Home-Based Child Care Practices and Experiences Study

Sample and Methods Report

October 2024

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Erikson Institute

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Introduction

Families with young children under age 3 rely on home-based child care (HBCC) – care in a provider's or a child's home – more than any other type of nonparental child care setting (Barnett and Li 2021). HBCC is commonly used by families of infants and toddlers, families of school-age children, families working nontraditional hours, and those living in rural areas (Anderson and Mikesell 2019; Datta et al. 2021; Henly and Adams 2018). In addition, families of color, those from immigrant backgrounds, and those living in low-income communities have historically relied on HBCC (Sethi et al. 2020).

More than five million HBCC providers offer care to more than 12 million children under age 13. The majority of these providers are family, friends, and neighbors (FFN) who are exempt from state licensing and who are unpaid (Datta et al 2021). Many FFN providers are women of color living in disinvested and under-resourced communities (Schochet et al. 2023) who do not participate in publicly funded systems such as Child Care Development Fund (CCDF) subsidy programs.

Despite the prevalence of FFN care for many of the nation's most vulnerable children, there is limited empirical research examining what this care looks like or the types of supports and resources that FFN providers access (Bromer et al. 2021). The Home-Based Child Care Practices and Experiences Study (HBCC P&E Study), funded by the Office of Planning, Research, and Evaluation (OPRE) within the Administration for Children and Families (ACF), aimed to gather qualitative data on the experiences, strengths, resources, and strategies used by FFN providers and how these experiences are informed by aspects of their personal, community, or professional characteristics and their geographic locations. In addition, the study collected data from families who use FFN care and community members who support FFN providers to help the study team gain a better understanding of quality and support in the FFN sector.

Primary research questions

The HBCC P&E Study addresses the following research questions:

1. What are the features of child care quality that FFN providers prioritize? Why do FFN providers prioritize these features? How might personal, community, social, or professional characteristics shape these priorities?
2. How do FFN providers implement features of quality, including the features they consider most important?
3. What are the resources, including sources of knowledge and individual, family, and community strengths, that FFN providers use or access?
    a. How do providers acquire or access these resources?
    b. Which resources do providers find most helpful? Why?
    c. What challenges do FFN providers face in using or accessing resources?
4. What are the features of quality that families prioritize and experience in FFN care and why do they prioritize them?

5. How do the features of quality that providers consider most important and that families consider most important align?

Purpose

The purpose of this report is to describe the unique sampling approach and methodology used in the HBCC P&E Study. Beginning with background on FFN care and study goals, the report details the HBCC P&E Study's data collection methods, sample, and screening procedures, provides tables describing the analytic sample, and concludes with reflections on study methods and an overview of analytic methods.

Key Highlights

The HBCC P&E Study team collected data virtually on a rolling basis from FFN providers, family members, and community members over a six-month period from September 2023 through February 2024. Each provider participated in the study over approximately two months. The study aimed to include 60 providers, 120 families served by those providers, and 60 community members who supported the providers. It ultimately collected data from 48 FFN providers, 27 family members, and 26 community members:

- Most providers in the study sample identify as Hispanic/Latino/a (40 percent) or Black or African American (33 percent).
- Most providers in the study sample care for one to three children, though one-fifth (21 percent) care for four or more children.
- Most providers (71 percent) in the study sample care for at least one relative, 29 percent of providers care for at least one friend or acquaintance, and 13 percent of providers did not know at least one child or family before providing care.
- One-fifth (19 percent) of providers in the study sample care for children with physical or medical conditions that affect their care.
- Most providers (62 percent) in the study sample care for at least one school-age child, nearly half (45 percent) of providers care for at least one preschool-age child, 40 percent of providers care for at least one toddler, and 21 percent of providers care for at least one infant.
- Most family members (63 percent) reported that they were relatives of the provider who cares for their children.
- Most community members (65 percent) included in the sample are informal sources of support, such as providers' friends and family. Thirty-five percent of the community members in the sample are formal sources of support, such as staff who work for the trusted partner organization or other community organizations that offer support and quality improvement opportunities to FFN providers.

Methods

The HBCC P&E Study used semi-ethnographic, open-ended methods to generate rich information about the practices and experiences of FFN providers, the experiences of families of children in their care, and the experiences of community members who offer support. Providers, family members, and community

members completed qualitative interviews. Providers also completed photo and audio journals, which reduced the intrusiveness and bias of the study team.

Qualitative interviews gathered information about:

- Providers' stories of offering care; how identity influences caregiving; sources of support & knowledge
- Family and community member experiences with and perspectives on FFN care

Providers' photo and audio journals gathered information about:

- Features of care that providers prioritize
- Caregiving conditions and experiences including joys and frustrations

I. Introduction

Millions of families with children in the United States rely on home-based child care (HBCC), or child care and early education (CCEE) offered in a provider's or child's home. While it is the most common form of nonparental child care, research on HBCC is limited, especially compared to center-based CCEE, Head Start, and pre-kindergarten (Datta et al. 2021a; Datta et al. 2021b; Bromer et al. 2021). The Office of Planning, Research, and Evaluation (OPRE) in the Administration for Children and Families (ACF), U.S. Department of Health and Human Services, contracted with Mathematica and Erikson Institute to examine HBCC supply and quality through the Home-Based Child Care Supply and Quality (HBCCSQ) project.

Existing descriptive research on features of quality in HBCC has focused on regulated or "listed" family child care (FCC) providers, with limited empirical research describing family, friend, and neighbor (FFN) providers who are legally exempt from state licensing or other state regulations for child care and are often unlisted on state registries and databases (Del Grosso et al. 2021; Bromer et al. 2021). To address the gaps in the existing literature relating to FFN care, the HBCCSQ project team conducted the HBCC Practices and Experiences Study (HBCC P&E Study) to explore what quality FFN care looks like from the perspectives of providers and families. Specifically, the HBCC P&E Study was designed to describe: (1) the features of quality that FFN providers prioritize and the ways their identity influences how they enact quality caregiving with children and families; (2) the sources of support and knowledge that FFN providers rely on; (3) the features of child care quality that families prioritize and experience in FFN care and why they prioritize them; and (4) how the features of child care quality that providers and families consider most important align.

Findings from the HBCC P&E Study can inform quality improvement efforts, and, specifically, how to better align such efforts with the aspects of quality that FFN providers and families find most important in these settings. Findings about the sources of support and knowledge that FFN providers most rely on may increase understanding of the types of policies and activities that may be more in line with FFN providers' experiences and preferences and more likely to enhance quality.

This report describes the unique sampling approach and methodology used in the HBCC P&E Study. Beginning with background on FFN care and study goals, the report details the HBCC P&E Study's data collection methods, sample, and screening procedures, provides tables describing the *analytic* sample, and concludes with an overview of analytic methods.

HBCC P&E Study data (transcripts) are archived at the Child and Family Data Archive within the Inter-university Consortium for Political and Social

This report describes how the HBCC P&E Study team:

1. Obtained the sample of FFN providers, the families of the children cared for by the providers, and the community members who are sources of support and knowledge for the providers
2. Used semi-ethnographic, open-ended methods, including semi-structured interviews and photo and audio journals, to generate rich information about the experiences of FFN providers
3. Reviewed, coded, and analyzed the data

Research. Information about how to apply for access and explore the data is in the HBCC P&E Study User's Manual (Acosta et al. 2024).[1]

A. Background on FFN care

Research suggests that families of infants and toddlers, families working jobs with nontraditional hours, and those living in rural areas rely disproportionately on HBCC (Anderson and Mikesell 2019; Henly and Adams 2018). In addition, families of color, those from immigrant backgrounds, and those living in low-income communities have historically relied on HBCC (Sethi et al. 2020). Many HBCC providers themselves are women of color living in disinvested and under-resourced communities (Schochet et al. 2023). According to the 2019 National Survey of Early Care and Education (NSECE), more than five million HBCC providers offer care to more than 12 million children under age 13. This includes FCC providers who are typically licensed, registered, or certified by their state to offer child care in their homes, as well as FFN providers who are exempt from state licensing and may or may not be paid, or who participate in publicly funded systems such as CCDF subsidy programs. According to the 2019 NSECE, the majority of HBCC providers in the United States are categorized as "unlisted" providers (likely FFN). These providers far outnumber "listed" FCC providers and center-based programs. Moreover, the number of unlisted FFN providers who do not receive payment is almost quadruple the number of unlisted providers who are paid for child care (Datta et al. 2021).

Unlisted providers vary widely in terms of their relationship to and experiences with children in care. In 2019, a majority of unlisted providers had a prior relationship to children in their care and provided care for small numbers of children (one to three). Compared to listed HBCC providers (FCC), far more unlisted providers cared for school-age children. Over half of all unlisted providers report engaging in one-on-one activities with children, two-thirds of unlisted paid providers report planning activities, and close to one-third report using a curriculum (Schochet et al. 2022c).

Unlisted providers vary in their demographic and community characteristics. About one-third to one-half of unlisted providers identify as Hispanic/Latino/a or Black, non-Hispanic; fewer than one in six immigrated to the United States; and between one-quarter and one-third speak a language other than English. In addition, fewer than 20 percent live in rural communities, and one-quarter to one-third live in high-poverty communities (Schochet et al. 2022a; Schochet et al. 2023). Compared to listed (FCC) providers and unlisted unpaid providers, unlisted paid providers were more likely to identify as Hispanic/Latino/a or Black, non-Hispanic, to live in high-poverty communities, to report low household incomes and more family members in their households, and to report not owning their own home (Schochet et al. 2022a; Schochet et al. 2023).

Unlisted providers report having varied access to formal CCEE programs or supports. One in three unlisted paid providers had experience offering licensed or regulated child care in the past 10 years. Small proportions of unlisted providers reported having attended a sponsored workshop, enrolled in a course for credit about caring for children, participated in a health or safety training, or received coaching or help

[1] HBCC P&E Study data and documentation can be accessed through the Child and Family Data Archive at the Inter-university Consortium for Political and Social Research (ICPSR) at: https://doi.org/10.3886/ICPSR39160.

from a home visitor in the past year. More unlisted paid providers engaged in any of these activities compared to unlisted unpaid providers (Schochet et al. 2022b).

Despite the prevalence of FFN care and the critical role these providers play in caring for many of the nation's most vulnerable children, the field lacks research about how quality features of FFN settings relate to child and family outcomes (Bromer et al. 2021). Moreover, existing CCEE research and measurement has primarily adopted a center-based perspective. Many quality measures and QRIS standards and indicators are developed for centers and might not capture the features of care associated with quality in FFN—especially features that are implemented differently or are more likely to occur in FFN than in other CCEE settings (Bromer et al. 2021; Forry et al. 2013; Porter et al. 2010; Tonyan et al. 2017). For example, culturally congruent care that has the potential to support and be responsive to children's heritage and linguistic backgrounds is common in FFN care (Shivers and Farago 2016).

In addition to a lack of research on features of quality in FFN care, little is known about the types of supports and resources that FFN providers access. State policies vary in terms of the extent to which FFN providers are included in subsidy programs or quality improvement initiatives. Local communities may have parenting or targeted FFN initiatives that offer providers opportunities to meet other caregivers and learn about child development, although these initiatives are not widespread (Hatfield and Hoke 2016; Ragonese-Barnes et al. 2024; Shivers and Farago 2016). A recent national scan of 61 HBCC networks across 31 states found that about half (49 percent) serve FFN providers in addition to licensed FCC providers but only three networks reported exclusively serving FFN providers (Ragonese-Barnes et al 2024).

B. HBCC P&E Study goals

The HBCC P&E Study aimed to gather qualitative data on the experiences, strengths, resources, and strategies used by FFN providers and how these experiences are informed by aspects of their personal, community, or professional characteristics and their geographic location. The study collected data from families who use FFN care and community members who support FFN providers to gain a better understanding of quality and support in the FFN sector. Study findings will provide a foundation for future research on HBCC (as described in the HBCCSQ project's research agenda). The HBCC P&E Study selected methods and designed data collection instruments to address the following five research questions:

1. What are the features of child care quality that FFN providers prioritize? Why do FFN providers prioritize these features? How might personal, community, social, or professional characteristics shape these priorities?
2. How do FFN providers implement features of quality, including the features they consider most important?
3. What are the resources, including sources of knowledge and individual, family, and community strengths, that FFN providers use or access?
    a. How do providers acquire or access these resources?
    b. Which resources do providers find most helpful? Why?
    c. What challenges do FFN providers face in using or accessing resources?

4. What are the features of quality that families prioritize and experience in FFN care and why do they prioritize them?
5. How do the features of quality that providers consider most important and that families consider most important align?

By answering these five research questions, the study team aimed to achieve the following study goals:

1. Address gaps in understanding why and how FFN providers enact specific caregiving practices with children and supports for families;
2. Increase understanding of disparities in access to publicly funded CCEE supports;
3. Inform efforts to better align quality improvement efforts with the needs and interests of FFN providers and the families they serve;
4. Identify opportunities for improving access to resources and supports that can help FFN providers and the children and families they serve thrive; and
5. Inform efforts to build the supply of child care providers who participate in publicly funded systems such as subsidy, licensing, and QRIS.

C. HBCC P&E Study design

The HBCC P&E Study was designed as a small-scale, qualitative study to generate rich detail about the experiences of FFN providers.[2]

The study collected data from FFN providers, family members of children cared for by the FFN providers, and community members or individuals whom the providers named as a source of knowledge, support, or other resources. The study aimed to include 60 providers, 120 family members (or two family members per provider), and 60 community members (or one community member per provider). Data were virtually collected over a six-month period from September 2023 through February 2024.

HBCC P&E Study definition of FFN providers

The HBCC P&E Study defined *family, friend, and neighbor (FFN) providers* as those who are legally exempt from state licensing or other state regulations for child care providers that specify noncustodial care of children in the provider's own home. The P&E study limited participation to FFN providers who were unlicensed but currently received resources and supports, or who expressed interest in receiving resources and supports in the future from CCEE systems.

The study team used non-probability, purposive sampling to identify potential respondents.[3] The study team recognized that FFN providers, especially

[2] Office of Management and Budget information collection request number 202305-0970-008 and control number 0970-0612.

[3] Because participants were purposively selected, they are not representative of their populations. The range of characteristics of providers, settings, and communities included in the study was limited. The study's findings shed light on the experiences of some FFN providers—those who are involved or might later become involved in CCEE systems. This study intended to present internally valid descriptions of this population in chosen sites, not to promote statistical generalization to other sites or service populations. However, we cannot conclude whether any findings are representative of these subgroups of FFN providers throughout the country, nor whether they are representative of the experiences of all FFN providers.

those from under-resourced communities, may be hesitant to participate in a government-funded research study because of the inequitable ways that research and policy have often been conducted in communities of color (Brown et al. 2019). For this reason, the HBCC P&E Study established relationships and partnered with four trusted partner community organizations (trusted partner organizations) that offer support to FFN providers across four study sites in two communities (Bay Area, California, and New York, New York) and two states (Alabama and Arizona).[4] The study team hoped that if providers learned about the study from an organization that providers turn to for support, it would increase their willingness to participate. Additionally, the study team assumed FFN providers who work with trusted partner organizations are more likely to be providers who are engaged with or interested in engaging with CCEE systems.

Study site selection

When considering possible sites, the team purposively selected sites with community organizations that were willing and able to support the study. These organizations had the capacity to work with the study team to identify 30 providers who were interested in the study, to ultimately recruit 15 providers. Additionally, the study team selected sites that (1) support providers from a range of backgrounds including those more likely to live in under-resourced communities (e.g., communities with high levels of concentrated poverty); (2) are in states with different policy contexts, such as child care licensing thresholds (numbers of children allowed in home-based child care settings), policies on subsidy eligibility, participation of FFN providers in Quality Rating and Improvement Systems (QRIS), and the Child and Adult Care Food Program (CACFP); and (3) are in states with different quality improvement supports available for FFN providers.

The site selection process was iterative. The study team first identified several sites across the country with existing community organizations who work directly with FFN providers. The team created a matrix using publicly available information and existing knowledge of the sites comparing the aforementioned characteristics. At this point, the study team flagged sites in states that had more and less restrictive licensing requirements, for example requirements so strict that they would lead to almost all HBCC providers having to become licensed. Sites were excluded in states where there is no licensing of HBCC and therefore no defined distinction between FFN and FCC providers. Finally, the team identified sites to reach out to by balancing the different characteristics of interest across the remaining sites. The study team aimed to select at least one site in a state that (1) had more restrictive licensing requirements (Alabama and California), (2) required a more extensive regulatory process for FFN providers to receive subsidies (Arizona), and (3) had minimal requirements around subsidy participation for FFN providers (New York). This allowed for more variation in terms of understanding a range of policy contexts and provider experiences with subsidy and other systems. We conducted initial outreach to the selected sites to learn more about the providers in their network, ask about their site and community context, and assess their capacity to work with us and recruit the targeted number of providers. If a site was not willing or able to participate, the team went back to the matrix to identify a new site.

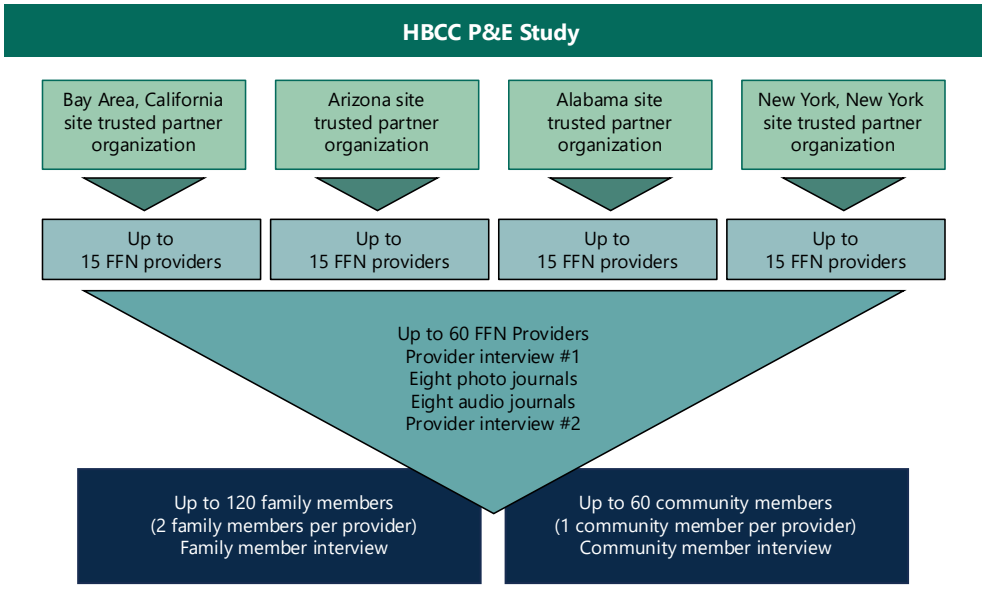
[4] The Arizona trusted partner community organization also offers support to FFN providers in Nevada.

Provider eligibility and recruitment

The study team asked the trusted partner organizations to help identify and recruit providers who met the study eligibility criteria.[5] Providers had to be at least 18 years old and had to (1) provide care for children, other than their own, for at least 15 hours per week; (2) provide care in their own home; (3) not have a current license to provide HBCC; (4) be comfortable speaking with the study team in English or Spanish; and (5) meet at least one of the following criteria: (a) currently receives payment for providing care, (b) had considered licensing, and/or (c) had prior CCEE work (center based or FCC) or volunteer experience, or related training. To try to ensure a sample of FFN providers with a variety of characteristics, trusted partner organizations were also asked to identify and recruit with a mix of individual and provider characteristics in mind. This sampling approach means that the study sheds light on the experiences of some FFN providers – those who are involved or might later become involved in CCEE systems. We cannot conclude that any findings are representative of subgroups of FFN providers, nor that the findings are representative of the experiences of all FFN providers.

After the trusted partners identified providers, the study team worked with each participating provider with the goal of recruiting and interviewing up to two parents or guardians of two different children cared for by each provider. To be eligible for the HBCC P&E Study, family members had to be 18 years or older and be the parents or guardians of children cared for by a participating FFN provider. The study team also worked with each participating provider to identify a community member who was a frequent or primary source of support for them, either formally or informally, to include in the study. Figure 1 shows the HBCC P&E Study structure, including the target number of participants per FFN provider, family member, and community member group (see Figure 3 for final numbers for the analytic sample).

Figure 1. HBCC P&E Study design



[5] The FFN providers who participated in the study may or may not have an association with the trusted partner organization.

Data collection strategies and instruments

The study used a combination of qualitative and participatory research methods. These included photo journaling (photo voice methodology, Lantos et al. 2021), audio journaling (Bandini et al. 2021), and qualitative interviewing (Saldaña 2021). The study primarily used an open-ended approach to asking questions and an inductive approach to data analysis in order to avoid imposing preconceived ideas about child care quality on the study participants. Photo and audio journals, in particular, were used to gather authentic examples of providers' lived experiences. Both photo and audio journals were designed to reduce the intrusiveness of researcher-led activities by giving providers control and agency over the data collection process. Photo and audio journals were also intended to reduce researcher bias in data collection and allow participants multiple ways of communicating their experiences (Lantos et al. 2021; Owens et al. 2019; Wang and Burris 1997).

Each of the data collection strategies is briefly described below and in more detail in the section on data collection instruments. The instruments are included in the HBCC P&E Study User's Manual (Acosta et al. 2024). Table 1 details how each data source was designed to align with each of the study's five research questions.

- **Provider interviews.** Each provider participated in two semi-structured interviews (provider interview #1 and #2). These were designed to produce data on (1) providers' background, children in care, and own children in care; (2) how providers describe the care they offer children and families, including practices and beliefs about caregiving; (3) how caregiving practices intersect with aspects of providers' personal, community, or professional characteristics; and (4) the sources of knowledge and support that providers rely on and prioritize.
- **Photo journals.** Each provider collected eight photographs over a four-week period (some providers chose to collect more than eight photographs). Photographs and follow-up discussions about these photographs in provider interview #2 enabled providers to share what quality practices "look like" with the study team. The provider photographs were designed to help the study team answer research questions focused on the features of quality that are most important to FFN providers and how they implement these features.
- **Audio journals.** Each provider recorded eight audio journals over a four-week period (some providers chose to record more than eight journals) concurrent with providers' photographs. Audio journals enabled providers to share their caregiving experiences through open-ended narratives. The audio journals produced data on how providers think about caregiving practices and family supports as well as on their weekly experiences offering care, including their joys and frustrations.

Each provider in the study also participated in one **logistics call** with the study team. The logistics call took place in advance of the photo and audio journaling period, to offer support and guidance to providers on how to use the study smartphone and software application to take photographs and send photo and audio journals to the study team. Logistics calls were not a data source.

- **Family member interviews.** The study team conducted interviews with up to two family members of two different children served by each provider. Family interviews generated data on the features of quality in FFN care that families prioritize.

- **Community member interviews.** The study team conducted interviews with one or two community members for each provider. Community member interviews produced data on the formal and informal sources of knowledge and support that FFN providers rely upon.

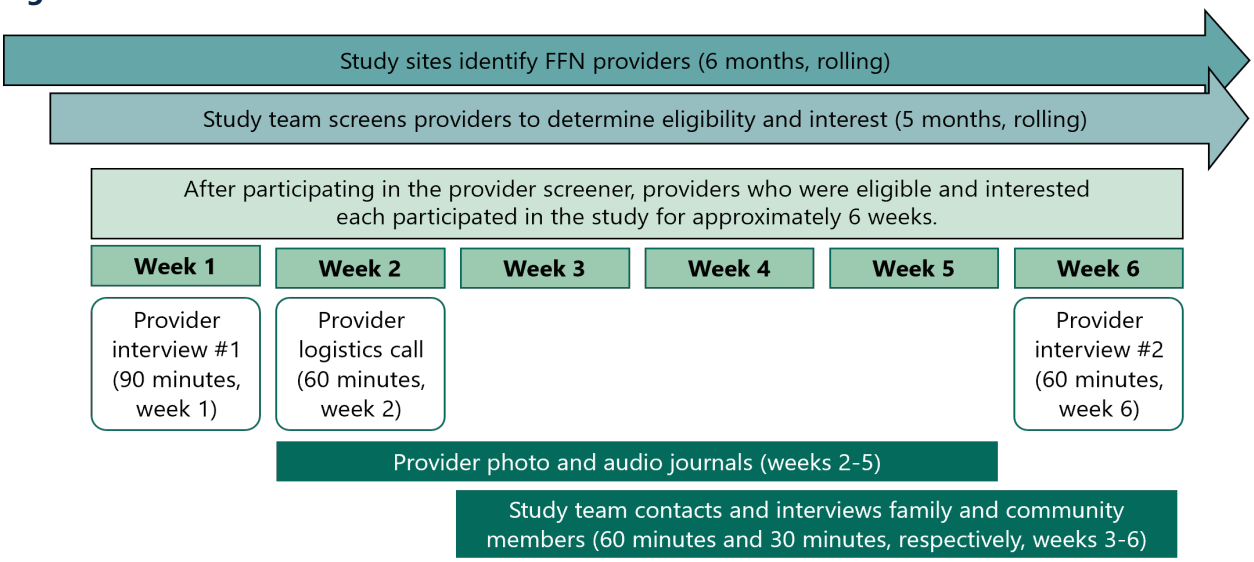
Table 1. Alignment of study research questions and data collection activities

Research question	Data collection activities
1. What are the features of child care quality that FFN providers prioritize? Why do FNN providers prioritize these features? How might personal, community, social, or professional characteristics shape these priorities?	**Provider interview #1** gathered information from providers about the aspects of care they prioritize. **Provider photo journals** and **provider audio journals** documented what providers prioritize and think is important about the care they offer children and families; they also illuminated some of the caregiving conditions, including the stressors that put pressure on FFN providers and the opportunities and joys of taking care of children. **Provider interview #2** focused on provider–child interactions, supporting provider–family relationships, and how providers' views about caregiving are informed by aspects of their personal, community, or professional characteristics.
2. How do FFN providers implement features of quality, including the features they consider most important?	**Provider photo journals** and **provider audio journals** documented how each provider implements features of quality that they think are most important, providing context and explaining why they think these are important (the study team provided prompts to help inform their responses). **Provider interview #2** asked providers to elaborate on certain quality features shown in their photos and asked providers about other quality features not shown in their photos (such as features related to provider–child interactions and provider–family relationships).
3. What are the resources, including sources of knowledge and individual, family, and community strengths, that FFN providers use or access? a. How do providers acquire or access these resources? b. Which resources do providers find most helpful? Why? c. What challenges do FFN providers face in using or accessing resources?	**Provider interview #1** gathered information about the resources and sources of knowledge and strength that providers use or access. **Community member interviews** provided information about how community resources support the work of FFN providers.
4. What are the features of quality that families prioritize and experience in FFN care and why do they prioritize them?	**Family member interviews** provided information about which features of quality families prioritize and appreciate, why they find them important, and how they experience these features in FFN settings.
5. How do the features of quality that providers consider most important and that families consider most important align?	**Provider interviews #1 and #2** and **audio journals** gathered information from providers about the aspects of care they prioritize. **Family member interviews** provided information about which features of quality families prioritize and appreciate, why they find them important, and how they experience these features in FFN settings. These two data sources may allow for comparison of provider and family perceptions of features of quality.

II. Data Collection Methods

The study team collected data virtually on a rolling basis from FFN providers, family members, and community members over a six-month period. Each provider participated in the study over approximately two months. Providers were not required to complete all activities to participate in the P&E Study. For example, a provider could complete interviews #1 and #2 but not participate in the photo and audio journals. Figure 2 shows the timeline of data collection for the study and for individual providers in the study.

Figure 2. Data collection timeline



A. Data collection instruments development and procedures

Development

The development of the HBCC P&E Study data collection instruments was guided by the HBCCSQ project's conceptual framework (Bromer et al. 2024). The study team drew on previous research, including previous qualitative and ethnographic research with FFN and other HBCC providers and with families, when available. For example, some questions were drawn from the NSECE, to help put questions into context and provide topics to ask about in more depth (NSECE Project Team 2019). Because of the HBCC P&E Study's unique sampling approaches and methodology and the overall lack of research on features of quality in FFN care, other questions were developed by the study team in consultation with experts outside the study. The experts included researchers with expertise in HBCC quality, culturally responsive care, and qualitative research design. Administrators and staff members from the trusted partner organizations at the study sites and the study experts provided written and verbal feedback on the draft instruments.

Pre-test

As part of development, the study team conducted a small pre-test of the English versions of the draft data collection instruments with FFN providers in two sites that became part of the full HBCC P&E Study (New York City and Arizona). Providers, family members, and community members who participated in the pre-test were not eligible to participate in the HBCC P&E Study.

The English pre-test was conducted in two phases between September 5 and November 8, 2022.

- The goal of the first phase of the pre-test was to test the feasibility of gathering photo and audio journals from providers using a journal software application, EthOS. The study team hoped to identify ways to improve the logistical supports and guidance offered to providers on EthOS, and to identify issues providers had with the application. Given the goals, phase one included pre-testing three instruments: (1) the provider logistics call, (2) provider photo journals, and (3) provider audio journals. Three providers participated in this phase of the pre-test. Although providers were asked to complete the photo and audio journals over a four-week period during the full study, the pre-test period was condensed to two weeks.
- The purpose of the second phase of the pre-test was to test the full data collection process. This included the provider screener, the provider logistics call, provider interviews #1 and #2, an abbreviated two-week version of the photo and audio journals, and family and community member interviews. The second phase of the pre-test was conducted with a total of six providers, three family members, and two community members at the New York and Arizona study sites. Throughout the pre-test, interviewers tracked the length of each interview, recorded any questions and assistance needed (related to the content, the equipment, the journal software application, or the video conference call), and assessed the process of having providers assist with recruiting family and community members. The study team streamlined, revised, and shortened data collection instruments in response to feedback received during the pre-test.

The study team also pre-tested Spanish versions of the study's recruitment materials and provider screener in June 2023. The goal of this pre-test was to ensure the Spanish versions of the recruitment materials and provider screener were easy to understand and used language consistent with how providers describe their work. Two Spanish-speaking staff members designated from the study's New York and Arizona sites (one from each site) provided written feedback on the language used and clarity of the provider screener and recruitment materials. Three FFN providers who were native Spanish speakers also reviewed the materials and participated in an interview and the provider screener with the study team. The study team revised wording across all data collection instruments and made changes to supplement interviewer guidance in response to feedback received during the pre-test. For example, one provider suggested we use the term *familiares* instead of *parientes,* as that term is commonly understood by Spanish-speaking FFN providers.

Providers, family members, community members, and the trusted partner organizations who participated in study pre-tests were compensated. Trusted partner organizations received $200 for their staff's reviews of materials and for recruiting providers to participate in the pre-test. Providers were compensated $50 for participation in the pre-test of provider interview #1, $100 for provider interview #2, and $80 for photo and audio journals; family members were compensated $60, and community members were compensated

$40 for their participation in the study pre-test activities. Providers were compensated $50 for participating in the pre-test of the Spanish versions of the recruitment materials and provider screener.

Instruments and procedures

The section below describes the eight data collection instruments and procedures, including the purpose of data collected by each instrument, the number of participants who participated in each data collection activity, and each instrument's mode and duration. Each instrument was offered in English or Spanish. See Table 1 above for how the instruments align with the study's research questions.

1. Provider screener

Instrument. The provider screener was used to determine potential providers' eligibility and interest in participating in the study. The screener collected information about providers' characteristics and the characteristics of children they care for, providers' care environment, providers' interest in formal CCEE engagement including education, training, or licensing, and/or participation in subsidy or CACFP.

Procedures. The study team worked with the trusted partner organizations to obtain permission to collect provider contact information and contact potential providers to participate in the study. One hundred and thirteen potential participants were screened over the telephone with the provider screener, which took approximately 20 minutes. Data collectors took detailed notes on the screener conversation and entered data into a spreadsheet for analysis and archiving. For additional information on the sample of providers, see Section B. Study Sample, 1. Providers and Tables 4, 7, and 9.

2. Provider interview #1

Instrument. Provider interview #1 was designed to gain an initial understanding of the types of care providers offer and providers' backgrounds and experiences, and to begin answering the study's guiding questions. The interview also helped obtain information about providers' sources of support and knowledge (community members or other supports) and the strengths of these supports. The study team designed provider interview #1 to generate data around five main components:

1. Demographic characteristics about providers (in addition to those collected during the provider screener)
2. Characteristics of children that providers care for
3. How providers came to offer FFN care and their motivations
4. Providers' sources of knowledge and support
5. Providers' experiences with formal CCEE systems and policies

In addition to the five main components of the interview, data collectors also prepared the providers for the remaining data collection activities by giving an overview of the study activities, including the photo and audio journals and the family and community member interviews.

Procedures. After providers were deemed eligible via the screener and consented to participate in the study, they completed provider interview #1. Forty-eight providers participated in provider interview #1 by telephone, which took approximately 90 minutes. With consent, provider interview #1 was recorded and transcribed for analysis and archiving. For additional information on the sample of providers, see Section B. Study Sample, 1. Providers and Tables 4-9.

3. Provider logistics call

Instrument. The provider logistics call supported providers' use of the study smartphone and EthOS software application for submitting photo and audio journals. During the logistics call, the study team provided guidance on taking photographs and recording audio journals, demonstrated using the software application on the study-provided smartphone to accomplish these tasks, and discussed obtaining parent consent and child assent (if children were age 10 or older) for photos that could include children. The study team also discussed with the providers the process for sharing contact information for family members and community members who agreed to be contacted by the study team.

Procedures. After provider interview #1, providers who were interested in participating in the subsequent photo and audio journal data collection activities received the logistics call. Before the call, the study team sent providers a study smartphone and packet of materials. Thirty-eight providers participated in the provider logistics call over the phone, which took approximately one hour. Data collectors wrote down anything notable discussed on the logistics call in the analytic memos (see VI. Analytic Methods). Information from the logistics call was not recorded for transcription or archived.

4. Provider photo journals

Instrument. Provider photo journals were intended to identify the features of quality that FFN providers prioritize. Photo journals were selected as a participatory approach to give providers control and agency over the data collection process and (when combined with provider interview #2) gather rich and authentic stories about providers' caregiving experiences. Prompts for photographs focused on different aspects of caregiving, including home spaces, activities with children, being together and routines, identity, and community. Weekly prompts asked providers to take two photographs (per week) of something important to them as well as more specific activities or experiences that might occur in child care (for example, take a photograph of an activity where children can be active; take a photograph of an activity where children learned something new).

Procedures. After completing the logistics call, thirty-three providers completed the photo journals, which took providers approximately two hours total over a four-week period. The study team asked providers to submit eight photographs (two photographs per week) over a four-week period. The study team programmed the EthOS app with two sets of prompts providers could respond to each week—one "required" prompt and one prompt of providers' choosing. The study team also asked providers to include a short description to caption each photograph. To collect the photo journals, the study team gave the providers study smartphones with the EthOS app—a paid software designed for ethnographic and diary studies—so they could take photographs and securely share their photographs with the study team. The study team programmed EthOS with requests for eight photographs of daily life in HBCC that providers could access by opening the EthOS app. The study team asked providers to discuss the photographs during provider interview #2. Specifically, the study team asked providers to share reasons

for taking select photographs and what the photographs show about their care of children that is important them. Photographs and associated captions were not archived because of their sensitive nature.

5. Provider audio journals

Instrument. Provider audio journals were designed to allow FFN providers to share how they implement aspects of caregiving that they feel are important and to reflect on their experiences of caregiving conditions. Audio journals were used to reduce the intrusiveness of researcher-led activities and reduce barriers due to literacy, language, or time for some participants. Prompts for audio journals were focused on different domains of caregiving, including aspects of provider–child interactions and provider–family relationships. A second set of prompts asked providers to talk about something important, fulfilling, or joyful and something challenging, frustrating, or burdensome about caring for children.

Procedures. After completing the logistics call, thirty-four providers participated in the audio journals, which took providers approximately two hours total over a four-week period. The study team asked providers to record and submit eight audio journals (two per week) over a four-week period. Providers used the EthOS app on their study phones to receive prompts and record audio journals. The study team programmed the EthOS app with two sets of prompts that providers could respond to each week—one "required" prompt and one prompt of providers' choosing relevant to their weekly experience. Provider audio journals were transcribed for analysis and archiving.

6. Provider interview #2

Instrument. Provider interview #2 explored providers' stories of offering care and how providers' identity influences their caregiving. The interview was intended to co-create meaning with providers about photographs shared in the photo journal portion of data collection. Therefore, the study team designed provider interview #2 to generate data around five main components:

1. Photo journals providers took and shared (if applicable)
2. What is important to providers
3. Providers' cultural identities and practices
4. Providers' relationships with children and families
5. How community and neighborhood context influences providers' practices with children

Procedures. Forty-five providers participated in provider interview #2 over Zoom, which took approximately 60 minutes each. Provider interview #2 was completed over Zoom because it included discussion of providers' photo journals (the study team asked providers to talk about why they took specific photographs and what the photographs show about aspects of care that are important to them). The software was downloaded on providers' study-provided smartphones so that interviewers could display providers' photo journals via video. Three providers completed provider interview #2 but did not complete the photo journals. For these providers, interviewers used a modified protocol to ask about caregiving conditions and specific aspects of care. The modified version of provider interview #2 was conducted by telephone. With consent, provider interview #2 was recorded and transcribed for analysis and archiving.

7. Family member interview

Instrument. Family member interviews explored the features of quality in FFN care that families prioritize and appreciate, why they find them important, and how they experience these features in FFN settings.

Procedures. Twenty-seven family members of children cared for by participating FFN providers took part in an interview by telephone, which took approximately one hour. With consent, family member interviews were recorded and transcribed for analysis and archiving. For additional information on the sample of family members, see Section B. Study Sample, 2. Family members and Table 10.

8. Community member interview

Instrument. Community member interviews examined the sources of knowledge and support that FFN providers rely upon. Interviewers used distinct protocols depending on whether the community member was a formal (CCEE agency) or informal (non-agency) source of support for the provider. During the interviews, the study team asked about the supports and resources community members offer that sustain FFN providers' work caring for children.

Procedures. Twenty-six community members participated in an interview by telephone, which took approximately 30 minutes. With consent, community member interviews were recorded and transcribed for analysis and archiving. For additional information on the sample of community members, see Section B. Study Sample, 3. Community members and Table 11.

III. Study Sample and Screening

The study team aimed to include 60 FFN providers in the sample, with two family members (120 total), and one community member (60 total) per provider (Figure 1). To facilitate recruitment and meet sample size goals, as well as show appreciation to participants, the study team offered financial tokens of appreciation. Providers, family members, and community members who completed data collection activities received amounts corresponding with the time estimated to complete the activities. Providers who completed all data collection activities received a total of $250 (a $75 gift card for each provider interview [#1 and #2], and a $100 gift card for photo and audio journals); family members who completed an interview received a $50 gift card; and community members who completed an interview received a $25 gift card. In addition, for their help identifying and recruiting providers and assisting the study team, an honoraria of $1,900 was offered to each trusted partner organization to meet the individual needs of the organization.

A. Recruitment

1. Providers

Using providers' contact information shared by the trusted partner organizations at study sites, the study team attempted to contact and screen 138 potential participants on a rolling basis to determine their eligibility and interest (Table 2). Of the 138 providers who participated in the screener, 33 were ineligible (24 percent), 23 were ultimately not interested in participating in the study (17 percent), and 57 agreed to participate (41 percent). The study team attempted but was unable to reach 25 providers who gave permission for trusted partner organizations to share their contact information with the study team. These providers were classified as unresponsive (18 percent). The study team attempted to contact providers six times before considering them unresponsive. The study team attempted multiple modes of communication when contact information was provided (for example, telephone calls, text messages, and emails) and attempted to contact providers at varying times of the day and days of the week, including evenings and weekends.

Because of the higher-than-expected nonresponse and refusal rates, the study team attempted to contact more than 30 providers from the California site, which resulted in recruiting 21 providers from this site. Over-recruiting from the California site also offset the smaller-than-targeted recruitment pool from the Arizona site (Table 2). Additionally, given the Arizona trusted partner community organization also offers support to providers in Nevada, providers who live in Nevada were part of the recruitment pool.

The study team recruited 57 providers into the study, meaning providers completed the screener and agreed to complete provider interview #1. Ultimately, 48 of the 57 providers completed provider interview #1 (84 percent).

Table 2. Number of providers identified for recruitment and recruitment status, by study site

Study site	Provider contact information obtained to be part of recruitment pool	Unresponsive[a]	Ineligible	Refused	Recruited
Alabama	32	6	7	5	14
Arizona[b]	22	4	6	0	12
Bay Area, California	51	8	14	8	21
New York, New York	33	7	6	10	10
Total	**138**	**25**	**33**	**23**	**57**[c]

[a] Providers were categorized as "unresponsive" when they did not respond to six attempted contacts (including telephone calls, text messages, and emails) at different times of the day and days of the week. These providers were not screened.

[b] Includes providers who live in Nevada.

[c] Only providers who completed provider interview #1 were included in the analytic sample. Forty-eight of the 57 recruited providers completed provider interview #1 and are considered part of the analytic sample. Nine recruited providers agreed to participate in provider interview #1 but did not complete the interview.

Table 3 shows the number of ineligible providers, by reason.

Table 3. Number of providers identified as ineligible, by reason

Ineligibility reason	Number of ineligible providers
Is currently licensed or in the process of getting licensed	5
Does not care for children for at least 15 hours per week	7
Does not care for children in their own home	9
Language barrier (did not feel comfortable speaking with the study team in English or Spanish)	3
Not caring for any children or is primary guardian of children	7
Other	2[a]
Total	**33**

[a] One provider participated in the pre-test and one provider had no indication of interest in public system participation.

2. Family members

Once providers were recruited, the study team worked with each participating provider with the goal of recruiting and interviewing up to two parents or guardians of children cared for by each provider, or 120 families.

The study team discussed the process for interviewing up to two family members with providers during data collection (during either provider interview #1, the provider logistics call, or provider interview #2). The study team explained to providers that family members would be from two different families and would be parents or guardians of children they care for. The study team asked the provider to give a contact form (and a flyer about the study) to a family member of each child in the provider's care. Providers asked the family members to sign the contact forms if they agreed, and then collected the forms and shared them with the study team via the EthOS application on their study phone or through a telephone call with a study team member. Once the provider returned the signed contact forms (or

otherwise gave the contact information), the study team reached out to up to two family members for a brief conversation explaining the study, confirming their interest in participating, and scheduling a time for the interview that was convenient for them.

Ultimately, the study team did not meet the target number of 120 family members. Twenty-six providers shared contact information for family members (54 percent of providers who completed provider interview #1). This resulted in contact information for 33 family members. Of these 33 family members, 5 were unresponsive (15 percent), one was not contacted (3 percent),[6] and 27 (at least one family member for 22 providers) agreed to participate in the study (82 percent). All family members who agreed to participate completed a family member interview (100 percent). Recruiting family members was not required for providers participating in the study, and some providers did not feel comfortable asking family members to participate. Additionally, some providers cared for one child or multiple children from only one family and therefore did not have as many families to share as expected.

3. Community members

During provider interview #1, the study team asked providers to identify community members who are frequent or primary sources of support for them, either formal or informal. Based on this information, interviewers discussed with the provider which community members to consider interviewing.

The study team asked the provider to reach out to the top three community member options to give them a flyer about the study and ask if they agreed to be contacted for an interview. With community members' consent, providers then completed a log of community member contact information for interviews and shared the form with the study team through the EthOS application or through a telephone call with a study team member. After providers returned the forms (or otherwise shared the contact information), the study team selected one community member per provider and contacted them to confirm their interest in participating and to arrange a time for the interview. Because more providers initially reported informal sources of support, the study team shifted its approach midway through data collection to prioritize contacting providers' formal sources of support when providers identified multiple community members. In some cases, the study team interviewed two community members per provider.

Ultimately, the study team did not meet the target number of 60 community members. Twenty-nine providers shared contact information for community members (60 percent of providers who completed provider interview #1). This resulted in contact information for 43 community members. Of these 43 community members, one community member refused (2 percent), four were unresponsive (9 percent), 11 were not contacted (26 percent),[7] and 27 (at least one community member for 25 providers) agreed to participate in the study (63 percent). Nearly all community members who agreed to participate completed a community member interview (*N* = 26; 96 percent). As with family member recruitment, recruiting community members was not required for participation in the study, and some providers could not identify community members who served as frequent or primary sources of support for them.

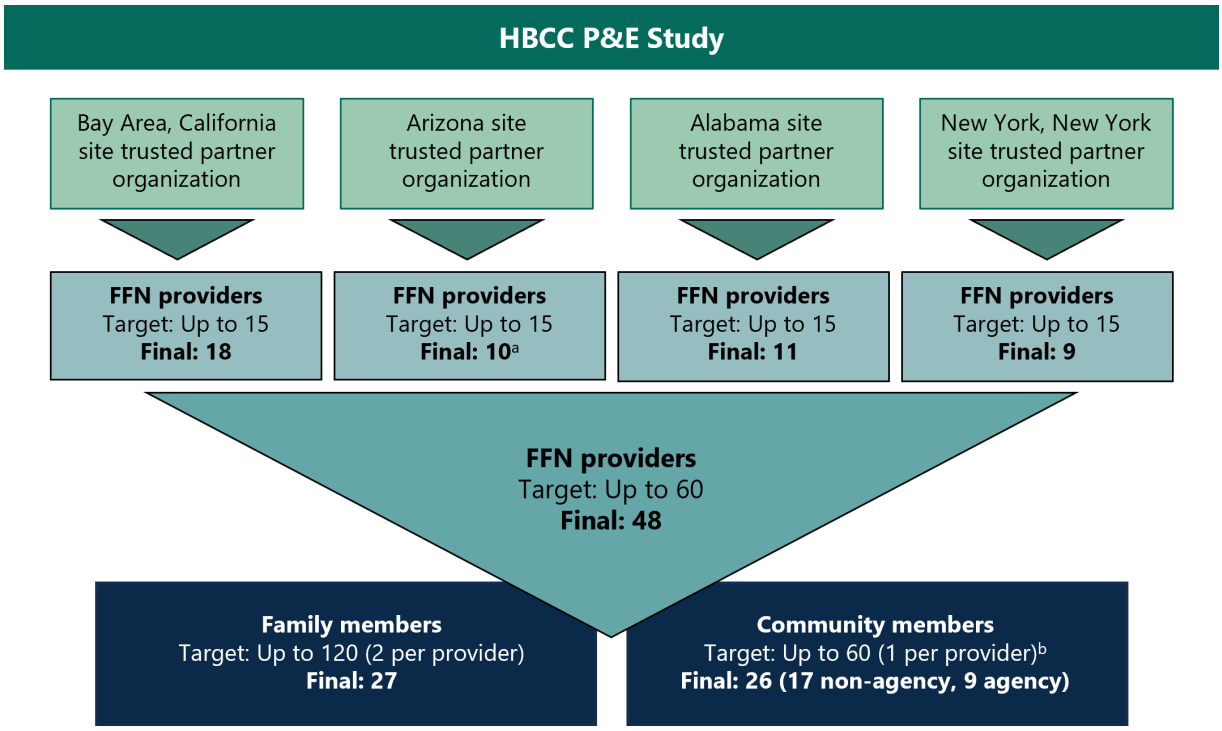
[6] The study team aimed to recruit 1-2 family members per provider. One provider gave contact information for more family members than was needed.

[7] The study team aimed to recruit 1-2 community members per provider. Some providers gave contact information for more community members than was needed or gave contact information for a community member who was already interviewed.

B. Study sample

The HBCC P&E Study collected data from 48 FFN providers, 27 family members, and 26 community members. Providers were included in the final analytic sample if they completed both the study screener and provider interview #1. Family members and community members were included in the analytic sample if they completed their respective interviews. Figure 3 shows the sampling structure for the study, including the target and final numbers of participating providers, family members, and community members. The lower sample size, particularly for family and community members, limits the ability to conduct one-to-one comparisons of providers and family or community members. It is possible that the small number of family and community members who participated have different characteristics than those who were not interested in participating.

Figure 3. Sampling structure target and final analytic sample



[a]Includes one provider who lives in Nevada.

[b]The study team aimed to select one community member to interview per provider. However, to increase the number of community members who were formal (agency) sources of support, we interviewed two community members for two providers.

1. Providers

The average age of providers in the study sample is 47 years. Almost all providers in the study sample (96 percent) identify as female. Most providers identify as Hispanic/Latino/a (40 percent) or Black (33 percent). Slightly less than half (42 percent) of providers were born outside of the United States. Likewise, slightly less than half (48 percent) of providers speak English only while 44 percent speak Spanish only or Spanish and English. Most providers in the study sample care for one to three children and most (62 percent) care for at least one school-age child. Most providers in the study sample care for at least one relative or at least one friend or acquaintance (71 percent and 29 percent, respectively), while 13 percent of providers did not know at least one child or child's family before providing care.

While our sample was similar to national data on unlisted home-based child care in many ways, including the relationship to children in care and the ages and numbers of children cared for (Schochet et al. 2022c), the study sample was also different from national data in key ways. To answer our research questions, we prioritized sites that included providers of color, providers who speak a language other than English, and providers who are immigrants. Our sample reflects that focus and, compared to national data on unlisted providers, includes a higher proportion of providers who identify as Hispanic/Latino/a or Black, providers who speak a language other than English, and providers who immigrated to the United States (Schochet et al. 2022a).

Tables 4 through 9 provide characteristics of providers in the study sample (Table 4), their economic and health characteristics (Tables 5 and 6), characteristics of the care they provide (Table 7), characteristics of children in their care (Table 8), and their involvement with CCEE systems (Table 9).

Table 4. HBCC P&E Study FFN provider characteristics

	Number of providers	Percentage/mean
Age (mean)[a]	**48**	**46.8**
Sex	**47**	**100%**
Female	45	96%
Male	2	4%
Race/ethnicity[b]	**48**	**100%**
American Indian or Alaska Native, non-Hispanic	0	0%
Asian or Pacific Islander, non-Hispanic	3	6%
Black, non-Hispanic	16	33%
Hispanic/Latino/a	19	40%
Multiracial[c]	4	8%
White, non-Hispanic	6	13%
Other, non-Hispanic	0	0%
Born outside of the United States	**48**	**100%**
Yes	20	42%
No	28	58%
Languages spoken by provider	**48**	**100%**
English only	23	48%
Spanish only	15	31%
English and Spanish	6	13%
Other	4	8%
Highest level grade or level of schooling	**48**	**100%**
8th grade or less	2	4%
9th-12th grade, no diploma	4	8%
High school graduate or GED	10	21%
Technical or trade school	1	2%
Some college credit but no degree	10	21%
Associate's degree (AA, AS)	10	21%

	Number of providers	Percentage/mean
Bachelor's degree (BA, BS, AB)	10	21%
Graduate or professional degree	1	2%
Currently enrolled in a degree program	**33**	**100%**
Yes	6	18%
No	27	82%
Geography of provider's home community[d]	**48**	**100%**
Rural	7	15%
Urban	41	85%
Current marital or relationship status	**46**	**100%**
Married	21	46%
Single	16	35%
Divorced or widowed	6	13%
Live with partner, unmarried	3	7%
Other	0	0%

Source: Data come from questions asked during the provider screener and coded responses to open-ended questions asked during provider interview #1.

[a] Provider age was estimated using provider's birth year.

[b] Provider race/ethnicity is based on coded responses to what providers reported in an open-ended question and may not fully reflect a provider's race/ethnicity. For example, a provider was coded as Black, non-Hispanic if they identified as Black or African American but did not self-identify as Hispanic or Latino/a.

[c] Includes providers who identify as multiracial or provided two or more race/ethnicity categories.

[d] Urbanicity is determined by provider's address, using the Health Resources & Services Administration (HRSA) Rural Health Grants Eligibility Analyzer; https://data.hrsa.gov/tools/rural-health. See https://www.hrsa.gov/rural-health/about-us/what-is-rural for methodology.

Table 5. HBCC P&E Study FFN provider economic characteristics

	Number of providers	Percentage
Experiences difficulty paying bills	**48**	**100%**
Never	20	42%
Once in a while	15	31%
Somewhat often	7	15%
Very often	6	13%
Engages in other paid work	**47**	**100%**
Yes	11	23%
No	36	77%
Receives government assistance	**46**	**100%**
Yes	23	50%
No	23	50%
Owns home	**48**	**100%**
Yes	15	31%
No	33	69%

Source: Data come from coded responses to questions asked during provider interview #1.

Table 6. HBCC P&E Study FFN provider health characteristics

	Number of providers	Percentage/mean
General health	**47**	**100%**
Excellent	6	13%
Very good	13	28%
Good	21	45%
Fair	6	13%
Poor	1	2%
Covered by health insurance	**47**	**100%**
Yes	38	81%
No	9	19%
Number of days sick or in pain in the previous month (mean)	**47**	**4.17**
Mental or physical health affects ability to provide child care	**48**	**100%**
Yes	8	17%
No	40	83%

Source: Data come from coded responses to questions asked during provider interview #1.

Table 7. Characteristics of the care provided by HBCC P&E Study FFN providers

	Number of providers	Percentage/mean
Number of children in care (mean)	**48**	**2.56**
Hours per week that provider offers care (mean)	**48**	**31.43**
Number of years cared for the children currently in their care (mean)[a]	**47**	**3.68**
Where care takes place	**48**	**100%**
Provider's home (is not [any] child's home)	32	67%
Provider's home (is also [at least one] child's home)	9	19%
Place of care varies	6	13%
Somewhere else	1	2%
Receives payment for child care[b]	**48**	**100%**
Yes	31	65%
No	17	35%
Age(s) (select all that apply)	**47**	**100%**
Infants (0 to 12 months)	10	21%
Toddlers (13 to 36 months)	19	40%
Preschool-age children (3 or 4 years old)	21	45%
School-age children (5 years or older)	29	62%
Hours of day (select all that apply)	**43**	**100%**
Standard daytime hours (6:00 a.m. to 5:59 p.m.)	43	100%
Early morning (4:00 a.m. to 5:59 a.m.)	6	14%
Evening (6 p.m. to 7:59 p.m.)	17	40%
Late nights (8 p.m. to 11:59 p.m.)	7	16%
Overnight (12 a.m. to 3:59 a.m.)	9	21%
Weekend care	10	23%
Other adult helps care for children	**48**	**100%**
Yes	29	60%
No	19	40%
If yes, relationship to other adult who helps with care	**29**	**100%**
Provider's spouse	12	41%
Provider's child	4	14%
Provider's parent	3	10%
Provider's sibling	2	7%
Provider's grandchild	1	3%
Provider names multiple relatives who help	6	21%
Provider's friend	1	3%
Provider relationship to children[c]	**48**	**100%**
Provider did not know children or family before providing care	6	13%
Provider is child's grandparent	17	35%
Provider is child's aunt/uncle	10	21%

	Number of providers	Percentage/mean
Provider is child's cousin	1	2%
Provider is child's other relative	7	15%
Provider is family friend	6	13%
Provider is family acquaintance	7	15%
Other (non-relative)	1	2%

Source: Data come from questions asked during the provider screener and coded responses to questions asked during provider interview #1. Although some providers in the sample also care for their own children in addition to others' children, these questions were asked about the children in the provider's care who are not their own children.

[a] If a provider cares for multiple children, this is the child who has been in the provider's care the longest.

[b] Payment can include payment from families or reimbursements from state programs.

[c] Providers may be included in multiple categories if they care for more than one child.

Table 8. Characteristics of children cared for by HBCC P&E Study FFN providers

	Number of providers[a]	Percentage
Physical or medical conditions	**47**	**100%**
Yes	9	19%
No	38	81%
Emotional or developmental conditions	**47**	**100%**
Yes	10	21%
No	37	79%
Gender	**48**	**100%**
Female	35	73%
Male	37	77%
Other, nonbinary	0	0%
Languages spoken in child's home	**48**	**100%**
English only	25	52%
Spanish only[b]	5	10%
English and Spanish	16	33%
Other	2	4%
Race/ethnicity	**48**	**100%**
American Indian or Alaska Native	3	6%
Asian or Pacific Islander	5	10%
Black	18	38%
Hispanic/Latino/a	28	58%
White	7	15%
Other	0	0%

Source: Data come from coded responses to questions asked during provider interview #1.

[a] Providers were asked if any children in their care had physical or medical conditions; emotional or developmental conditions; or spoke English, Spanish, or other languages in their home. Providers were asked to describe the race/ethnicity of all children in their care. Therefore, findings are presented at the provider-level, rather than child-level unit of analysis.

[b] One provider also reported caring for children who speak a language in addition to Spanish.

Table 9. HBCC P&E Study FFN providers' involvement with CCEE systems

	Number of providers	Percentage
Receives payment from child care subsidy program	**48**	**100%**
Yes	9	19%
No	39	81%
Participates in the Child and Adult Care Food Program	**48**	**100%**
Yes	4	8%
No	44	92%
Has previous CCEE experience or related education	**48**	**100%**
Yes	7	15%
No	41	85%
Has considered child care licensing/registration/ certification	**48**	**100%**
Previously considered	14	29%
Currently considering[a]	23	48%
Never considered	8	17%
Previously licensed	3	6%

Source: Data come from coded responses to questions asked during the screener and provider interview #1.

[a] Currently considering and not previously licensed.

2. Family members

Most family members (63 percent) in the study sample were relatives of the provider who cares for their children. Nearly one-quarter (22 percent) of the 27 family members included in the study sample did not know the provider prior to placing children in their care. Table 10 provides characteristics of family members in the study sample.

Table 10. HBCC P&E Study family member characteristics

	Number of family members	Percentage/mean
Relationship to provider	**27**	**100%**
Did not know provider prior to placing children in care	6	22%
Family member is provider's child	9	33%
Family member is provider's sibling	4	15%
Family member is provider's cousin	0	0%
Family member is provider's other relative	4	15%
Family member is provider's family friend	4	15%
Family member is provider's acquaintance	0	0%
Other (non-relative)	0	0%
Age (mean)[a]	**27**	**32.4**
Gender	**27**	**100%**
Female	26	96%
Male	1	4%
Other, nonbinary	0	0%
Race/ethnicity[b]	**27**	**100%**
American Indian or Alaska Native, non-Hispanic	0	0%
Asian or Pacific Islander, non-Hispanic	0	0%
Black, non-Hispanic	7	26%
Hispanic/Latino/a	15	56%
Multiracial[c]	3	11%
White, non-Hispanic	1	4%
Other, non-Hispanic	1	4%
Born outside of the U.S.	**26**	**100%**
Yes	11	42%
No	15	58%
Languages spoken at home	**27**	**100%**
English only	11	41%
Spanish only	7	26%
English and Spanish	8	30%
English and Other	1	4%

	Number of family members	Percentage/mean
Highest grade or level of schooling	**27**	**100%**
8th grade or less	0	0%
9th-12th grade, no diploma	2	7%
High school graduate or GED	10	37%
Technical or trade school	1	4%
Some college credit but no degree	7	26%
Associate's degree (AA, AS)	3	11%
Bachelor's degree (BA, BS, AB)	2	7%
Graduate or professional degree	2	7%

Source: Data come from coded responses to questions asked during the family member interview.

[a] Family member age was estimated using family member's birth year.

[b] Family member race/ethnicity is based on coded responses to what family members reported in an open-ended question and may not fully reflect a family member's race/ethnicity. For example, a family member was coded as Black, non-Hispanic if they identified as Black or African American but did not self-identify as Hispanic or Latino/a.

[c] Includes family members who identify as multiracial or provided two or more race/ethnicity categories.

3. Community members

Seventeen of the 26 community members (65 percent) included in the sample are informal sources of support, such as providers' friends and family. Nine of the 26 community members (35 percent) in the sample are formal sources of support, such as staff who work for the trusted partner organization or other community organizations that offer support and quality improvement opportunities to FFN providers. Table 11 provides characteristics of community members in the study sample.

Table 11. HBCC P&E Study community member characteristics

	Number of community members	Percentage/ mean
Type of support	**26**	**100%**
Formal (agency)	9	35%
Informal (non-agency)	17	65%
Relationship to provider	**26**	**100%**
Community member is provider's relative	10	38%
Community member is provider's friend	7	27%
Community member works at agency that supports FFN providers	9	35%
Other (non-relative)	0	0%
Age (mean)[a]	**25**	**50.0**
Gender	**23**	**100%**
Female	21	91%
Male	1	4%
Other, nonbinary	1	4%
Race/ethnicity[b]	**24**	**100%**
American Indian or Alaska Native, non-Hispanic	0	0%
Asian or Pacific Islander, non-Hispanic	1	4%
Black, non-Hispanic	5	21%
Hispanic/Latino/a	10	42%
Multiracial[c]	4	17%
White, non-Hispanic	2	8%
Other, non-Hispanic	2	8%
Born outside of the U.S.	**24**	**100%**
Yes	10	42%
No	14	58%
Languages spoken with provider	**24**	**100%**
English only	11	46%
Spanish only	5	21%
English and Spanish[d]	7	29%
Other	1	4%

	Number of community members	Percentage/ mean
Highest grade or level of schooling	**24**	**100%**
8th grade or less	1	4%
9th-12th grade, no diploma	0	0%
High school graduate or GED	6	25%
Technical or trade school	1	4%
Some college credit but no degree	2	8%
Associate's degree (AA, AS)	3	13%
Bachelor's degree (BA, BS, AB)	8	33%
Graduate or professional degree	3	13%

Source: Data come from coded responses to questions asked during the community member interview.

[a] Community member age was estimated using community member's birth year.

[b] Community member race/ethnicity is based on coded responses to what community members reported in an open-ended question and may not fully reflect a community member's race/ethnicity. For example, a community member was coded as Black, non-Hispanic if they identified as Black or African American but did not self-identify as Hispanic or Latino/a.

[c] This includes community members who identify as multiracial or provided two or more race/ethnicity categories.

[d] One community member also reported speaking two other languages in addition to English and Spanish.

IV. Data Collection Activity Participation and Sample Attrition

Participating providers were not required to complete all data collection activities, and participating in each activity was at providers' discretion. However, of the 48 FFN providers who participated in the study, almost all (45) completed both provider interview #1 and #2. Approximately 71 percent (34 providers) also completed at least two weeks of the audio and photo journal activities (one of these providers completed only audio journals). A small number of providers (3) did not complete both provider interview #1 and #2. Among these providers, one provider stopped communicating with the study team, whereas the other two shared their reasons for stopping their participation, which included that they no longer had enough time or they were experiencing a family emergency. Table 12 presents the number of respondents who completed each study activity by site, and Table 13 presents the number of respondents who completed each study activity by language of completion.

Table 12. Number of responses by data collection activity and study site

Study site	Provider interview #1	Photo journals	Audio journals	Provider interview #2	Family member interview	Community member interview
Alabama	11	5	5	11	4	6
Arizona	10	9	9	10	9	6
Bay Area, California	18	13	13	16	5	8
New York, New York	9	6	7	8	9	6
Total	**48**	**33**	**34**	**45**	**27**	**26**

Table 13. Number of responses by data collection activity and language of completion

Language	Provider interview #1	Photo journals	Audio journals	Provider interview #2	Family member interview	Community member interview
English	32	21	22	29	16	19
Spanish	16	12	12	16	11	7
Total	**48**	**33**	**34**	**45**	**27**	**26**

V. Reflections on Study Methods

The interview and audio journal transcripts captured participants' reflections on the study methods. Some providers felt that the study gave them an opportunity to reflect on what they do or gave them a new perspective. Others shared that participating in this study was a positive experience.

Participant Reflections on Study Methods

"It's that with this whole experience it really gave me a different perspective as to what I do. Because sometimes when you do things for so long you don't see the influences that you have or don't have…. I looked at my outside area and I've been looking at it for a year now and not really seeing any changes that are necessary. But when I had to go out and actually take pictures of it, I saw that there's room for improvement. And so it's been a growth for me as well and so I do appreciate you are letting me participate in this study."

"This experience has opened my eyes a lot to just what goes on. Even though I don't realize it, what all goes on to taking care of the kids, the day to day stuff, if you stop and think about what you do, it's pretty cool. Being a grandma is pretty neat."

"But I just really enjoyed talking and there's some things out there that I went through because a long time ago I couldn't talk. I just had to keep things within me, about what I went through in life. But now I've been able to talk and try to express myself more. That's what we all need. Express ourselves. You don't hold it back. Just express it and see what the other person feels. And so we can get along better in this world. But I really enjoyed it."

"Hello, good afternoon, this week I have felt very happy. Happy in our last week of practice… it has been a pleasant experience to be able to tell how I feel. Being able to relate the experiences that I have had because one simply lives them, but when you tell them it is a real way to feel what you have done or what you have gone through with the children and that makes me feel very good. It is very good to be able to express myself and to be able to tell about my experience." ◢

VI. Analytic Methods

The study team used inductive and deductive analytic approaches to answer the study's five research questions. We conducted a systematic and iterative process of coding and analysis throughout and after the data collection period. During data collection, analytic memos documented preliminary themes, theories, and observations that emerged during interviews and listening to audio journals. The study team developed preliminary codebooks based on emergent themes from study participant narratives. These codebooks were then modified through an additional reading and discussion of full interview and audio journal transcripts. Final codebooks were developed, interview and audio journal transcripts were coded using NVivo qualitative software, and interrater reliability checks were conducted.

A. Transcript preparation

All interviews with providers, family members, and community members were transcribed by an external service. Interviews completed in Spanish were translated and transcribed into English. The audio journals were transcribed by the EthOS application's artificial intelligence in English and Spanish. The study team reviewed and cleaned the EthOS transcriptions and translated the Spanish transcripts into English.

Once the transcripts were ready, the final step to prepare for analytic coding and analysis was structural coding. Members of the study team were trained on structural coding and completed this first phase of coding as transcripts were ready. Structural codes were developed based on the interview questions, photograph requests, and audio journal prompts. The structural code book followed the sequence of each interview protocol. Structural coding was used to organize transcript data in preparation for more detailed and analytic coding processes (Saldaña 2021).

B. Inductive analyses

For research questions 1, 2, 4, and 5, we started with "In Vivo" coding. "In Vivo" coding uses the words of participants to develop themes rather than using an a priori set of constructs (Saldaña 2021). The development of the "In Vivo" codebooks was an iterative process that began during data collection. After conducting each interview and after viewing photographs and listening to audio journals each week, interviewers wrote memos on the preliminary themes, theories, and observations using key words and phrases that participants used. Interviewers then entered the key words and phrases into a coding spreadsheet. On a weekly basis, study team members synthesized and grouped key words or phrases that were entered into the spreadsheet, combining concepts and themes that were similar. When possible, we aimed to retain the language used by respondents rather than imposing external terminology. We tested the preliminary versions of the codebooks with sections of cleaned transcripts that focused on the applicable research question and identified additional themes and synthesized categories further to avoid duplication. New codes that emerged during the analytic coding process were added to the codebooks.

Members of the study team coded all transcripts using the final codebooks. We ran initial reliability checks across 20 transcripts (four of each type: provider interview #1, provider interview #2, audio journals, family member interviews, and community member interviews) across the four sites using NVivo software. The study team discussed discrepancies below 80 percent agreement and agreed on how the discrepancies should be resolved. The study team participated in weekly meetings to discuss any additional coding questions.

Once the initial coding was completed, we grouped codes related to the same or similar themes together. We used both Axial and Theoretical coding approaches to further answer the research questions, for example, about how and why features of quality are implemented. Axial coding involves identifying categories of themes from the narratives that are connected to In Vivo codes. Theoretical coding involves identifying and "discovering" the broader themes or concepts that are central to our study. For example, what characterizes the ways FFN providers and families perceive quality and broadly what is important to them.

C. Deductive and additional analyses

We used deductive analysis approaches to examine themes that have been identified in prior research such as the types of supports providers rely on and the ways that providers support families (Bromer and Henly, 2009; Turner 2022; Pillado and Savage, 2023; Danna-Poston, 2021). We created spreadsheets with a priori categories that interviewers and members of the study team used to code sections of the transcript narratives. In all deductive analyses, we allowed for the inclusion of emergent themes. In addition, demographic and care characteristics were obtained via open ended questions. Data on provider and care characteristics were coded and turned into variables that could be connected with transcript and audio journal narratives in the NVivo files. This allowed the study team to examine provider experiences within subgroups.

Additional details about the specific analytic approaches used to answer each research question will be included in the HBCC P&E Study report and briefs.

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