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ABSTRACT

Training is often difficult to acquire for family day care providers because most training initiatives are workshops or seminars, which require a specific time frame and which are frequently scattered and lack continuity. A practicum project developed and implemented one unit, or module, of a 13-module self-instructional training program using an existing curriculum for family child care providers. Each module takes an average of 4 to 6 weeks for the provider to complete, and has a self-assessment component to help identify strengths and weaknesses. There are activities in each module as well as readings and references. The training incorporated support by means of a master provider who served as a mentor and a cluster group to validate providers' participation. The goal at the end of the 10-week implementation was to increase the quality of care in the pilot group as measured by the Family Day Care Rating Scale before and after the implementation period. The pilot group consisted of four providers and one mentor. Responses of providers showed a high level of provider satisfaction with the training. The quality of care provided also increased as indicated by the pre- and post-project assessment. Results suggest that this program can prepare providers for National Association for Family Child Care (NAFCC) Accreditation, or for the Child Development Associate (CDA) credential, if instituted by a resource and referral agency or a providers' association. (Twelve appendices include mentor and provider application forms, provider and mentor program evaluation forms, and pre- and post-assessment scores. Contains 74 references and a 24-item bibliography.) (HTH)

Improving the Quality of Family Child Care Through the Implementation of a Mentoring and Self-Instructional Training Program for Family Child Care Providers

by

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Cohort 63

A Practicum Report Presented to the
Master's Program in Child Care, Youth Care, and Family Support
in Partial Fulfillment of the Requirements
for the Degree of Master of Science

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Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the works of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my work, presented here, will earn similar respect.

1/12/95

Date

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Signature of Student

Abstract

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Family child care quality has been under scrutiny and regarded as being of poor quality. Research shows that the majority of family child care is adequate or custodial in quality, but due to the greater exposure to family child care, the quality of care needs to be raised through training. Training is often difficult for providers to obtain because most training initiatives are workshops or seminars which require a specific time frame for the provider. This format also is frequently scattered and lacks continuity.

The author implemented one unit, or module, of a self instructional training program utilizing an existing curriculum for family child care providers. It incorporated support via a master provider serving as a mentor and a cluster group to validate providers participation.

The responses by providers showed a high level of provider satisfaction with the training. A pre-assessment and post assessement measuring the quality of care provided to children indicates improvements in the level of care. The complete training program involves thirteen modules. Viewing the need to "make training count", this program can prepare the provider for NAFCC Accreditation, or for the CDA credential if instituted by a resource and referral agency or a providers association.

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Chapter I: Introduction and Background

The Setting Where the Problem Occurs

The setting for this practicum involved family child care homes in a mostly rural county in central New Jersey. In order to alleviate misconceptions of family child care and to comprehend the particular population being addressed, a broader understanding of family child care will first be presented.

What is Family Child Care?

Family child care is an arrangement where a small group of children, generally numbering less than 6, are being cared for in the home of an unrelated provider. Family child care or family day care is defined differently by state regulation in each state. Family child care is the most frequently used form of child care. It is most popular with infants and toddlers. Exact numbers of FCC homes cannot be reached since many arrangements across the country are informal and income is often not reported, making it impossible to determine the number of unregistered, unlicensed providers. There were 273,926 registered FCC homes in 1993 (The Children's Foundation, 1994) with the number of unregistered providers ranging from 550,00 to 1.1 million in 1990 according to the Profile of Child Care Settings Study (cited in Hofferth &

Kisker, 1993). It is estimated that 3.3 million children are served by these unregulated providers.

The field of family child care is so diverse that each individual family child care home even within one community could be quite different. Some states require licensing or registration, whereas, others offer voluntary systems or no regulation at all. Group size, or the number of children cared for by the provider varies greatly from state to state, from 4 children in Arizona to 12 children in Texas (Children's Foundation, 1993). To further confuse the issue, some states allow for a large group family child care home allowing up to 20 children in a home in South Dakota.

The training requirements also vary greatly from state to state. The number of states with some requirements have increased from only 19 states with regulations on FCC in 1984 to 40 states in 1993. Ten of those states require only an orientation and 11 require only CPR or first aid training. The remaining states require between 4-20 hours of training annually (Harms & Miller, 1994, p.1).

Family child care has not reached the level of consensus among its members that the center based portion of early childhood education has reached. The National Association for Family Child

Care (NAFCC), previously the National Association for Family Day Care, just celebrated its tenth anniversary. Some state and local FCC associations are older than the national association. State FCC organizations are not affiliated with NAFCC although they support it. Different groups of providers have different values. Some FCC providers incorporate center like activities. Others claim those providers are taking the "family" out of FCC. Some providers offer more structured activities and others treat a child in FCC exactly as one of their own and go about their daily business of shopping, errands, and household chores. While these activities may be acceptable to some families, they are not acceptable to others. It has been suggested that families seeking FCC look for providers that have similar values to their own. Just as family values differ, values in family child care differ.

Family child care is as diverse as the many cities and towns across the country. Perhaps FCC mirrors its community. Children are not raised in a vacuum and the environment plays a strong role. The environment includes the child's neighborhood and family as well as the economic conditions and the parents employment.

Therefore, the demographics impact significantly on the services to children. Bear in mind that since the number of

families served by one provider is very small. General statistics may not be an indicator of services provided by FCC within a different community.

The Setting Where the Problem Occurs

The county targeted in this paper is rapidly growing with a large number of young families due to new home construction and several large corporations in the vicinity. The population grew from 198,372 in 1970, to 203,129 in 1980 and 240,279 in 1990, with 7% of the 1990 population under the age of five (Information Publications, 1993). This has lead to a deficit of quality care in the area. The county is considered to be rural and suburban although there are over 250,00 people living within the county's 305 square mile area. There are no major cities within its borders.

There are currently approximately 4,200 registered providers (DYFS, 1994) throughout the state, which probably represents only 15% of the children in family child care. The sponsoring organization reports approximately 200 registered providers within this county. It is difficult to estimate the number of unregistered providers since many do not report their income. The estimates of numbers of unregistered providers are extrapolated from the number of children who need care, and

subtracting all known forms of care, such as relatives, nannies, centers, and those children in registered FCC homes. Over 20% of the registered providers in this county are members of the state providers association (Alys Muller, personal communication, September 2, 1994). Networking and membership in organizations is considered to be an indicator of professionalism (Kontos, 1992).

The median household income was $55,519 in 1990 (Upclose Publishing, 1993). Latest reports from the U.S. Census as reported in the Star Ledger (Cohen, Sept. 2, 1994), reports this county as the second highest median income in the state and ranks as number three nationally.

Mollenhauer (1994) recently conducted a research study within this state through a written questionnaire. The survey was mailed to over 3000 members of family child care associations, networks and sponsoring organizations. Each person was sent three surveys and was asked to pass the other surveys on to unregistered providers that they knew. Over 800 providers responded. The responses came from mostly registered providers, 87.4% , thus under representing the unregulated providers which are believed to be a much greater number than registered.

Mollenhauer (1994) paints the picture of who the family child care providers are in New Jersey. Less than 5% of FCC

providers are under 25 years of age and less than 8% are over 55 year old. The majority are married, 78.9% and are providing care out of a house, 86.1%, versus an apartment, 12.1%, or a condominium, 1.9%. The percentage of providers living in an urban, suburban and rural areas are 20%, 61.1% and 18.9% respectively. The primary language of the provider is English, 90%, but 9.4 % speak Spanish as their primary language and, .5% speak another language.

While nationally the predominance of family child care providers are believed to have a low level of educational attainment (Kontos, 1992) with an average of 11.9 years (Divine-Hawkins, 1981), Mollenhauer shows that only 10% of the respondents had less than a high school diploma and 3.4% had a high school diploma. The remainder ranged from some college to a doctorate degree with 30.2% and 27.4% respectively having some college or an AA degree. This seems to be fit with the education of the county residents overall with 44.4% of the people over 25 year old having at least a bachelor's degree, 42% have a high school diploma, and 13.7% do not have a high school diploma (Upclose Publishing, 1993).

The state of New Jersey recognized FCC through regulation in 1987. The state of New Jersey has a voluntary system of

registration for family child care providers. That means basically anyone can legally be a FCC provider and care for up to five children at a given time for a fee. A sixth child constitutes a center which must be licensed. Only FCC providers who register are required to meet the standards or regulations set by the state. Changes in these regulations are currently being adopted which do not substantially change the quality of care. A registered FCC provider must be a minimum 18 years of age and attend a six hour preservice orientation training (N.J.A.C. 10:126-5.2). Registration is done through sponsoring organizations which are resource and referral agencies (R & R's) which have contracts with the state authorizing them to register FCC providers. The sponsoring organizations also monitor registered providers homes, make parent referrals, conduct training sessions and provide technical assistance. The certificate of registration is effective for three years. Upon renewal the provider must either show six hours of training attended or repeat the preservice orientation training (N.J.A.C. 10:126-5.6). In the absence of a mandatory system, the providers who do not want to meet the standards may operate within the state without the benefits of registration.

There are certain benefits that provides get from

registration. Once registered, the provider is able to obtain affordable liability insurance. In the past some townships disallowed family child care as a business operating in a residential zone, and condominium organizations likewise precluded family child care because it was a business operating out of the condominium. In 1992, registered family child care gained legal status of operation without special zoning variances in residential zones under P.L. 1992, Chapter 13 (S-110) (cited in The New Jersey Child Care Advisory Council, 1993). This added an important benefit to providers and an incentive to become registered. Registered providers can also take advantage of the Child Care Food Program since there is no means testing for the children in care. The sponsoring organization offers many free training and subsidized training experiences.

The sponsoring organization in the targeted county also represents several other counties. They seem to be innovative in their approaches to met the needs of FCC providers and procure funding from corporations in addition to the state and federal funds available.

The sponsoring organization in this county has been very supportive of family child care through the development of alternative programs to meet the training needs of the providers.

Topics for training are solicited from the providers. Likewise in recognition of the experience and knowledge of the providers, they have asked providers to conduct or facilitate training for family child care providers.

In addition to the sponsoring organization there is also an independent agency that has formed a network for providers supplying services similar to the sponsoring organization, with the exception of registration. This network has established its own standards which are higher than the state regulations and monitors its providers more frequently.

Role in the Setting

The practicum was undertaken by a registered family child care provider. The provider is accredited by the National Association for Family Child Care (NAFCC) and a validator for NAFCC accreditation. She is an active member of the state FCC association and was a prior board member. She attends seminars and conferences frequently, in excess of 60 hours per year. The provider attends several national conferences annually and has gleaned information and attitudes of FCC providers from other parts of the country. Through participation in community functions and the afore mentioned workshops, the provider has gained visibility within FCC and the child care profession in

general as well as having the opportunity to view FCC from many perspectives. From these experiences, the provider began presenting workshops during the past year.

Chapter II: Study of the Problem

Problem Statement

There is a direct correlation between quality of care and the level of training (Eheart, 1987; Grubb, 1993; Jones & Meisels, 1987; Kaplan & Smock, 1982; Nelson, 1989; Vartuli, 1988) professionalism (Galinsky et al., 1994; Grubb, 1993; Rosenthal, 1988, and regulation (Cox & Richardz, 1987; Grubb, 1993; Nelson, 1991; Stalling & Porter, 1980; Zigler & Lang, 1991) of family child care providers. Yet the quality of care is variable at best. There is no comprehensive training program meeting the diverse needs and time constraints of family child care providers being implemented in this county. Through a review of literature and discussions with parents, child care providers, and FCC organizations, there is a need for improving the quality of care of family child care providers. While some providers complain that they can not recruit children, other providers are receiving numerous calls, but have no vacancies. It is not a lack of supply, but a lack of quality positions available in FCC homes (Divine-Hawkins, 1981) It was the intent of this practicum to increase the quality of family child care homes through implementation of a comprehensive training program for FCC

providers which meet their needs as adult learners.

Since credentials and accreditation are valuable ways for parents to readily identify a provider of high quality care, the training should be applicable to either the NAFCC accreditation or the National Association for the Education of Young Children (NAEYC) recognized credential of Child Development Associate (CDA).

Documentation of the Problem

The Problem

The educational and experiential backgrounds of the providers differ considerably. The state requires no minimum standards for the provider since registration is voluntary. Unlike centers, there are no staff in-service trainings, therefore training itself is voluntary.

In the Families and Work Institute study of family child care and relative care (Galinsky, Howes, Kontos, & Shim, 1994), only 9% of the homes were found to be of good quality, with another 56% being rated as adequate, and 35% were rated as inadequate. In another study, Sale (1988) found 9% superior, 28% good, 52% custodial, and 11% poor.

Only 25.9 % of providers responding to a survey (Mollenhauer, 1994) attend monthly training and 4.1% attend weekly

training. That leaves the other 70% of providers ranging from no training at all to attending once or twice a year. The majority of respondents were registered, 89.4%, thus over representing that group. Based on the number of children of working mothers, it has been estimated that 90% to 94% (Eheart & Leavitt 1986; Wandersman, 1982) of family child care children are in the homes of unregistered providers. Those providers lack the resources of the sponsoring organization thus the implication that they receive less training than providers in the registered system.

The NAFCC accreditation is a symbol of quality care. Yet only 13 FCC providers in this state are accredited (Elaine Piper, personal communication, July 28, 1994). This number represents a decrease from the previous year.

Over concern with the apparent lack of interest in the NAFCC Accreditation, the issue was discussed informally with active providers in the community. Initially, they responded that the cost was prohibitive. After further discussion, the cost itself was not the real issue. The true issue seemed to be value and cost effectiveness. What would she get for her investment of money and time? What if she decides to teach in a preschool setting? Their answers reinforced the need for a continuum and a career ladder for early childhood.

Analysis of the Problem

What is Quality in Family Child Care?

Quality needs to be defined before it can be assessed. Quality itself is very subjective. When quality is measured, certain criteria or standards are really being measured. Quality is perceived differently by early childhood experts, providers, and the families that use family child care. A visual description of a FCC home might be one that is warm and cozy and arranged to facilitate the growth and development of a multi-aged group of children. It must provide safety for all infants and children while allowing the preschool age children the freedom to accomplish age appropriate experiences. Aspects of the home should remain which provide the feeling of warmth. In family child care, the arrangement of the environment is important to the quality of care (Koralek, Colker, Dodge, 1993, p. 91). The family child care provider takes on the role of the director, the administrator and the care provider. It is the provider who sets the environment, makes the purchases and makes administrative types of decisions. Quality assessments need to examine each of these roles as it does in center care. One clear definition of quality in family child care may never happen (Divine-Hawkins, 1981) due to the diversity of family child care.

How the early childhood profession defines quality. Quality is not easy to define. It is most often measured via a list of standards or criteria developed. Ehrlich (1993) lists four element found in any high quality early childhood program. First, is the adult to child ratio should be small enough to enable each child to have sufficient time with the caregiver. Second, the size of the group, regardless of the number of caregivers should remain workable. Third, the caregiver should have training in early childhood development. And fourth, turnover of caregivers should be minimal, that is there should be a continuity in the caregiver. Job satisfaction (Jorde-Bloom, 1989) might be added to the list and it impacts heavily on turnover. While this is not a comprehensive list, it does outline four key aspects of quality care. Note that training of the provider is a characteristic of quality care.

How providers define quality. The attitudes of providers differ from the experts in early childhood (Eheart & Leavitt, 1986). Providers reported patience and love of children to be the main two ingredients in quality care. Training and professionalism were not considered important to the children's welfare. Providers often feel that parenting and raising their own children are sufficient qualifications for providing family

child care (DeBord, 1993; Kontos, 1992). Yet there is very little parenting education available. Parenting education is mostly informal and involves networking with other parents.

How parents define quality. Galinsky et al. (1994) found five items that parents identified as indicators of quality care. Attention to the child's safety was first. Second was a high level of communication between the provider and the parent. Third was cleanliness. The fourth and fifth indicators were the attention the child receives from the provider and the provider's warmth toward the children. This coincides with other findings emphasizing the provider and child relationship as the center issue of quality (Phillips and Howes, 1987; Phillips, Skarr & McCartney, 1987). When seeking high quality care, Galinsky et al. (1994) recommends looking for three predictors, intentionality, desire to learn, and regulation.

Predictors of quality. It can be difficult to separate personal or family values from the overall assessment of quality within a home. This can make it difficult for parents to assess the quality of care. There are some similar characteristics both parents and providers value. An important provision of quality care is the mutual agreement between the parent and the provider as to the children's needs (Atkinson, 1991; Powell, 1989). Some

studies have found that agreement on the terms of quality exists (Galinsky et al., 1994; Pence & Goelman, 1987). Although providers know what they should be doing, providers do not always provide the quality of care they intend and self assessments were not found to be reliable (Poresky, 1977).

The National Child Care Center Study showed children of low income children to be in high quality center care due to subsidies provided by the government. Middle income children were found to be in the lowest quality of center care. Kontos (1991) suggested that in family child care there is a minimal use of subsidies and expected to find low income children to be in the lowest quality care. Kontos (1994) found fees to be an unreliable predictor of quality. Galinsky et al. (1994) did find low income children in family child care to be disproportionately in low quality care.

How quality effects children. More young children are in child care and for a longer number of hours. Approximately 25-35% (Kontos, 1992) of children under the age of six are in family child care homes and an undetermined number of after school children are in care. The increased amount of exposure to child care increases the importance of quality care. Children in high quality care are more socially and emotionally competent (Howes & Stewart, 1987) and securely attached to the provider and

cognitively competent (Galinsky et al., 1994)

Recognized Accreditation and Credentialing Systems

Out of the National Family Day Care Home Study, came the recommendation for a family child care credentialing system to give credibility to the work, build a profession and provide a standard for parents (Divine-Hawkins, 1981). Since then, many programs have been developed, some nationwide and other restricted to a state or even an urban area (Modigliani, 1990).

Modigliani (1990) identified and compared five different accreditation systems used in family child care environments. Harms and Miller (1994) examined four systems of recognition. A total of seven different systems were identified and these two works are not comprehensive. There are other programs for recognition of quality care. The inherent problem is the lack of consensus and lack of direction.

To establish a system of recognition, criteria or standards must be identified along with reliable valid methods of measuring the criteria. The family child care field has not adopted the standards set by NAEYC for center based care. The guidelines do not meet the unique and diverse circumstances of family child care (Windflower Enterprises, 1994). The National Association for Family Child Care has developed its own set of standards

(Abbott-Shim & Sibley, 1987) through an accreditation instrument. The program has been criticized by some (Harms & Miller, 1994) since the criteria were not developed first and the evaluation is based in part on provider self report.

The CDA credential for family child care has been down played because it does not address the administrative and business components of family child care. The terminology of accreditation and a credential should be clarified. Bratton and Hildebrand (cited in Harms & Miller, 1994, p.7) define accreditation and certification as types of credentials, but accreditation refers to a program, whereas, certification is given to a person for recognition of a level of competence. From that perspective, CDA and NAFCC accreditation are quite different. The CDA goes with the person if they change positions or works in another location. The NAFCC accreditation is specific to the program only in the home which was accredited.

It is important to bear in mind that FCC is still in the grassroots stage of development. Several organizations have been instrumental in setting direction and have been working on collaboratively to develop a identity to family child care. The Children's Foundation (1994) is discussing the concept of national standards with providers and agencies. Windflower established the

FAAIR Coalition in 1992 in response to NAEYC's model of professional development, which was viewed as excluding most of the FCC providers. It has since been changed to a "framework" and NAFCC has been invited to develop their own framework to bridge with NAEYC. Thelma Harms (1994) has been working in collaboration with other organizations and professionals to develop quality criteria for family child care providers. Although consensus has not been attained, the FCC field is moving in a more professional direction.

Training, Professionalism, and Turnover

Training is directly related to high quality care (Jones & Meisels, 1987; Kaplan & Smock, 1982; Nelson, 1989; Vartuli, 1988). Eheart (1987) states "training is recognized as essential to the provision of quality care". This element is recurring throughout the literature and supported by the findings of the National Family Day Care Home Study (Divine-Hawkins, 1981). What is unclear from the research is the direction of the relationship (Kontos, 1992).

Professionalism, training, job satisfaction, commitment and turnover appear to be highly interrelated. Providers who are committed to their profession of family child care are more intentional in care giving practices (Galinsky et al., 1994).

Commitment come from feeling one's work is worthwhile and valued (Jones, 1991; Kontos, 1992; Pence & Goelman, 1987) and from the wages and training attached to the work (Benson, 1985). The socioeconomic background and the level of education of the provider relates to the level of commitment. While some people question the direct relationship of training on quality as being inconclusive, training does increase job satisfaction and wages (Kaplan & Smock, 1988). These factors can decrease turnover. The turnover in FCC has been estimated to be as high or higher than center care (Atkinson, 1988; Kontos, 1992; Nelson, 1989). Atkinson (1993) found 35% of FCC providers quit within one year and another 29% reported having little commitment. Training can also have an indirect affect on quality by increasing networks and the sense of professionalism.

Providers who have a higher education and report having training also rate higher quality of care (DeBord, 1993; Galinsky et al., 1994). Providers who care for larger groups of children have been found to have an educational background pertaining to early childhood education (Galinsky et al., 1994; Wandersman, 1981). These providers are more professional and provide higher levels of quality. Training is often a assessment characteristic of quality. Short term training program are not effective

(Rosenthal, 1988) since they do not have time to alter attitudes and behaviors.

Workshops and home visits are the most common forms of FCC training (Kontos, 1992, p.145). Recruiting providers to obtain training has been difficult. Eheart and Leavitt (1986) found providers do not want training. With a field that lacks a career ladder, has a high rate of turnover, and low wages, it seems obvious that providers could be disinterested in investing time and energy into training. This also points to a possible role of training, to increase provider satisfaction and stability (Bollin, 1993). Providers who have intrinsic reasons for getting involved in training are the most likely participants (Modigliani, 1990). Sale (1988) found self motivation to be the greatest influence on quality coupled with a support system. So most providers involved in training are concerned with professionalism, pride, networking and social aspects of training. Extrinsic forces play a very small part since additional training does not increase income (Modigliani, 1990).

Providers reported lack of time and energy, accessibility, and fear of failure as the three greatest obstacles to training (Modigliani, 1990). Snow (1982) agrees with accessibility, but adds recognition of the caregiver as the second aspect. Lack of

accessibility seems to be a common thread of training resistance (DeBord, 1993; Galinsky et al., 1994; Vartuli, 1988). DeBord (1993) also found that providers need respect and recognition of contributions. Once the initial resistance is overcome and the provider attends training, the resistance decreases (Wattenberg, 1977). Wattenburg recommends using a "buddy system" to overcome this resistance. She also classifies providers into four types and suggests that different approaches work with each group. Traditional providers are similar to the traditional stay at home mother who never worked outside the home. Neighborhood and peer group types of training are recommended. The modernized provider has worked outside of the home and is more likely to prefer accredited course work. The transitional provider is in transition between the traditional and modern provider. Short term but more formalized training is preferred. The novice is new to family child care and perhaps somewhat overwhelmed. She would respond well to home based training and guidance.

New family child care providers often express the need for training or information on the business aspect of family child care. FCC providers are operating a small business and need training in administrative issues as well as child development (Debord, 1993, Modigliani, 1990). The lack of training available

for directors of centers has been documented (Jorde-Bloom, 1992), but little attention has been paid to the business and administrative aspects in research on family child care. An equitable type of training is necessary for family child care.

Regulations

State regulations, or lack of them, can be viewed as a contributing factor. States that have mandatory regulations for family child care have higher quality of care (Zigler & Lang, 1991). Registered providers have more training than unregulated providers (Cox & Richardz, 1987). As a group, unregulated providers are in the greatest need of training, yet they are the least accessible and the most difficult to recruit (Nelson, 1991). Regulation was found to be equal in importance to training (Stalling & Porter, 1980). This is due at least in part to the system which affords greater availability to regulated providers Galinsky et al., 1994). Pennsylvania requires twelve hours of training biennially for regulated FCC providers (Pennsylvania State Department of Public Welfare, 1993) and have developed an intensive support system to make the training available throughout the state. Monitoring should also be used to assure that the standards are being meet (Divine-Hawkins, 1981).

The Children's Foundation compiles the regulations of each

state annually. They have noticed a trend toward stronger regulations in FCC (April, 1994). They clarify the difference between registration and licensing. The terms are often used interchangeably, however, licensing is a minimal standard to protect the public from incompetent practices, whereas, registration is a lesser standard used when the government does not want to license (1993). Morgan et al. (1985) refers to licensing as the "floor of quality" and "a ceiling is represented by the goals of the profession" (p.15). Grubb (1993) showed a relationship between compliance with minimal standards and high quality care. He found both compliance and quality are a result of training. Specifically, he mentioned understanding the rationale behind standards as improving compliance with standards. Nelson (1991) found regulated and unregulated providers to be similar in levels of compliance, however, the regulated providers were observed to determine levels of compliance whereas, unregulated providers self reported their level of compliance. Self reports are not as accurate a measurement (Eheart & Leavitt, 1989; Poresky, 1977). Regulation also has the function of raising the level of awareness of providers by setting the minimal standards (Leavitt, 1991). Professionalism also had an impact on increased quality (Grubb, 1993; Rosenthal, 1988). Rosenthal

(1988) contends that quality of care can not be looked at in isolation, but must be viewed along with the environment and the beliefs and attitudes of the provider.

Attitudes toward regulation vary by the attitude or orientation of the provider to the occupation of family child care (Nelson, 1991). Regulation has been resisted by providers attitudes. Many providers see no benefit to regulation and view it as an intrusion by the government (Nelson, 1991). Leavitt (1991) views the lack of national standards as a lack of commitment to quality care for children on the part of society at large.

Intentionality

Many insights come from the recent Galinsky et al. study (1994). Galinsky et al. refers to the concept of "intentionality" in care giving. Intentional providers have chosen family child care as their work. They are committed to caring for children and provide a nurturing home environment. They seek out learning opportunities and prefer to associate with other providers so that they can share their knowledge and learn from others. None of the providers in the Families and Work Institute study (Galinsky et al, 1994) who were providing good quality care considered there work to be temporary.

Providers with more formal education were more sensitive and responsive to the children, and in turn rated higher on global quality. Also providers with more family child care training were more sensitivity. The number of years of experience within family child care is not associated with higher quality of care. In fact, the providers in this study who had the most years of experience were harsher and more detached, but they also had the least training in family child care. Planned activities were connected with more responsive and sensitivity on the part of the provider. Thinking ahead and planning activities so that the materials are available to the children, whether the activity be structured or open, is one more indication of intentionality. Providers who are more involved with family child care associations or the Child and Adult Care Food Program, and those that are more involved with other family child care providers are more sensitive and responsive, and provide higher level of care. Networking with other providers offers a way of learning from others and makes the work more intentional.

Regulation is linked to this also. Providers who are registered are linked to other providers, resources, and training. They are more likely to seek out opportunities to learn. A larger group size, of four to six children, rated higher quality than

small groups of one or two children. This was also found by Dunn (1993) and can again be explained by intentionality. Group dynamics also plays a part. More interaction among the children might occur when the size of the group is increased, while at the same time the provider must be more attentive and prepared to handle the larger group. Higher quality care was also associated with providers who charge higher rates and follow standard business practices.

Chapter III: Goals and Objectives

Goal

The goal at the end of the ten week implementation of the practicum project was to increase the quality of care of family child care providers in the pilot group using the Family Day Care Rating Scale to measure the level of care before and after the training implementation period.

Objectives

I initially identified seven objectives to be accomplished through the implementation of the practicum. Some of the objectives were modified during the practicum. All modifications are explained along with the rationale for the change.

1. Recruit eight providers and two mentors for the program through free community service advertisement on the local cable station, word of mouth, and the local resource and referral agency. A questionnaire will be developed by the author to establish the criteria for the providers and the mentors.

The initial goal of eight providers and two mentors was reduced to four providers and one mentor. Difficulty came with the timing of the project over the last three months of the year. In addition to the normal time restraints during that time of

year, a local program which was initiated earlier in the year was commencing in December. It also included a mentoring component. That program was supported with corporate funds and was able to pay the mentors for their time. Only one mentor could be located for this practicum. It was my desire to retain the four to one ratio and therefore recruited only four providers. The four providers were located informally and the cable advertisement was not necessary.

2. Utilize an existing systematic comprehensive training program for family child care providers which is recognized to meet national standards and criteria. Implement one module of a monitored self instructional training program for family child care providers over a four to six week period, with the providers scoring 80% on the posttest developed with the curriculum at the end of the six week period.

3. Evaluate the quality of care provided by the target group of providers before and after training, using the Harms and Clifford (1989) Family Day Care Rating Scale administered by the trainer.

4. Develop a support system for family child care providers through mentoring, by assigning one experienced provider as mentor to four providers. The mentor will contact the provider a minimum

of once a week and be available for the provider to contact when needed. The benefit of the mentor will be measured by a questionnaire completed by the provider at the end of the module.

5. Meet FCC provider needs for networking and sharing experiences through a group session at the end of the self instruction period, facilitated by a trainer. The meeting will be hosted by one of the providers, mentors, or trainer, in their home. If the program were ongoing, the site of the meeting would rotate among the members of the group. The benefit of the group session will be measured by a self questionnaire completed at the end of the group session.

6. Measure provider satisfaction with each aspect of the program through a self questionnaire administered during the cluster group meeting at the end of the training implementation.

7. At the end of the ten week practicum implementation and using the information gathered from the aforementioned objectives, develop recommendations for the extension and financing of the program for the future.

Chapter IV: Solution Strategy

Review of Existing Programs, Models, and Approaches

There are many existing training programs, credentialing programs, and training approaches directed at adult learner. I will briefly examine these programs which are pertinent to the stated goal and objectives.

Galinsky et al. study (1994) showed that intentional providers, those that view caring for children as their chosen job, are more attentive, affectionate, and offer higher quality care and these factors are all associated with greater growth and development in children. Quality seemed to be higher when there were three to six children being cared for versus just one or two, and when the providers had training. Out of this study, come the recommendation that family child care training toward high quality care should be funded by both government and business.

Mentoring

The two major functions of mentoring (Chao, Walz & Gardner, 1992) are career related and psychosocial. Career related aspec s are equated with imparting information and the psychosocial aspects involve role modeling, counseling, friendship and acceptance. The career related function generally develops first

and is followed by the psychosocial aspects. The development of psychosocial aspects can take much longer to develop but the psychosocial aspects of mentoring can contribute significantly to the family child care provider. The experienced active provider has great experiential information to share with a trainee. Not only does the mentee grow but also the mentor. It is a growth experience for a mentor to express and share information with another provider who has less experience (Cassidy & Myers, 1993).

Adult Learner

It is appropriate to discuss the special needs of the adult learner at this time. Many reasons are associated with provider's reluctance to obtain training. Adult education has been based on on the same techniques that are used to teach children, imparting knowledge on children. Using the traditional schooling techniques adults feel childish and form a barrier to training. Knowles (1970) views adult education as separate and different from our traditional concept of school learning methods. His concept is based on four assumptions. A mature person is "self-directing" rather than dependent like a child. Adults are building a reservoir of experiences which is a resource for learning. Adults have a learning readiness for developmental tasks, but the tasks are oriented to society. Adults need to apply the knowledge

they acquire in an immediate fashion with a problem solving orientation rather than increasing the knowledge base. Out of these assumptions, Knowles developed implications for successful training experiences for adults.

The recommendations for training providers in early childhood have reflected the acceptance of these principles or assumptions. The following recommendations are relevant to training program for family child care providers.

1. Avoid traditional classroom settings which make adults feel childlike (Knowles, 1970).

2. Training should be accessible by location and time (Galinski et al., 1994).

3. Providers need the opportunity to share their experiences (Knowles, 1970).

4. They need to have a sense of immediate relevance of the information being learned (Knowles, 1970).

5. They learn at their own individualized pace.

6. Adult learners do not change their style or preference for learning (Sonnenfield & Ingols, 1986) as they mature. A variety of learning styles need to be acceptable (Galinski et al., 1994).

7. Training should be provider friendly by using other

providers as mentors and trainers (Galinski et al., 1994).

8. Training should be geared to different levels of learners (Galinski et al., 1994).

9. Training should be linked to greater compensation (Galinski et al., 1994).

10. Training should be linked to a credit system (Galinski et al., 1994).

11. Training should be required annually for family child care providers (Galinski et al., 1994).

12. Training should be linked with provider associations (Galinski et al., 1994). They can plan and deliver the training as well as serve as mentors and home visitors.

Local Initiatives

There are several training approaches currently being used within this county. The American Business Collaboration is funding the Children First program. The one year program involves training and mentoring aimed at improving the quality of care in family child care homes.

A major pharmaceutical corporation has been conducting "Saturday Morning Seminars" for early childhood providers of both centers and family child care. Ortho brings in a nationally renown early childhood expert twice a year. The program has been

well received by family child care providers and center caregivers. The program is free of charge and always begins with a large continental breakfast. This allows time for networking with other early childhood professionals. The family child care provider feels highly respected in this atmosphere.

The local resource and referral (R & R) agency had conducted monthly meetings in the evening specifically for FCC providers. As attendance continued to dwindle and training were canceled due to lack of attendance, two other initiatives took form. First, cluster groups were provided in part of the county. It started in a township were a larger number of active providers resided. The cluster groups meet four times a year, rotating the location of the meeting in a provider's home. The success of this initial program lead to the organization of additional cluster groups in other areas. The second initiative involves CDA training. The R & R is providing CDA training to both center and family child care providers. The training is free of cost to the FCC providers.

Analysis of Accrediting and Credentialing Systems

There are two nationally accepted forms of accreditation or credentialing for family child care providers (Harms & Miller, 1994; Modigliani, 1990).

CDA. The CDA Credential is administered by The Council for

Early Childhood Professional Recognition (Modigliani, 1990; Harms & Miller, 1994). Although there are two methods of attaining this credential, by direct assessment or through the professional preparation program, the professional preparation program is not available in New Jersey (Thomson, 1994). The prerequisites for the CDA include a high school diploma or GED, 480 hours of working with children under the age of five and 120 hours of formal training with a minimum of ten hours in each functional area.

The assessment itself consists of a written knowledge test, a portfolio completed by the candidate, and observation of the candidate working with children. The fee for CDA assessment is $325. The CDA credential is available to center based caregivers also.

The CDA is conferred to the person, initially for a period of three years. If the provider moves to another state, the CDA is still valid.

NAFCC Accreditation. Accreditation is recognized nationwide also (Harms & Miller, 1994; Modigliani, 1990). This symbol of quality is specifically designed for family child care providers. It takes into account the business aspects as well as the child oriented issues. The prerequisites of this program is compliance with mandatory and voluntary regulations within the state and 18

months as a family child care provider.

The accreditation is valid for three years, but there is also an annual update showing professional growth. The accreditation is only valid in the home environment which was observed. If the provider moves, she must be re-accredited. If the provider moves on to center based care, the accreditation is useless. It only pertains to the program the provider was operating in her home. There is no linkage between FCC and center care. The fee for accreditation is $150.

NAFCC does not require any specific guidelines to prepare for accreditation. The emphasis is placed on experiential knowledge.

Analysis of Existing Curricula

There are numerous curricula geared to family child care providers (Aguirre & Marshall, 1988; Campbell, 1991; Cryer, 1985; Koralek et al., 1993b; Eddowes & Martin, 1990; Harmon, 1985; Kaplan & Smock, 1982; Modigliani, 1991; Vartuli, 1988). The curricula were narrowed down to those which were geared to independent study and to the provider who already has experience in family child care. New providers are so inundated with immediate problems, that they have a greater need for the group workshops rather than in home study course. While Vartuli (1988)

Cryer (1985) and Harmon (1985) meet the independent study criteria, it is felt that the course is too basic for the adult learners in this county. Two programs look promising (Aguirre & Marshall, 1988, Koralek et al., 1993b).

Texas A & M University. Aguirre and Marshall (1988) developed a program in Texas involving manuals and accompanying videotapes. It covers four areas of concern including health and safety, child development, nutrition and business aspects of family child care. It is designed to be implemented through existing agencies. The program was interactive in that activities were recommended through the manuals. The two videotapes were each approximately one hour in length. Participants reported spending between one and nine hours on each of the four manuals, in addition to viewing the videotapes.

Group sessions were combined with individual contacts. This was effective since some providers were unable to attend the group sessions due to time conflicts. Providers had expressed the desire for continuing education units (CEU). This program was applicable to CEU's based on an acceptable score on the posttest. The providers reported a high level of satisfaction with the program.

Caring for Children in Family Child Care. The curriculum,

Caring for Children in Family Child Care (Koralek, et al., 1993b), was originally developed for CDA credentialing for the U. S. Army Child Development Services. This curriculum was developing incorporating a previous curriculum, Caring for Infants and Toddlers, Caring for Preschool Children, and The Creative Curriculum for Family Child Care. It was specifically created with the functional areas as defined in the CDA and the training addresses all of the criteria in the NAFCC accreditation assessment profile.

The program is divided into thirteen modules to coincide with the CDA. Each module takes an average of four to six weeks for the provider to complete. Each learning module has a self assessment to be completed by the provider. The self assessment is intended to help identify areas of strength and weakness to assist the providers planning their own training. There are activities in each module as well as readings and references.

The program (Dodge et al., 1994) is based on the concept that training obtained by providers should be worthwhile by having it lead toward a credential, a degree, or accreditation.

Description of Solution Strategy

Many of the factors involved in quality are interrelated. However the one common strand that runs through all literature is

that training can increase quality either directly or indirectly and it has the greatest impact of any controllable factor.

Providers' intentionality in child care has been strongly supported (Galinsky et al., 1994) as a contributing factor linked to quality care. Providers who have chosen early childhood education as their profession should have a means to achieve that goal. Due to the long hours a FCC provider spends in direct care of children, it is difficult to find time for a formal educational program to attain a credential or accreditation (Modigliani, 1990). We need to make training count. It could count toward maintaining standards within state regulation, getting a credential or accreditation, getting respect, or getting more income.

Although regulation is documented to have a positive relationship to quality when accompanied by training, it is not within my powers to control.

The solution strategy incorporates effective elements from the existing programs within the community. A long term training program is more effective in achieving high quality care. This project can be used as a tool to demonstrate the need and desire for this type of training and the effectiveness of the strategy chosen. The strategy reflects the time constraints of the

project.

The most crucial element of training is accessibility to the providers. With any group of providers, there is a wide range of time constraints. It is the intent that some of these providers may go on to college level or more formal education programs. Providers are reluctant to make a long term commitment to early childhood. They want to sample it prior to making a major financial commitment to a formal degree program. The CDA credential and perhaps the NAFCC Accreditation are on the first rung of the early childhood professional ladder. This program could serve as the first stepping stone for those providers who have the interest in a career or providing quality. The self instructional materials support the time constraints of the providers.

Providers need to feel validated and share their experiences. That will accomplished through a group session for each module. Since the pilot project shall consist of only one module, there shall be one group session.

Mentoring and peer teaching have been successful in local cluster groups as well as nationally. A mentor was assigned to a group of providers to support them.

This project was geared toward the intentional provider.

Although they may be offering custodial quality of care, they can attain higher levels of quality and have the desire to do so. When providers understand the rationale of regulations and the underlying development stages of children, they are more likely to apply the set standards on a consistent basis.

The curriculum chosen needs to be recognized nationally and allow for the aforementioned elements. The curriculum that will be implemented is Caring for Children in Family Child Care (Koralek et al., 1993b). The curriculum has been implemented with military personnel and was adapted for use to the general public. It combines the features pertinent to the adult learner in a comprehensive non-threatening user friendly manner.

The income of providers is low and so must the cost of a training program to the provider. The pilot will be free of charge, however, it is the intent that the project be sponsored in the future by a corporation or other funding source. There is a significant cost linked to NAFCC Accreditation and to the CDA assessment. There are scholarships available to supplement those costs.

Training also must be on a continuum. Effective training programs are cumulative (Copple, 1991) not single session workshops. Since the majority of providers in this state are not

accredited or credentialed, and those with college degrees are not in an area related to early childhood, the thrust of training needs to begin first with attainment of a CDA or NAFCC accreditation. The curriculum selected can be used toward the CDA credential. No training of any type is linked to NAFCC Accreditation, however, the training program will enable the provider to obtain the NAFCC Accreditation.

Membership in a professional group is an indicator of quality and the willingness to obtain training. Out of 21 counties in this state, this county represents 13.8 % of the membership of the state FCC provider association.

Chapter V: Strategy Employed

Actions Taken

The practicum was implemented over a ten week period. It utilized the solution strategy discussed above, with modifications which are explained below. Appendix D contains the proposed calendar plan for implementation.

Due to the limited amount of time during implementation, two crucial steps were undertaken prior to implementation of the proposal. Four providers who are currently providing care for unrelated children were recruited along with one experienced provider to serve as mentor. This was accomplished informally through personal contacts and word of mouth. The schedule was designed around the date that the mentor could begin working on the project. Due to the difficulty in obtaining a mentor, the trainer serving as mentor was considered. The author served as the trainer. Although the trainer was an experienced family child care provider and qualified as a mentor, it was believed to be optimal to have a separate person performing these two distinct function. Trainers, unlike mentors, do not generally bond with providers. Although the supportive function of mentor could have been accomplished by the trainer in this specific situation, it

was felt that it could not easily be replicated for future use in agencies. Forms which were used in selecting participants are contained in Appendix A and B.

Due to the lack of funding through an agency or other source, permission to photocopy the text of one module was obtained (see Appendix C).

Preassessment and Orientation of Participants

During the first two weeks, materials were gathered and photocopied by the trainer, including the text of the selected module, the FDCRS forms and posttest assessment.

The trainer familiarized the mentor with program. An overview of the program was given to the mentor along with a copy of the module text. The trainer developed a six week guideline for the mentor (see Appendix G).

The trainer pretested the providers using FDCRS. This is an in home assessment of the quality of care. The FDCRS consists of 32 items, all correlating to the CDA. Since only one module was being offered in the training program for this practicum, the items pertinent to that one module were the only items assessed. A total of thirteen items were assessed. Each item is assessed on a scale of 1 to 7, with 1 being inadequate and 7 being excellent.

The trainer also explained the program and distributed the

module text at the time on an individualized basis. The trainer developed a six week guideline for the provider (see Appendix H).

Training Implementation

Implementation of training occurred during a six week period. The providers completed one module of the self-instructional curriculum at their own pace, but guided by the outline given to them.

Weekly telephone calls occurred between the mentor and trainees. The mentor served a supportive function and encouraged the trainees. It was also the function of the mentor to keep the trainee on the appropriate timeline to complete the module. The mentor provided technical assistance when needed. The mentor asked thought provoking questions during the weekly conversations, which were in the guidelines (see Appendix G) developed by the trainer.

Weekly telephone conversations were held between the trainer and the mentor. The trainer monitored the progress of the trainees through the mentor. The mentor would convey any difficulties that trainees are experiencing.

Sharing Experiences and Evaluation

At the end of the six week training period, a two hour cluster group meeting was held one evening at a participants home.

Arranging a mutually agreed upon meeting night was expected to be difficult. With other commitments, only one evening was available to all participants. The evening of the meeting, two providers canceled at the last minute. One provider was ill, and the other one's husband and toddler were ill. Winter is notorious for creating this dilemma with family child care providers.

The cluster group consisted of only four people: two providers, the mentor, and the trainer. The trainer guided discussion related to the curriculum completed. The discussion was geared to sharing experiences regarding the knowledge content of the module. The participants had a lively discussion despite the small group.

The trainer administered a curriculum posttest, designed by the authors of the curriculum, at the group meeting to measure the level of core knowledge from the module. The meeting concluded with providers completing a questionnaire evaluating the implementation of the program.

The trainer again went to provider's home and used the FDCRS as a posttest to observe the measurable difference in the deliverance of care.

The two providers who were unable to attend the cluster group meeting, were given the written posttest and the

questionnaire at the time of the home visit. This modification in methodology did not affect the results, however, it is not recommended to be the sole method throughout the thirteen modules in the curriculum.

Results

The goal of the practicum was to increase the quality of care in family child care homes as measured by the FDCRS. The results of the preassessment and postassessment using the Harms and Clifford FDCRS indicates an observable difference in the quality of care. This involved some minor changes on the part of the provider. Essentially, each provider identified their own areas of strengths and weaknesses. By allowing the provider do the self-identification, the provider's willingness to change increased since they served an active role even in the identification process. They in turn discussed it with either the mentor or the trainer.

Objective One

The initial objective of recruiting eight providers and two mentors was reduced to four providers and one mentor. Difficulty arose from the timing of the project at the last three months of the calendar year. In addition to the normal time restraints during that time of year, a local program which was initiated

earlier in the year, was commencing in December. It also included a mentoring component. That program was supported with corporate funds and was able to pay mentors for their time. Only one mentor could be located for this practicum. It was my desire to maintain the four to one ratio and therefore recruited only four providers. However, many providers were interested in the program for the future. Again, competition plays a part. Providers obtain equipment and materials from corporately sponsored initiatives.

Objective Two

The second objective was to implement one module of an existing systematic comprehensive training curriculum for family child care providers over a four to six week period, with providers scoring a minimum of 80% on the posttest developed with the curriculum. All four providers completed the module within the allotted time span. They also all scored a minimum of 96% on the posttest (see Appendix J), which is significantly higher than the required score of 80%.

Objective Three

The third objective was to evaluate the quality of care provided by the target group of providers before and after training by using the Harms and Clifford (1989) Family Day Care Rating Scale. This objective was also met and showed an increase

in level of quality (see Appendix I). The degree of change was remarkably high, ranging from .39 to 1.62 on a scale of 1 to 7. The highest level of preassessment care showed the lowest increase, while the lowest preassessment score showed the greatest increase.

Objective Four

The fourth objective was to develop a support system for family child care providers through mentoring. On a scale of 1 to 5, with one representing the greatest level of satisfaction, the mean level of reported provider satisfaction with the mentoring was a 2.3 (see Appendix K).. The psychosocial function of mentoring takes much longer to develop than the career related aspects of mentoring (Chao, Walz & Gardner, 1992). A six week period is not a sufficient period of time to build a close knit relationship with another person. It would be expected that the level of satisfaction with the mentor would increase with the longer term commitment of the full thirteen module curriculum.

Objective Five

The fifth objective was to develop a network for providers to share their experiences with other providers through the cluster group meeting. The mean score for cluster group meeting was 1.5 on the scale of 1 to 5 (see Appendix K). Although only

half the providers attended the meeting, those who were unable to attend expressed disappointment to have missed the meeting. They expressed a strong desire to attend.

Objective Six

The sixth objective was to measure pro vider satisfaction with the program. The overall satisfaction with the program again attained a mean score of 1.5 on a scale of 1 to 5 (see Appendix K).

Objective Seven

The last objective, was to development recommendations for the extension and financing of this program in the future. Providers expressed the desire to continue the training program, if it were available free of charge. Two providers would be willing and able to pay $100 to $150 for the entire training course. Discussion of the implications of this pilot program and recommendations appear in the following chapter.

Chapter VI: Conclusion

Family child care quality has been under scrutiny by professionals and regarded by some as being of poor quality (Eheart & Leavitt, 1989). Training is viewed as being directly related to quality care (Jones & Meisels, 1987; Kaplan & Smock, 1982; Nelson, 1989; Vartuli, 1988). Low attendance at training is sometimes construed to show lack of interest in training, when in fact, it could indicate the limited time resources of the provider (Galinsky et al., 1994). When time frames are flexible, such as the at home study program, providers are interested, move along at their own pace, and most importantly meet the goals and objectives of the training.

Implications

The foremost implication of this pilot program is clear. Providers are interested in training. Training needs to be both convenient and pertinent.

Training of providers does improve the quality of care provided. Some changes made by providers seemed relatively minor, such as displaying children's artwork. But it also showed a willingness to comply and make the changes as well as to participate in self-improvement. The unforeseen circumstances whereby two providers could not attend the cluster group meeting

exemplify the difficulties providers have in attending training outside the home. They were both very cooperative in arranging the two home visits.

While self-improvement seemed important to providers, a credential or accreditation was not important. Only one provider indicated on her application that she had an interest in the CDA credential. This support Knowles (1970) concept of the adult learner. Adults are interested in learning what can be immediately applied to their situation.

Mentoring was intended to involve master providers and utilize them as a community resource and potentially increasing the leadership within the family child care community. Mentors need not specifically be a family child care provider, but must be perceived as provider friendly and understanding of the field of family child care. This is supported by works by Galinsky, et al (1994). The mentor should not be a regulatory member of an agency since that could conflict with the personal nature of mentoring. The mentor and trainer could be the same person providing the size of the trainees is manageable. In fact in some instances, the trainer serving as mentor could increase the consistency within the training process.

Recommendations

It is not intended that this project be duplicated. It is the intend of this project to show the viability of the curriculum for the child care community. The process used in this practicum, could be used to train providers in any one area or module of the curriculum. The curriculum is designed so each module can be used in isolation. Two features that providers expressed high satisfaction with were the convenience of at home study and the friendly manner in which the material was presented in the text.

The following recommendations and modifications are suggested.

1. Providers' associations should support this curriculum. The provider association should become more involved in training providers. They offer a non-regulatory approach, which lends itself to the mentoring component of the curriculum.

2. Resource and referral agencies should offer this as an alternative method of training for providers interested in NAFCC Accreditation or to obtain the CDA credential. The program could initially be supported through corporate funds, with providers contributing a few dollars at the onset of each module. Scholarships for the needier providers should be available.

3. Mandatory attendance at the cluster group meetings should be discouraged. Providers are interested in attending

these meetings and put forth the effort to attend. Mandating attendance will discourage providers from participation in the overall program. A minimum of attending half of the cluster group meetings could be encouraged.

4. A buddy system can serve as an alternative for the cluster group meeting. Participants could be paired off to assist each other. Also, a list of participants in the program, along with their phone numbers could be compiled for each participant. They can then freely call each other if they want to discuss the material, or develop a closer network.

5. The cost of the materials is prohibitive to providers. A one time fee is difficult and will discourage many providers from participation. Providers enjoy the materials and will want to keep them as a resource, therefore, a lending library is not recommended. The cost could be broken down into a per module cost of $5, versus the cost of the books at $70. The fee could be paid monthly, or whenever a new module was to begin.

6. The benefits of accreditation and credentialling must be communicated more effectively to providers, making it relevant to the provider.

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Appendix A

Mentor Application

Mentor Application

Name: _____

Address: _____

Town: _____ Zip: _____

Telephone: _____

Are you registered? _____

How long have you been providing family child care? _____

What, if any, form of credential do you hold in early childhood education? _____

Are you a validator for a credential program? _____

Number of children currently in your care and their ages:

_____

What are your long term goals? _____

_____

_____ _____

Why are you interested in providing technical assistance to other providers? _____

_____

_____

What are your strengths? _____

_____

What professional organization, such as NAEYC, NJAEYC, NAFCC or

NJFCCPA are you a member?_____

_____

Please provide a list of training you have received during the past five years.

Appendix B

Provider Training Application

Provider Training Application

Name: _____

Address: _____

Town: _____ Zip: _____

Telephone: _____

Are you registered? _____

How long have you been providing family child care? _____

Number of children currently in your care and their ages:

_____

_____

What are your long term goals? _____

_____

What professional organization(s), such as NAEYC, NJAEYC, NAFCC or NJFCCPA are you a member? _____

Why are you interested in this training program? _____

_____

_____

Appendix C

Letter to Teaching Strategies

Joanne Labish Taylor
75 Rohill Road
Neshanic, NJ 08853
(908)369-4812

September 29, 1994

Diane Trister Dodge
Teaching Strategies, Inc.
P.O. Box 42243
Washington, DC, 20015

Dear Ms. Dodge,

I am a family child care provider and graduate student at Nova Southeastern University. I have been interested in Caring for Children in Family Child Care since it was introduced in Anaheim at the NAEYC National Conference. I gathered further information on the implementation of the program in Atlanta at the Save the Children Technical Assistance Conference, after which I purchased both volumes and the trainer's guide.

I am currently working on a practicum project which involves addressing a problem within my field. I have chosen to implement one module of the curriculum. Since I have no funding for this project and am confined to a short timeline, I am requesting permission to make ten copies of one module, **Module 3: Learning Environment**, to use in this pilot project. It is my hope that the pilot will demonstrate the need for this program in our community. Agencies and organizations can back the program and seek grants to fund the implementation.

I would also be interested in any results of agencies utilizing the program for CDA credentialing.

Sincerely,

Joanne Labish Taylor

Appendix D

Calendar Plan for Implementaion

Calendar Plan for Implementation

Due to the limited amount of time during implementaion, two crucial steps will be undertaken prior to implementation. Eight providers who are currently providing care for unrelated children will be recruited along with two experienced providers to serve as mentors shall be recruited. This will be accomplished throughbroadcasting on caable television within the county and word of mouth.

Due to lack of funding through any angency or other source, permission to photocopy the text of one module will be sought.

Weeks One and Two

Materials shall be gathered and photocopies shall be made. The text of the selected module, the FDCRS form and the posttest assessment shall be photocopied.

The trainer will pretest the providers using the FDCRS. This is an in home assessment of the quality of care. The trainer shall also explain the program and distribute the module text at that time, on an individualized basis.

Weeks Three through Eight

Implementation of the training component will occur during this six week period. The providers will complete one module of the self instructional curriculum.

Weekly telephone calls shall be maintained between the mentor and the trainees. Mentors will serve a supportive function and encourage the trainees. It will also be the function of the mentor to keep the trainee on the appropriate timeline to complete the module. The mentor can also provide technical assistance when needed.

There shall be weekly telephone conversations between the mentor and the trainer. The trainer will monitor the progress of the trainees through the mentor. Mentors will convey any difficulties the trainees are experiencing to the trainer.

Week Nine and Ten

The trainer will use the FDCRS as a posttes in the provider's home to observe the measurable difference in the deliverance of quality care.

A two hour training cluster group meeting will be held one evening in a participant's home. At this meeting, the trainer will administer the curriculum posttest to measure the level of core knowledge related to the module. Providers and mentors will complete questionnaires evaluating satisfaction with the program at the conclusion of the group meeting.

Appendix E

Provider Program Evaluation

Provider Program Evaluation

Please rate the following aspects of the program with 1 being the most satisfied and five being the least satisfied.

How would you rate the content of the self study materials?

1 2 3 4 5

COMMENT:

How helpful was the cluster group meeting?

1 2 3 4 5

COMMENT:

How beneficial was the mentoring?

1 2 3 4 5

COMMENT:

What is your overall satisfaction with the program?

1 2 3 4 5

COMMENT:

Would you continue the program if it is extended at no charge?

1 2 3 4 5

COMMENT:

If there were a cost involved for the program, how much would you be willing (or able) to pay?

_____$70 (books alone cost this amount)

_____$100-$150

_____over $150

What do you feel are the major strengths of the program?

What aspects did you dislike about the program?

What modifications would you make to this program?

What changes have you made in your family child care home as a result of this training?

Appendix F

Mentor Program Evaluation

Mentor Program Evaluation

What difficulties, if any, did the providers have with the self-study material?

What difficulties did you have working with the providers?

What changes would you recommend for the program?

How much time did you actually spend with the providers on the phone?

Appendix G

Mentor Guidelines

GUIDELINES FOR MENTOR

Call each provider once a week.

Discuss the completed activity briefly with the provider.

Ask questions geared to the reading completed.

Keep a log of your phone calls.

Be available for the provider to call you.

WEEK 1

Introduce yourself.

WEEK 2

Discuss the provider's inventory. Are the children interested in the materials and toys available? Do they meet the developmental needs of the children?

Discuss what toys might be made or recycled inexpensively.

WEEK 3

Discuss the provider's chart of "messages" in the environment and new ideas to try.Offer suggestions on how the provider might get the materials to make the changes. Suggest that the provider observe children and note children's reactions to the changes.

WEEK 4

Discuss changes the provider would like to make to the outdoor environment and why. Discuss how these changes might be accomplished.

WEEK 5

Reinforce concept of a daily routine for children. Discuss the provider's routine and how it might be adjusted. Discuss "teachable moments" when the routine should be adjusted to accommodate learning.

WEEK 6

Cluster group meeting to share experiences.

Evaluation of the program's strengths and weaknesses.

Appendix H

Provider Guidelines

GUIDELINES FOR PROVIDERS

WEEK 1

Introduction
In home evaluation by trainer
Self assessment by provider
Receive materials
Provider and trainer will discuss self assessment by phone.

WEEK 2

Read Module #3, Section I, "Using Your Home as a Learning Environment".
Complete the activity, "Equipment and Materials" inventory.
Complete the activity, "Improvements to the Learning Environment".
Discuss these activities with you mentor.

WEEK 3

Read Section II, "Shaping the Messages in Your Learning Environment".
Complete the activity, "Messages in the Learning Environment".
Discuss the activity with your mentor.

WEEK 4

Read Section III, "Using the Outdoors as a Learning Environment".
Complete the activity, "The Outdoor Environment".
Discuss the activity with the mentor.

WEEK 5

Read Section IV, "Managing the Day".
Complete the activity, "Assessment of Daily Routines".
Complete the activity, "My Daily Plan".
Discuss activities with the mentor.

WEEK 6

Cluster group meeting to share experiences.
Complete posttest and questionnaires to allow for evaluation of programs strengths and weaknesses

Appendix I

Comparison of FDCRS Preassessment and Postassessment Scores

Table 1

Comparison of FDCRS Preassessment and Postassessment Scores

Provider	Preassessment	Postassessment	Change
1	3.23	4.85	+1.62
2	4.23	5.38	+1.15
3	4.54	5.92	+1.42
4	5.69	6.08	+ .39
Mean	4.4225	5.5575	+1.145

Appendix J

Written Posttest Scores

Table 2

Written Posttest Scores

Provider	Percentage Score
1	100
2	96
3	96
4	98
Mean	98.5

Appendix K

Provider Program Evaluation Results

Table 3

Provider Program Evaluation Results

Component	Mean Rating (n=4)
Self-Study Material	1
Cluster Group	1.5 *
Mentoring	2.3
Overall Satisfaction	1.5
Desire to Continue	1.5

*n=2, other providers were unable to attend the meeting