other children in the caregiver's home in the home visit activities.

Duration and Frequency of Home Visits.¹

All programs reported conducting home visits to caregivers; in 20 programs, staff said they visited caregivers on a weekly to monthly basis (see Box). Two programs did not conduct regular home visits. One required caregivers to participate in three home visits per year, and additional visits could be provided at the caregiver's request. Another program conducted an initial home visit with caregivers and then followed up monthly by telephone, at a group socialization event, or at the family's home visit (if the caregiver and family lived in the same home). Nearly all programs said that home visits typically lasted for 60 to 90 minutes. One program scheduled 45 minute visits, and another reported that the visit lasted until the child lost interest in the activities.

Frequency of Home Visits Reported by Pilot Staff

	Percentage of Programs
Weekly	6
Biweekly	12
Monthly	2
Three times a year	1
Initial visit only	1
N = 22 programs	

In the majority of programs, home visitors said they were usually able to complete their visits as scheduled. In a few sites, however, home visitors had difficulties with scheduling or completing them. For example, caregivers occasionally canceled scheduled visits because of illness or conflicts with work schedules (see Box). Another common barrier to completing home visits was that some caregivers provided care to the Early Head Start child on an irregular schedule or during nonstandard work hours. When

Home Visitor Quote on the Difficulties of Scheduling Home Visits

"One of my grandparents works until 2, so we can only do home visits after 2. Sometimes we have to cancel and reschedule. And my other grandparent, she had her other children in the home, they're 10 and 12. So after school was out, she was very busy with them and their appointments. So we had to reschedule 2 or 3 times. They want to do home visits, it's just hard."

¹ As described in Chapter I, we are collecting data on the frequency and duration of caregiver home visits in the program recordkeeping system designed for this evaluation. This report contains information about the frequency and duration of home visits based on reports from program staff. The final report will provide data on frequency and duration of home visits from the program recordkeeping system.

caregivers did not have a regular schedule for providing care, sometimes the child would not be in their care at the scheduled visit time. Some programs reported conducting these visits despite the absence of the child; others rescheduled the visits.

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

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

Home visitors also reported that they used the initial visit to collect information about the caregivers' needs and interests to help plan future visits. The most common means for collecting this information were interest surveys and needs assessments. Interest surveys asked caregivers about the types of information and activities they wanted to cover during home visits and about their interest in group activities. Only four programs reported conducting a formal needs assessment with caregivers; however, many reported informally assessing caregiver's needs or recording caregivers' expressed needs. All programs collected information on caregiver demographics, contact information, and child characteristics. Programs also commonly reported completing a partnership agreement that outlined the responsibilities of the caregiver and the home visitor. For example, the caregiver would agree to participate in all scheduled home visits and call and reschedule if she was not able to attend a visit. A few programs reported completing a safety checklist, a child-rearing survey, confidentiality/release forms, or a developmental assessment of the child during the initial visit.

Typical Home Visits. After the initial visit, programs took three main approaches to planning subsequent visits. In eight programs, home visitors reported that the primary focus of the visits was the child's developmental goals established by the parents and Early Head Start home visitor. Caregiver needs were addressed only as they related to working with the child on those goals. In another eight programs, home visitors said that visits were planned according to the needs and interests of the

Primary Focus of Caregiver Home Visits	
	Number of Programs
Child's developmental goals	8
Caregiver's goals and interests	8
Mixed focus on caregiver and child	6
N = 22 programs	

caregivers. In most of these programs, the visits focused on child development topics identified by the caregivers, but in a few sites, they might also focus on caregivers' social service needs. This was especially true of the program that targeted fathers. In two programs that focused more on caregiver needs, the child was not always present during the visits. The remaining six programs reported focusing on both child development and caregiver needs. In addition to their primary focus, the majority of programs reporting focusing at least one visit on the safety of the caregiving environment; many used home health and safety checklists for this purpose.

The types of activities conducted during a typical home visit were similar across all twenty programs that conducted regular visits; they were also very similar to the activities conducted during visits with parents. The majority of home visitors said their visits included an activity with the child, caregiver, and home visitor; a discussion with the caregiver on a specific topic, such as health and safety practices or educational uses of toys and books; and the completion of a record of the visit. More than half of the programs reported that child-caregiver activities were the primary activity during every visit. The activities were often selected to address a specific goal defined for the child, such as learning colors or addressing a delay in speech or motor skills. Home visitors explained that they individualized the activities to fit the needs of the child. Often, they also used the activities as an opportunity to model developmentally-appropriate practices for the caregivers (see Box).

Caregiver Quote on Home Visits

"...when she comes, she never sat on the furniture until we were doing a craft out in the kitchen. She always immediately would come in and was down on the floor with him so that they were on the same level. I thought that was—at first I questioned it, but after a while I got to thinking, well, he's down there and so she goes down there. That way they are eye to eye."

Discussions with the caregivers ranged from addressing health concerns—such as encouraging caregivers not to smoke in the same room as the child—to suggesting new activities to do with the child during the coming week or following up on activities suggested the previous week. Depending on the program's focus, the home visit might also include time to address the emotional and social service needs of the caregivers. At the end of the visit, most programs required that a home visit record be completed, often signed by the caregiver. Programs developed forms for this purpose that collected information on the activities completed during the visit, the information shared with the caregiver, plans for follow-up, and in some programs, observations of the child. Some programs made this form available to parents so that they were informed of the home visit activities.

Curricula Used for Home Visits.

Programs adopted a variety of curricula for the caregiver home visits; half used Parents As Teachers (PAT) (see Box). Six programs did not report the curriculum they used or reported they did not use a curriculum. The other sixteen programs reported using a curriculum, but nearly all home visitors explained that they used

Curricula Used by Programs

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

it as a guide or a resource rather than following it closely (see Box). Home visitors referred to the curricula and often used activity ideas; however, many felt that the curricula did not meet the specific needs of the caregivers or children. For example, the home visitor from a program that served fathers explained that the curriculum the program was using was targeted to working with fathers in a group setting. He, however, was working with the fathers one-on-one and thus needed to adapt the materials for this purpose. Other home visitors reported that the curricula adopted by their programs contained activities targeted to older children and were not applicable to infants, or they were targeted to formal child care providers rather than kith and kin caregivers.

**Home Visitor Quote about
Individualizing the Curriculum**

“The curriculum is good to have, but we have to come up with our own things because the needs of each provider and child are a little bit different. That is a bit of a challenge, but that is why we need to spend so much time looking for information. You need to find good information for them so you can really answer their questions, so that is also how you build a good relationship.”

Information Requested by Caregivers. Home visitors reported that caregivers asked many questions and requested information on various topics during home visits. The types of information requested varied by the age of the child and the specific needs of the caregiver. One common request was information on toilet training strategies, including advice on when to begin training the children. Another common type of information caregivers requested was on child development milestones. Staff reported that caregivers often asked where a child should be developmentally, if a child was on target developmentally, and what the caregiver could do to help a child when a delay was suspected. For example, caregivers asked home visitors when a child should be able to sit up independently. If the child was not sitting independently at a specific age, they asked how they could help the child. The third type of commonly requested information was ideas for new educational activities to with the children. In particular, caregivers that cared for multiple children were eager for new ideas and activities for entertaining and engaging them. Home visitors reported bringing caregivers new materials, showing them how to use materials around the house to make toys and games, and simply suggesting activities caregivers could do with children.

Addressing the Needs of Other Children in the Home. As discussed in Chapter III, many caregivers provide care for multiple children. These situations ranged from caring for one other grandchild to handling seven or more other children in a family child care home. Home visitors in many programs reported making efforts to interact with all children in the home. They often planned activities to accommodate the other children. For example, a home visitor planned a painting activity that children of any age could participate in. One home visitor reported setting up various activity centers so that all children were engaged during the visit; others brought appropriate activities for older children. Some programs reported interacting with the other children in the home as a goal of the pilot. Others merely found it difficult to isolate the Early Head Start child from the other children during the visit.

Group Activities

Twenty-one programs offered at least one of the following types of group activities to caregivers: training workshops or series, group socialization events for caregivers and children, and caregiver support groups (see Box). These events include those planned especially for pilot caregivers and children as well as group activities offered by programs or community partners to which caregivers were invited. One program did not plan group activities for caregivers because it expected caregivers to have little interest and not enough time to attend the events. In the rest of this section, we describe the types of group activities that were offered, community partner involvement in group activities, and caregiver attendance at group activities.

Group Activities Offered to Caregivers

	Number of Programs
Caregiver trainings	18
Socialization events	16
Support groups	4

N = 22 programs

Note: Some programs offered more than one type of group activity.

Caregiver Training. Half of the pilot sites offered training workshops and series designed specifically for the caregivers; nine programs provided the training directly, and four provided training through their community partners (see Box). The frequency of training varied considerably across these programs. During the pilot's first year, seven programs had offered five or fewer training workshops. For example, one program reported organizing three trainings—on grandparents as caregivers, communicating with parents, and early literacy. In another program, a community partner provided four caregiver trainings and offered each in English and Spanish. Four programs offered training series for caregivers; most of these occurred monthly or biweekly. In one site, for example, the pilot offered a biweekly training series based on WestEd's Program for Infant/Toddler Caregivers. After completing 12 months of training, caregivers would have enough training hours to apply for licensure. In another program, a community partner offered a seven-week training course on behavior management techniques.

Topics of Trainings Organized for Pilot Caregivers

- Grandparents as caregivers
- Communicating with parents
- Early literacy
- Infant-toddler nutrition
- Home safety
- Brain development
- Behavior management
- Schedules and routines
- Language development
- Airway obstructions
- Nursery rhymes
- Making hand puppets
- CPR and first aid
- Setting up the caregiving environment

In addition to training events organized specifically for pilot caregivers, a number of programs said they invited caregivers to parent trainings offered by Early Head Start or other training events offered by community partners. In particular, when programs partnered with CCR&Rs, caregivers were usually able to attend CCR&R trainings free of charge. Pilot staff reported that some caregivers attended CCR&R-sponsored training on CPR, first aid, care seat safety, and a few other topics, but overall few caregivers took advantage of these invitations.

Group Socialization Events. Early Head Start programs that provide services through the home-based option are required by the Head Start Program Performance Standards to offer at least two group socialization events per month for parents and children. Half of the pilot sites reported inviting caregivers to attend the socialization events organized for Early Head Start families. These included parent-child events, play groups, field trips, family fun nights, and other special events such as picnics or holiday parties. Although caregiver attendance was low overall, programs reported that relative caregivers, especially grandmothers, were much more likely to attend than unrelated caregivers. In a number of programs, staff reported that typically the caregiver would attend these events with the parent and child.

Four programs planned play groups and other socialization events specifically for caregivers and children enrolled in the pilot. One program offered weekly play groups for pilot participants. The others offered groups less frequently, such as four or five events per year. For example, the program that targeted fathers offered a number of father-child events, such as a pumpkin carving event and a trip to a nature center. Three of the four programs that scheduled socializations specifically for caregivers reported less frequent events. These programs had only offered socializations on occasion, rather than on a regular basis. Three programs cosponsored group socialization events with Even Start. For example, one site offered a monthly First Books event with Even Start. During the event, participants would read a book, do a related caregiver-child activity, and receive a copy of the book to keep.

Support Groups. Few programs offered support groups for caregivers. In one program, however, a weekly support group was scheduled; typical activities included arts and crafts, cooking, outside speakers, and videos on child development. In two programs, support groups for grandparent or relative caregivers were offered through community partners.

Attendance at Group Activities. Caregiver attendance at group events has been low across programs; many caregivers lack transportation or the time to attend. Other barriers cited by staff included health problems, conflicts with work schedules, and shyness. According to staff, socializations were better attended than training events or support groups; however, attendance was still low. As stated previously, grandparents were more likely to attend than unrelated caregivers. The program that served incarcerated teens reported high attendance rates at socializations, as they were opportunities for the incarcerated teen parent, the caregiver, and the child to interact.

Despite the challenges of encouraging attendance, a few programs were successful in increasing attendance over time. Typically, these programs provided transportation and food, sometimes even child care. A few offered the events at multiple times during the month to accommodate caregivers' various schedules. In addition, a number of them provided participation incentives. For example, a few programs gave caregivers stipends of \$10 to \$15 for attending events. Another paid caregivers \$1.00 an hour for the care they provided to the Early Head Start child if they met participation requirements. One gave an incentive payment of \$150 to caregivers when they completed 18 hours of training and home

visits. In a few programs, including the one that targeted foster parents, staff have made arrangements for pilot training to count towards training hours needed to obtain or maintain licensing. Others provided gift certificates, door prizes, books, and other items.

Materials and Equipment

All programs either gave or loaned materials and equipment to caregivers (see Box). Health and safety equipment—including first aid kits, smoke detectors, fire extinguishers, outlet plugs, cabinet locks, safety gates, and car seats—were the most common items given to caregivers. Often, pilot staff provided these items based on the results of a home safety check. A few other programs gave caregivers books, toys, art supplies, children’s music CDs, and equipment. In particular, some non-resident fathers and other caregivers needed cribs, high chairs, and other equipment to care for infants in their homes.

Materials and Equipment Given to Caregivers	
	Number of Programs
Health and safety equipment	14
Books	5
Toys, art supplies, children’s music	5
Other equipment	4
Stipend to purchase supplies	1
N = 22 programs	

Half of the programs gave caregivers access to a lending library, either directly through the Early Head Start program or through a community partner. Lending libraries typically offered books, educational toys, music, and, less frequently, equipment. Home visitors often brought toys and books on home visits, left them in the home, then rotated in new items during the following visit. In one program, a community partner operated a mobile lending library and would stop at caregivers’ homes at least three times a year. Other programs offered a lending library in their Early Head Start centers or other community locations.

Access to educational materials and equipment was an attractive component of the pilot for many families and caregivers (see Box). Sometimes home visitors even gave caregivers donated clothes and other items when they saw a need.

Quote from Parent on the Equipment Provided by the Pilot

“I think it’s important that if we ask them to care for our children that we make it as easy as possible for them. If I can get high chairs and gates that can stay at her home that makes her job easier, that makes it better for me.”

Referrals to Caregivers

Nearly all programs reported making some referrals for caregivers, and a few gave out community resource guides to caregivers at enrollment. The types and frequency of referrals varied across the pilot sites, in part depending on their target population and goals for the pilot (see Box next page). Sites that focused primarily on the children’s developmental goals made few referrals. However, programs that included a focus on caregivers’ social service needs, such as the program that targeted fathers, often made referrals to a broad range of

community service providers. Common referrals included food banks, utility assistance, free community activities and events, and physical and mental health services.

Help with Child Care Licensing

As described in Chapter III, few caregivers enrolled in the pilot have expressed interest in becoming licensed child care providers. More than half of the sites, however, reported referring one or two caregivers for help with licensing and registration. In addition, programs reported that some caregivers expressed interest in becoming licensed “down the road.” Others were in the process of obtaining a license when they enrolled in the pilot, so home visitors talked about assisting them by gathering the necessary information and paperwork. In a few cases, pilot sites also paid for first aid and CPR training to help caregivers obtain or maintain certification needed for licensing. In addition, as described previously, a few programs arranged for training provided through the pilot to count towards training hours required for licensing.

Referrals Requested by Caregivers

- Food banks
- HUD
- Legal assistance
- Utility assistance
- Tax preparation assistance
- Physical health services
- Mental health services
- Counseling
- Mediation
- Donation centers
- GED classes
- Adult education
- Job search services
- Lead abatement services
- Respite care

Staff at one site related a success story of a grandmother who became a licensed provider as a result of being enrolled in the pilot (see Box). When the grandmother first enrolled, the home visitor felt that she had low self-esteem and did not see herself as important in her grandchild’s life. Through the pilot home visits, the grandmother began to view her role as caregiver as important for the child’s development and at the same time developed an interest in caring for other children as well. The home visitor helped her obtain information on state licensing requirements, helped her obtain the required certifications in CPR and first aid, and put her in touch with the CCR&R to complete the background checks and other paperwork. The grandmother has since received her license to operate a family child care home and has started caring for two other children in addition to her grandchild.

Caregiver Quote on Licensing

“If it weren’t for her [the home visitor], I’d have never made it to my classes. She came and got me, because I don’t drive. She came and took me to every single one of my meetings. If it hadn’t been for her, I’d have never got my license.”

Strategies for Strengthening Parent-Caregiver Relationships

A central goal of the pilot was to strengthen the relationships between parents and kith and kin caregivers. Four programs explicitly defined this as a key goal in their program design (as discussed in Chapter II). Facilitating communication and strong relationships can support a related goal of the pilot—increasing continuity in caregiving across home and caregiver settings. Four programs provided specific training to home visitors on strengthening relationships and improving communication between parents and caregivers. Staff at other programs highlighted facilitating communication and strengthening relationships between parents and caregivers as a training need.

Staff from nearly all programs (19 of the 22 we visited) said they worked with parents and caregivers on improving their relationships. In a few programs, staff said that they would do so if necessary, but issues with parent-caregiver relationships had not come up during the first year of implementation. Pilot staff developed a number of key strategies for strengthening relationships and addressing conflicts between caregivers and parents (see Box).

Seven programs reported planning joint activities for parents and caregivers, including joint home visits, socialization events, and training workshops. A few programs also made scrapbooks and shared photographs and mementos from socializations and home

visits with the parents and caregivers to foster a bond between them. In six programs, home visitors reported that they explicitly encouraged direct communication between parents and caregivers when disagreements arose. For example, if a caregiver brought up a conflict or issue, the home visitor would brainstorm with her about strategies for approaching the parent about this problem. Home visitors who used this approach said direct communication was both an important skill for parents and caregivers to develop, and it also prevented home visitors from being placed in the middle of the conflict. One home visitor from a program using a single-home visitor staffing model explained that avoiding getting into a “he said, she said” situation with the parents and caregivers is essential for maintaining her relationships with them. Staff from programs using a dual-home visitor staffing model reported collaborating with the Early Head Start home visitor when conflict arose. Typically, the home visitors discussed the issue and established a consistent approach to take with each party. This guaranteed that the families and caregivers would receive a consistent message.

Another strategy used by programs to strengthen relationships was to share information about the services the caregiver received with the parent. Programs often created a home visit record that captured information about the activities conducted during the visit and the goals that were addressed, and four programs shared this record with the parents. Staff at programs that used this strategy described it as helpful way to keep families informed and to spark conversation between caregivers and families. At one program that served foster parents and biological parents, the form contained only information about the child’s routines and acted as the only means of communication between the parties. In addition, staff at four programs stressed the importance of being a neutral listener. They reported that often caregivers “just needed to vent” about an issue. If the issue was more serious, home visitors would address it using one of the other strategies described. One program offered a workshop to caregivers and families on communication skills and relationship building.

Strategies for Strengthening Relationships

	Number of Sites
Joint activities	7
Direct communication	6
Collaborate with Early Head Start home visitor	6
Share written information	4
Be a neutral listener	4
Address issues through training	1
N = 19 programs	

During parent and caregiver focus groups, we asked participants if the participation in the pilot had changed or improved their relationships. Most participants said that because they already had a good relationship, the pilot had little effect. Some caregivers, however, described how the pilot had helped them improve their relationship with the parent. For example, one caregiver said she “learned not to yell so much.” Another caregiver said she learned that her tone of voice with the parent was “too rough” and saw that when she gave advice or asked the parent for something in a gentle way, the parent was more receptive. In addition, some caregivers and parents felt that sharing information and activities from their home visits helped improve their relationship (see Box).

Quote from a Grandmother About How Participation in the Pilot Improved Her Relationship with Her Daughter

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

PARENT AND CAREGIVER SATISFACTION WITH PILOT SERVICES

During parent and caregiver focus groups, we asked participants about their satisfaction with services provided through the pilot and their recommendations for improvement. Participant opinions about the pilot were overwhelmingly positive. In part, this may be because those who attended the focus groups were most likely those participants who enjoyed participating in the pilot. Nevertheless, participants described aspects of the pilot that they particularly liked; in general, these aspects are similar to their stated motivations for enrolling in the pilot discussed earlier in the chapter. Both parents and caregivers said they liked the information the caregiver received on child development and the support provided to caregivers (see Box). In particular, parents liked that the caregivers received the same information as they did from Early Head Start about such topics as behavior management, toilet training, and home safety. Some parents, especially those using a grandparent as a caregiver, liked that the pilot provided caregivers with “updated” information on child development and child-rearing approaches. Many also said that they like the pilot because they thought it was beneficial for the Early Head Start child. Parents liked that their child

Aspects of the Pilot that Parents and Caregivers Liked

	Number of Programs
Parents	
Information caregiver receives	11
Beneficial for the child	9
Support for caregiver	8
Free equipment and materials	6
New activities and ideas	5
Caregivers	
Information caregiver receives	12
Support for caregiver	12
Beneficial for the child	8
New activities and ideas	5
Free equipment and materials	4

N = 20 parent focus groups and 18 caregiver focus groups in which satisfaction with the pilot was discussed.

received additional Early Head Start services through pilot home visits and group socializations. They also liked that the care environment was enhanced with new toys, books, and activity ideas.

Some caregivers said that they often find themselves at loss for new activities to do with the children in their care. Home visitors gave them many ideas for new activities; many of the activities could be done with things the caregivers already had at home. For example, one caregiver explained the home visitor gave the child uncooked pasta to play with. The child spent time pouring the pasta from bowl to bowl. The caregiver said she would never have thought of that idea on her own.

Both parents and caregivers discussed the materials, participation incentives, educational materials, and safety equipment caregivers received. In addition, they liked that the caregivers were receiving emotional support from the home visitors and were in some cases referred to needed social services. Caregivers in particular enjoyed their relationships with the home visitors and the regular adult company home visitors provided. Many described them as knowledgeable, easy to talk to, and good with the children (see Box).

Caregiver Quote About Her Satisfaction with the Pilot

“The first couple times it was like, okay, do your thing and go, but I love her now and we are buddies. She did her thing and said good-bye. Now, I kind of wish she could stay for longer, that’s how much she has won me over. She won me over because she is very knowledgeable about her business, she interacts so well with the kids, and her sincerity about the whole thing....”

Suggestions for Improving the Pilot

Overall, parents and caregivers expressed satisfaction with the pilot and did not report any particular aspects of it that they did not like. However, a number of participants made suggestions for improvements. For example, families and caregivers suggested that the pilot include field trips to community activities such as a local zoo or a park. The explained that these are activities they cannot always do on their own because of lack of transportation or cost. At least one parent in three programs said he or she would like to receive more information on the services the caregivers and child receive through the pilot and updates on the activities conducted during the home visits (see Box). This suggestion was specific to programs that used a dual-home visitor staffing model. Families and caregivers also made suggestions about the frequency and length of the home visits. Some wanted more or longer home visits, while others reported that the home visits were too frequent. These requests are difficult to interpret, however, because the frequency and duration of the visits varied not only by program but also by caregiver.

Parent Quote on Keeping Families Informed About Home Visits

“They [the home visitors] set up their own schedule with the caregiver and I don’t even know when they are going there. I would like to know when they will do the visit. That way I would be more prepared to ask on those days what happened.”

In this chapter, we have described programs’ strategies for recruiting families and caregivers for the pilot. We have also described in detail the services provided to caregivers

through the pilot, as well as parent and caregiver satisfaction with the program and suggestions for improving it. In the next chapter, we explore programs' early implementation successes and challenges; we also discuss the main themes that emerged from the programs' first year of pilot operations.

CHAPTER V

EARLY IMPLEMENTATION LESSONS

The experiences of Early Head Start programs in implementing the Enhanced Home Visiting Pilot can yield important guidance on program development and implementation to support future initiatives for kith and kin caregivers in other Early Head Start and early childhood programs. A key question for assessing implementation is the extent to which staff have been able to carry out the pilot program as planned. Especially because the pilot is breaking new ground in reaching out to kith and kin caregivers, identifying factors that may be helping pilot staff do what they intended or, alternately, impeding their efforts to achieve pilot goals can provide important implementation lessons for future program designers and practitioners.

This chapter discusses implementation lessons from the pilot gleaned from our first round of site visits in summer 2005. Because most of the programs began implementing their pilots about a year before our visit, the lessons we present focus on the earliest stages of implementation. We begin the chapter by examining the main successes and challenges programs experienced in their first year, primarily from the perspective of Early Head Start and community partner staff involved in delivering pilot services. We then discuss key implementation themes that have emerged from this early stage of the evaluation. A final report will examine these themes in more detail, exploring the extent to which implementation experiences change over time and identifying the strategies that programs develop for responding to the obstacles they face.

EARLY IMPLEMENTATION SUCCESSES

During site visit interviews, pilot and community partner staff described four main types of early implementation successes: (1) fostering relationships between parents, caregivers, and home visitors; (2) providing resources to improve the quality of care; (3) delivering pilot services to caregivers; and (4) changes in caregiving practices. At this early stage of implementation, most successes mentioned by pilot staff are activities that set the stage for potential improvements in the quality of care provided rather than actual changes in quality that home visitors have observed. For example, having trusting relationships with home visitors may motivate caregivers to implement changes that home visitors suggest. Similarly,

provision of information and materials may lead caregivers to do more age-appropriate activities with the children.

This evaluation is not designed to measure the effects of the pilot program on child care quality. Thus we will not be able to determine if the early successes reported here translate into quality improvements. Nevertheless, identifying program practices and strategies that enable staff to reach out to caregivers and provide them with information and training can be valuable for ongoing program development and more rigorous evaluation in the future. Below, we discuss each of the main successes identified by pilot sites in more detail.

Fostering Relationships Between Parents, Caregivers, and Home Visitors

Based on their experiences providing home-based services to families, Early Head Start staff believe that supportive relationships between parents, caregivers, and home visitors will serve as the foundation for achieving two of the main goals set by the pilot sites: (1) improving the quality of care the child receives and (2) increasing continuity of caregiving across home and kith and kin child care settings. As a result, pilot staff have focused heavily on establishing and building these relationships during the first year of implementation. In the rest of this section, we discuss specific successes cited by program staff in the area of relationships.

Pilot home visitors have developed trusting relationships with caregivers. Staff in half of the pilot sites reported that establishing trusting relationships with kith and kin caregivers was one of their most significant accomplishments. Many said that establishing trust was the primary focus of their initial contacts and home visits with caregivers. Because families already had trusting relationships with their own Early Head Start home visitors, many caregivers were inclined to trust the pilot staff. Pilot home visitors feel that trust is essential for getting into caregivers' homes for initial visits and for continuing to conduct the visits over time. Once trust is established, home visitors are able to address safety issues in the caregivers' homes or suggest changes in caregiving practices without offending them.

Pilot participation has improved communication and mutual respect between parents and caregivers. In half of the pilot sites, staff said they have been able to improve communication and help to resolve conflicts between parents and caregivers. For example, staff in these sites reports that parents and caregivers sometimes have disagreements about such issues as behavior management techniques or the timing of toilet training. Some caregivers are noncustodial parents who have longstanding disputes with the other parent. Home visitors' primary strategy for helping the parties resolve their differences is encouraging them to maintain focus on the needs of the child—to work things out “for the child’s sake.” Home visitors help both parties work on communication by encouraging them to talk openly and respectfully about disagreements, listening to their concerns, strategizing with them about how to approach different issues, and not taking sides. In addition, some home visitors said they try to point out the positive role that each party plays in the child’s life.

The important role that caregivers play in supporting the children's development has been acknowledged.

Staff in more than half of the pilot sites said that including the caregiver more formally in Early Head Start has helped both parents and caregivers recognize the important role caregivers play in supporting the children's healthy development. According to staff, this recognition has boosted the self-esteem of many caregivers and motivated them to learn more about child development and how they can work with the child on developmental goals (see Box). Moreover, this acknowledgment helps to foster more positive working relationships between parents and caregivers.

Home Visitor Quote About Recognition of the Caregiver's Role

"It's the provider realizing, even though she has been providing child care for 20 years, she never saw that her relationships with those children had such a big impact. She thought, 'I'm taking care of these children and I'm feeding them,' but I always bring a lesson on brain development and on social-emotional development, and I say, 'What you are doing is providing this child with the tools they will need to form relationships later in life. You are impacting this child in such a big way that you don't realize.' And then they start to feel that way, like, 'Everything I do will change this child's life somehow.' They feel so empowered by you saying that, that they really want to learn about it."

Caregivers' social isolation has been reduced, and many are more connected to the community. Pilot staff report that many caregivers are socially isolated. Some live in rural areas and lack transportation. Some are new immigrants who do not speak English and are not familiar with the community. Others are elderly, and some have difficulty getting out of the house because of their responsibilities as caregivers. Half of the programs cited reducing caregivers' sense of isolation as a significant success of their pilot. As reported in staff interviews and caregiver focus groups, caregivers feel less isolated because they receive regular home visits; they have someone to talk to about their concerns and questions about the children, and they receive emotional support and encouragement from the home visitors. Although attendance at group events has been low in many sites (discussed later in this chapter), a few sites reported that caregivers have formed support networks and have enjoyed meeting regularly. Likewise, some relative caregivers regularly attend group socialization events at the Early Head Start programs.

Home visitors described several other ways that they have helped caregivers connect to community resources, a goal established by half of the pilot sites. In eight programs, staff reported that they have referred many caregivers to other social service providers, such as home heating assistance programs, food banks, support groups, mental health services, health care providers, and GED and ESL courses. Other home visitors have taken caregivers and children on field trips to local playgrounds, libraries, nature centers, and other child-friendly places in the community. A few programs have given caregivers backpacks or fanny packs to facilitate trips outside with the children.

Parents and caregivers receive consistent information about child development and work together on the children's developmental goals. In a quarter of the pilot sites, staff identified consistency across parent and caregiver home visits as an important success of their pilot. Whether parents and caregivers had the same or different home visitors, eight programs took the approach of presenting similar information during both visits and

selecting the child-caregiver activity conducted during the visit based on the child's developmental goals set by the parent and Early Head Start home visitor. Pilot staff also said they encouraged the parent and caregiver to use consistent behavior management strategies across the two settings.

Fathers are more involved with their children and in program activities. One of the pilot sites targeted fathers for enrollment in the pilot. A few other sites enrolled some fathers, usually nonresidential fathers who cared for their children during regular visits. One home visitor cited fathers who have become comfortable holding, interacting, and playing with their children as a significant success of the program. Home visitors in these sites also reported that some fathers are participating more in Early Head Start program events and activities.

Providing Resources for Improving the Quality of Care

Another success that may set the stage for later improvements in the quality of care is the provision of information, equipment, and activities to caregivers. These resources are necessary precursors to changing caregiving environments and practices, and, if caregivers act on the information and make use of the equipment and resources, improvements in quality are likely to occur. In this section, we discuss programs' successes in providing child development information, safety equipment, toys, activities, and books to caregivers.

Caregivers are receiving information about children's development and developmentally-appropriate practices. In three-quarters of the pilot sites, staff said that being able to provide caregivers with information about stages of development and developmentally-appropriate caregiving practices is a significant success of the pilot. For example, some home visitors described how caregivers have learned to observe the children and identify developmental milestones. Home visitors also reported that many caregivers are enthusiastic about receiving child development information and advice on behavior management and other issues; in general, pilot staff report that relative caregivers—especially grandparents—are more receptive to receiving and acting on this information than nonrelative providers.

Caregivers have appropriate home safety equipment and materials for childproofing their homes. Staff in nearly half of the pilot sites said that improving home safety was an important success for the pilot. As described in Chapter IV, home visitors in the majority of sites reported performing a home safety check or conducting at least one home visit focused on home safety. Typically after this visit the home visitor or a community partner would provide the caregiver with needed safety equipment and items for childproofing the home, such as fire extinguishers, smoke detectors, safety gates, first aid kits, outlet covers, and cabinet locks. In addition to focusing on safety in the home, many programs also provided caregivers with car seats and training on car seat safety. A few home visitors also said they had been able to convince the caregiver or others in the caregiver's home not to smoke in the house, or at least not in the same room as the child.

Caregivers have more age-appropriate toys, books, and developmentally-appropriate activities to do with the children. In more than half of the pilot sites, staff felt that providing toys, books, and activities for caregivers to do with the children was a significant success. As described in Chapter IV, nearly all of the pilot programs either gave or loaned books to the caregivers, and many gave or loaned toys as well. Some also provided books as incentives for participating in trainings, socialization events, or home visits. Home visitors in some sites routinely left at least one activity for the caregiver and child to do together during the week (such as a matching game or a craft activity) and followed up on that activity the next week. A number of home visitors also reported teaching caregivers to use materials in their homes to make simple toys and games for the children (see Box).

Caregiver Quote about Activity Ideas

“I am not crafty. I cannot think of activities to do besides reading, so when [home visitor] came, she brought the best ideas that would take two seconds and a bucket, so I guess I was trying to make everything too complicated. She brings simple stuff, she is really good with the kids and they really love her. And I have learned a lot from her. Because she knows a lot about how the kids grow, and we have the best time, and I really love her.”

Delivering Pilot Services

Because few other initiatives exist for supporting kith and kin caregivers, the pilot sites had little guidance about how to design their programs. For example, little is known about how to reach out to caregivers, how best to deliver services and training, and the types and frequency of services that caregivers want. In this context, staff in many sites felt that simply implementing the services as planned and delivering services to caregivers on a regular basis was an important success. Here, we describe the main implementation successes identified by pilot staff.

Most programs are completing regular home visits. All but two of the sites planned to offer regular home visits to caregivers, and nearly all of them were able to complete home visits on a regular basis (weekly, biweekly, or monthly). In part, success in delivering home visits reflects success in gaining and maintaining the trust of caregivers. Moreover, home-based Early Head Start programs already know how to provide home-based services and work with families in a home setting. Many have found that the strategies they used to sustain regular home visits with families were also effective with caregivers.

At some pilot sites, participation in group activities has been high. Overall, pilot sites have struggled with how to increase caregiver participation in group training and socialization events. Nevertheless, one-third of the programs reported participation in group events as a success, because over time they were able to increase participation. Some programs increased caregiver participation by providing transportation to the events; one site invested in a bus and driver for the pilot. Most of the sites that reported success with group activities offered financial or material incentives to encourage participation.

Coordination with community partners and within Early Head Start programs has increased. Community partners in five of the pilot sites cited the strength of their

partnerships with Early Head Start as a positive outcome of the pilot. Similarly, staff in several programs reported that through the pilot they have established new community partnerships. Some also cited increased coordination of services within their own agencies as a success.

Services for kith and kin caregivers have become integrated into the Early Head Start program. Staff in several programs said that the pilot has raised awareness within the program of the needs of kith and kin caregivers; staff have accepted the pilot as part of Early Head Start and refer families and caregivers for enrollment. One program that targets fathers reported that as a result of the pilot, other Early Head Start staff are more aware of the importance of involving fathers and make more efforts to engage them in program activities.

Pilot services benefit all children in the caregivers' homes, including Early Head Start and non-Early Head Start children. Home visitors in several pilot sites reported that they bring activities for all children in the caregivers' homes, regardless of age, and that they attempt to include all of the children in home visit activities. Others said that because of improvements in home safety and increased availability of toys and materials, all children in the home are benefiting from the pilot (see Box).

**Home Visitor Quote on Reaching
Non-Early Head Start Children**

"We've touched kids, and not just our Early Head Start kids who are getting services anyway...we are also serving the other children who are in those homes. Hopefully over all those child care homes, those aunts, those grandmas we are seeing are offering better quality care because we have been in there and touched that home somehow. We're showed them how to make games, we've lent them blocks or other toys, so hopefully we're offering quality for the kids in those homes."

Changing Caregiving Practices

More than a quarter of the pilot sites felt that pilot services have produced changes in caregiver practices. For example, some of the home visitors observe that caregivers are interacting with the children more, such as doing follow-up activities that home visitors leave with them each week. Home visitors also reported observing caregivers talking and reading more to the children. In addition, some home visitors and parents reported that caregivers are relying less on TV to keep the children occupied. For example, during a focus group one parent noted that her son and her mother, who cares for the child, are watching less TV because the home visitor brings activities for them to do together (see Box).

**Parent Quote on Changes in
Caregiver Behavior**

"Just the fact that they are not watching TV...is good enough for me. I don't really care which activities they are doing!"

IMPLEMENTATION CHALLENGES

As expected for a new initiative, pilot sites faced a number of unanticipated implementation challenges during the first year of pilot operations. Nearly all programs had

more difficulty than they expected with recruiting caregivers for the pilot and in some cases maintaining a full caseload due to frequent caregiver turnover. Although most programs planned to offer some group trainings and events, the majority struggled with low levels of caregiver participation. Some programs faced staffing issues such as tensions among pilot and non-pilot staff, insufficient staff time, difficulty finding qualified staff, and staff turnover. Design issues delayed implementation in some programs; others had difficulties coordinating with community partners. Finally, home visitors discussed several challenges of working with the caregivers, including parent-caregiver tensions, caregivers' social service needs, and difficulty suggesting changes in caregiving practices. In the rest of this section, we discuss each of these challenges in more detail and describe strategies that some programs have used for addressing them.

Recruiting and Maintaining a Full Caseload of Caregivers

All but a few programs reported caregiver recruitment as their most difficult implementation challenge. At time of our site visits in summer 2005, few of the pilot sites were fully enrolled. In the rest of this section, we describe programs' main barriers to recruiting sufficient numbers of caregivers and then describe strategies programs have used to overcome recruitment obstacles.

Programs must recruit from a limited pool of Early Head Start families. As described in Chapter II, staff in half of the pilot sites expressed frustration that they can recruit families for the pilot only from the pool of home-based families already enrolled in the program. In some cases, programs learned that fewer families than expected were using kith and kin care. In other programs, fewer families and caregivers than anticipated wanted to enroll. Once program staff had approached all families using kith and kin care about enrollment in the pilot, they were not able to enroll more caregivers until new families enrolled in the Early Head Start program.

A few programs further limit the pool of eligible families by establishing additional eligibility criteria. Some programs put additional eligibility criteria in place that added to recruitment difficulties. For example, some programs required caregivers to provide care on a regular basis and for a substantial proportion of the week; sporadic caregivers were not eligible. In addition, some programs would not enroll registered or licensed family child care providers.

Recruitment into the pilot is a multi-stage process. Program staff must first approach parents about enrollment in the pilot. If the parent agrees, then the caregiver must be approached. This can be a lengthy and time-consuming process for staff; if either party is reluctant to enroll, recruitment is delayed.

Some programs had difficulty gaining caregivers' trust. Staff in some programs reported that caregivers are reluctant to enroll in the pilot because they fear that home visitors will report them to the child care licensing agency or child protective services. Others fear that home visitors will criticize their caregiving or their home and tell them what to do (see Box). In a few sites, staff reported that some caregivers simply did not want someone they did not know visiting them at home.

**Caregiver Quote about Concerns
Prior to Enrollment**

“I had reservations because it’s like, you have all these kids running around the house, and the house is never picked up, and you have somebody coming into your home and telling you, or to look around and think, ‘Oh my gosh, this lady shouldn’t have day care kids in there because it is a disaster area.’ If I have company over, all the toys are picked up and on the shelves. To have somebody come in the middle of that mess was like, I don’t know. But it has been a good thing.”

Some programs experienced more turnover in caregivers than expected. About one third of the programs reported that they have experienced more caregiver turnover than expected. In general, however, staff feel that this turnover is the result of families’ tumultuous lives rather than caregivers dropping out of the program. In fact, pilot staff reported that many of the caregivers want to continue participating in the pilot, but they cannot do so because the Early Head Start families left the program, moved out of the service area, or no longer needed child care. In some cases, disputes between parents and caregivers sever the caregiving relationship.

To increase and maintain a full caseload of caregivers, programs have devised a number of strategies:

- Provide enrollment incentives to caregivers—such gift certificates, equipment, and books
- Give families on the Early Head Start waiting list who use kith and kin care priority for enrollment
- Offer flexible and individualized services if caregivers express concerns about meeting participation requirements; for example, offer biweekly rather than weekly home visits
- Suggest that caregivers agree to just one or two initial home visits and then make a decision about enrollment if they express reluctance
- Encourage all Early Head Start staff to refer eligible families to the pilot and encourage them to enroll
- Hire home visitors who are from the local community and can quickly gain caregivers’ trust

As described in Chapter II, program staff also made several recommendations for revising the pilot eligibility criteria to expand the pool of families from which programs can recruit and enroll. For example, three programs that offer both home- and center-based services have found that many center-based families use kith and kin care, even though they receive some child care from Early Head Start, and programs would like to enroll these families in the pilot. In seven agencies that offer both Head Start and Early Head Start services, staff would like to continue visiting caregivers when children transition from Early Head Start to Head Start. Similarly, programs that aim to provide seamless birth-to-five services find it awkward to offer pilot services to some families and not others. Finally, eight programs that maintain lengthy waiting lists would like to expand their programs by enrolling new families in the pilot—essentially creating a kith and kin care option in which services would be provided primarily in the caregiver’s home.

Attendance at Group Events

In nearly two-thirds of the pilot sites, caregiver attendance at group training, socialization, and support group events has been lower than anticipated. Perhaps because community partners participate in organizing group events in many sites, community partners in 40 percent of the sites we visited also reported attendance at group activities as a significant challenge. Despite initial expectations, pilot staff have found that many caregivers do not attend trainings and other events. As described in Chapter IV, many face barriers to attending, such as lack of transportation or lack of free time because of their caregiving duties.

Community Partner Quote on Incentives for Group Events

“We now do the FNP store—that’s the Family Nutrition Program store—and at the end of each class I give them FNP bucks. That last class we have together I set up a table. I get plastic containers, kitchen timers, whisks and put them out, and they can buy what they want with their FNP bucks. The older ones, they have fun with that, they really get into that.”

Programs have responded to this challenge in a variety of ways. Some managers simply decided to redesign pilot services so that all essential training and child development information is provided during home visits; they felt that caregivers were not interested in groups and staff were devoting too much time and resources to planning the events. Some programs have opened events intended exclusively for caregivers to all Early Head Start parents; in some cases, more parents than caregivers attend the sessions. Conversely, other programs have decided to invite caregivers to Early Head Start group socialization and other events for parents and children rather than planning separate events. In general, pilot staff have found that relative caregivers, especially grandparents, enjoy attending these events with their children and grandchildren but that nonrelative providers do not usually attend.

Despite widespread difficulties with attendance at group events, some pilot sites have devised strategies for encouraging participation. For example, one program invested in a bus and driver to provide transportation for caregivers. Others provided transportation, food, and sometimes even child care so that caregivers could attend events. Providing incentives also has been a successful strategy for encouraging participation in training. For example, in one program caregivers can earn \$150 for completing an 18-hour training course. In

addition to monetary incentives, programs provide door prizes, such as a baby gate, a chair, or a stroller, as well as free books, toys, and vouchers that can be exchanged for free items (see Box previous page). Finally, in one program staff reported that caregivers attend events because they have developed a strong support network and enjoy being together; this program does fun activities with the caregivers such as cooking or crafts.

Staffing Issues

During the first year of pilot operations, about one-third of the programs experienced implementation challenges related to staffing the pilot. Three main types of staffing challenges were reported: (1) tension about the roles of various staff in working with families and caregivers, (2) insufficient staff time to provide pilot services, and (3) difficulties finding and retaining qualified staff. We discuss each of the staffing challenges in more detail here.

In some programs, tensions arose about coordinating services when multiple staff members began working with the same child and family. Especially during the initial months of implementation, Early Head Start home visitors in about half of the sites were resistant to involving the pilot home visitors in service delivery for “their” families and children. In some cases, there was lack of clarity about roles; in others, there were “turf issues” about who should do what with families and who should have access to families’ information (see Box). In most cases, these tensions were resolved within a few months through discussion and supervision, but they may have contributed to initial recruiting difficulties since some home visitors were reluctant to refer families to the pilot. In a few pilot sites in which community partners conducted home visits, lack of clarity about roles and insufficient coordination also created some tension.

Home Visitor Quote on Lack of Clarity about Roles with Families

“Some of the parents, we don’t even know what they look like. That’s sometimes the line we’re not sure we can cross, because they have their Early Head Start visit and we have the enhanced home visit, and there’s no crossing it. There’s a line in the sand, and there isn’t.”

Some home visitors did not have enough time to conduct home visits as frequently as intended. In the six sites that used a single-home visitor staffing model, completing weekly, 90-minute visits to families as required by the Head Start Performance Standards sometimes took precedence over caregiver visits. When home visitors had difficulty completing the family visits, they cut back on caregiver visits since their frequency is not mandated. In a few rural sites, travel time required to reach caregivers’ homes made completing visits at the intended frequency challenging. One site had to change its pilot design to meet the grant requirements and ended up without enough pilot staff to deliver services to caregivers at planned levels of intensity.

A few programs had difficulty finding qualified staff or experienced turnover when initial staff hired for the pilot did not work out. These gaps in staffing prevented programs from providing services to caregivers at planned levels of intensity, and they

sometimes created gaps in services to caregivers while programs worked on hiring new staff to replace those that left the pilot.

Design Issues

Programs experienced two types of implementation challenges related to the initial design of their pilot programs: (1) last minute changes in the design and (2) initial confusion among pilot staff due to lack of a clear design.

Some programs had to make last minute design changes to meet grant requirements. For example, one program planned to shift some of the required weekly visits from parents to caregivers—visiting each one twice a month. The program, therefore, developed a modest budget for supervision and materials and equipment for caregivers, but it did not plan to hire additional staff for the pilot. Once staff realized that they must continue providing weekly visits to parents plus caregiver visits, they did not have sufficient grant funds to implement their model as planned. Another program planned to enroll new families in the pilot, and another planned to enroll only regulated child care providers. Making last minute changes to comply with grant requirements created recruiting challenges for these programs.

A few programs did not develop a clear design for the pilot until after implementation was underway. Some program staff said that they wanted to learn about the needs and interests of enrolled caregivers before finalizing service delivery plans and developing lesson plans and forms for tracking pilot services. In some cases, this delay resulted in a design that better matched caregivers' needs. In others, however, it created confusion among pilot staff about what services they were supposed to provide and at what intensity.

Implementation Challenges Experienced by Pilot Home Visitors

During site visit interviews, home visitors described a range of issues that impeded their ability to deliver planned services during home visits. Tensions and disputes between parents and caregivers took up time during home visits and created turnover when disputes severed caregiving arrangements. Caregivers' social service needs sometimes dominated home visitors; low literacy skills created barriers to providing child development information and promoting literacy activities with children. Other challenges included how to positively influence caregivers' interactions with the children and how to encourage caregivers to do more activities with them. In the rest of this section, we describe these challenges in more detail.

Parent-caregiver tensions created challenges for home visitors. Although half of the sites identified improving parent-caregiver relationships as a success of the pilot (see previous section), these conflicts were also challenging for home visitors at times, especially when the same home visitor was visiting both the parent and the caregiver. Home visitors in half of the programs reported these conflicts as a significant challenge. Talking with

caregivers about these conflicts took valuable time during home visits, distracted home visitors and caregivers from their work with the child, and led to increased turnover when parents or caregivers ended care arrangements due to conflicts. Conflicts arose about behavior management, toilet training, and children's schedules. Sometimes they were related to longstanding disagreements within families or intergenerational conflicts between parents and their children. As described in Chapter IV, home visitors encourage both parties to talk openly and respectfully about their concerns and to attempt to resolve the conflicts for the child's well being (see Box).

**Home Visitor Quote About
Parent-Caregiver Conflicts**

“You're trying your best to help the caregiver, and the parent doesn't see it that way. Like I have [a grandmother] who just started in the program two weeks ago, and [child's father] sees me as a threat, that I'm going to turn grandma against him even more. But what I'm trying to do is just the opposite. I've tried to say to [grandmother], maybe you should try to talk more if something's bothering you rather than holding it in. Maybe if you discuss it in a nice way you can get over this not liking each other.”

Caregivers' social service needs distracted from the home visitors' focus on child development during the visits. In half of the pilot sites, home visitors said that caregivers' social service needs interfered at times with their attempts to focus on child development issues during home visits. In sites that did not identify addressing caregiver needs as a goal of their pilot, home visitors said that they try to minimize focus on the caregivers' needs beyond issues related to caring for the child, and they provide few referrals to other community services. In other programs, home visitors refer caregivers to a wide range of social services—such as home heating assistance, weatherization, food banks, health care providers, and mental health services. In a program that works primarily with fathers, the home visitor spent significant time helping with GED preparation and job searches. Some home visitors reported that caregivers' health problems, especially when caregivers are elderly or disabled, interfered with their ability to do activities with the child. Other home visitors mentioned that the low literacy levels of some caregivers impeded their ability to read handouts on child development and in some cases deterred caregivers from reading books to the children.

Some caregivers are reluctant to make changes in how they care for the children. Perhaps the most difficult struggle that home visitors faced was figuring out how to motivate caregivers to make positive changes in how they care for the children and how to make suggestions without offending them. Home visitors in many sites mentioned that some caregivers are reluctant to turn off the TV, even during home visits. A related challenge was how to encourage the caregivers to interact more with the children and to get down on the floor with them. One home visitor said, “[E]very time I go to that home I go straight to the floor and say, ‘Look what we are doing!’ Getting them motivated to do it can be difficult.” Home visitors reported that they begin by trying to change patterns of interaction during the home visits, such as suggesting that the caregiver turn off the TV while the home visitor is present and participate in the activity. They also model age-appropriate interaction during the visits, point out developmental milestones, encourage caregivers to observe the children, praise caregivers when they exhibit a positive behavior (such as talking to the child), and

leave toys and activities for the caregiver and child to use together. Many said they try to avoid making direct suggestions unless they observe a serious safety issue in the home.

EARLY IMPLEMENTATION THEMES

During their first year of implementing the Enhanced Home Visiting Pilot Project, participating Early Head Start programs have broken new ground in efforts to reach out to and support kith and kin caregivers. Although each pilot site is unique in its design, target population, service delivery strategies, and community partnerships, some common themes have emerged in programs' early implementation experiences. In the rest of this section, we examine two broad categories of themes: (1) design themes and (2) service delivery themes.

Design Themes

Across the 23 pilot sites we visited, we have identified four notable themes related to pilot design. First, programs are serving a diverse group of caregivers. Second, nearly all of the Early Head Start programs built on their experience operating home-based programs in designing the pilot. Third, caregivers have been generally responsive and happy with the services programs chose to offer them. Finally, there are advantages and disadvantages to the various staffing configurations that programs have chosen for the pilot. Below we discuss each of these themes in more depth.

Pilot sites are serving a diverse population of kith and kin caregivers. Programs are enrolling and serving a much more diverse group of caregivers than envisioned by the Bureau when the grant announcement was written. This has occurred primarily because Early Head Start families' lives are complicated, with many caregivers involved in the children's lives. Programs have taken the approach of "following the child" into the settings where he or she receives care—including regular, consistent care provided by relatives or family child care providers, sporadic care provided by a series of informal caregivers, care from custodial and noncustodial fathers, and care in foster homes.

Pilot sites have used the same approach they use for providing home visits to Early Head Start families to provide services to kith and kin caregivers. Most Early Head Start programs selected for the pilot based their designs on what they knew how to do best—they used their home-based services to families as the primary model for providing services to caregivers. Managers and front-line staff are experienced and skilled in providing these services, and many curricular and training resources are available to the pilot home visitors. Using this model has helped families understand and "buy in" to the pilot; because they receive similar services they can explain the pilot and its value to their caregivers.

In general, caregivers are receptive to the pilot and like the services they receive. Overall, caregivers who participated in the site visit focus groups expressed satisfaction with the services they are receiving. Many enjoy the emotional support and encouragement they receive from their home visitor, and they appreciate the ideas and materials they receive as well. Based on discussion in the focus groups, the home-based services and individualized

approach offered through the pilot appears to match the needs and interests of the caregivers.

There are trade-offs to using the same or different home visitors to work with parents and caregivers. Programs have taken two main approaches to staffing the pilot—assigning one home visitor to work with both the family and caregiver or assigning different home visitors to work with each party. When one home visitor works with both parties, services are well-coordinated, and the home visitor is able to develop an in-depth understanding of child’s life circumstances. However, because home visitors are mandated by the Head Start Program Performance Standards to complete weekly visits with parents, caregiver visits sometimes become a lower priority when home visitors are pressed for time. In addition, home visitors sometimes find it difficult to avoid getting pulled into conflicts between parents and caregivers. On the other hand, when parent and caregiver visits are conducted by different home visitors, the two home visitors must communicate frequently and coordinate closely to achieve continuity in services provided across the two settings.

Service Delivery Themes

Programs made important strides in delivering services to caregivers during the first year of pilot operation. We identified six notable themes related to delivering pilot services and describe each one below.

During the first year of implementation, staff focused heavily on building caregiver-parent-home visitor relationships and creating continuity for the child. During site visit interviews, many pilot staff emphasized their view that establishing trusting relationships with kith and kin caregivers and between parents and caregivers would lay an essential foundation for improving the quality of care the child receives and increasing continuity of caregiving across care settings. As a result, home visitors prioritized building trust with caregivers over influencing caregiving practices during early visits.

Home visitors deliver child development information and training by focusing on the child’s individual developmental goals during home visits. One third of the pilot sites used the child’s developmental goals established by the parent and Early Head Start home visitor as the primary basis for home visit activities with caregivers. Home visitors in the majority of sites included child-caregiver activities as part of each visit. In addition, home visitors worked with caregivers on learning about stages of development, age-appropriate behavioral expectations, and activities to promote healthy development, but they individualized specific activities according to the needs of the child. By focusing as much as possible on the child’s development during each visit, home visitors feel they are able to make suggestions about caregiving practices and encourage caregivers to do activities “for the good of the child.” Grandparents, in particular, responded well to this approach.

Individualization of services for caregivers is a hallmark of the pilot programs. As described previously, many pilot home visitors individualized home visit activities according to the needs of the child. They also individualized services to the needs of the caregivers—including the frequency and schedule of home visits, topics covered, and the

materials and equipment provided. One program working primarily with fathers met with fathers at the program office or other locations to address specific needs for education and training or to help obtain social services. During focus groups, caregivers expressed appreciation for this flexibility and said it made them feel comfortable participating in the pilot.

Providing equipment, toys, and home safety items makes the pilot attractive to caregivers. During focus groups, caregivers said that the equipment, toys, and materials they received through the pilot made enrollment and continued participation very attractive for them. Many do not have the resources to purchase toys, books, and home safety items. Programs also found these items to be attractive incentives for encouraging participation in group training events.

While most caregivers do not attend group activities, providing incentives and transportation increases their participation. Most programs had difficulty getting caregivers to participate in group training and other events. Many kith and kin caregivers felt they did not need training because they do not view themselves as child care providers. Others faced barriers such as lack of transportation or time to attend. Some programs, however—especially those that provided incentives—were able to achieve good participation in group events. In other programs, relative caregivers attended group socializations and field trips organized for Early Head Start families.

Most caregivers are not interested becoming regulated child care providers. Most pilot sites had one or two caregivers who expressed interest in becoming regulated child care providers, but overall few kith and kin caregivers expressed interest. Programs generally took the approach of assisting caregivers who were interested in connecting with the licensing agency and obtaining the training they needs, but they did not push caregivers who were not interested in pursuing this option.

Programs made significant progress in implementing the Enhanced Home Visiting Pilot during their first year of operation. They hired and trained staff, enrolled families and caregivers, and provided them with regular services. They also identified some implementation challenges and began developing and testing strategies for overcoming them. As the evaluation continues, we will continue exploring the themes identified in this report and identify new themes that emerge as implementation proceeds and pilot models evolve further. A final report will examine these themes in detail, exploring the extent to which implementation experiences change over time and the strategies that programs develop for responding to the obstacles they face in recruiting and serving caregivers.

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