

CHILD CARE CHARACTERISTICS AND QUALITY IN NEBRASKA

Carolyn Edwards, Ed.D.²
Lisa Knoche, M.S.¹
Abbie Raikes, M.P.H.¹
Helen Raikes, Ph.D.¹
Julia Torquati, Ph.D.²
Brian Wilcox, Ph.D.¹
with Lanette Christensen¹

¹*Center on Children, Families, and the Law, University of Nebraska-Lincoln*

²*Department of Family and Consumer Sciences, University of Nebraska-Lincoln*

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Additional copies will be available at <http://ccfl.unl.edu/projects/cprojects/childcare.html>

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Executive Summary

The Midwest Child Care Research Consortium conducted a study of child care quality and characteristics of the child care work force in Nebraska, Iowa, Kansas and Missouri to help states establish a baseline for tracking quality over time, following initiatives, policy and other changes. The measures are not based on Nebraska child care licensing standards. Rather, using research-based measures of quality, they assess the extent to which quality indicators are present among the child care settings and in the work force. The current study included a random telephone survey of 2022 Midwestern child care providers (508 from Nebraska), conducted during late spring and summer of 2001 by the Gallup Organization, and follow-up in-depth observations of 365 providers (85 from Nebraska), conducted by four Midwestern state universities. Key findings from the study are as follows:

1. In Nebraska, as is true across the Midwestern states, a majority of providers regard child care as their profession, have been providing child care for over five years and intend to stay in the field. This is despite low, fulltime earnings (averaging \$14,700 a year in Nebraska), which, for many providers, is below poverty level.
2. Using well-respected measures of quality, the researchers found that child care quality in Nebraska is comparable to that of Midwestern neighbors Missouri and Kansas and to child care nationwide; 34% of care observed was “good” quality; 48% was rated as minimal or mediocre quality and 18% was rated poor quality. Center-based infant/toddler, center-based preschool and licensed family child care were comparable to one another in quality and to similar care of Midwestern neighbors, while license exempt (approved) care averaged lower quality than other types of care in Nebraska. Other studies have shown that good quality on the measure used in the Midwest study predicts positive school readiness outcomes for children, and poor quality predicts poorer outcomes for children, especially for children in poverty.
3. A number of training, education, accreditation and workplace efforts were associated with higher quality including: Heads Up! Reading (in Nebraska preschool center-based settings); employee benefits such as health care (in center-based settings); the Child Development Associate Credential; participating in the USDA Food Program; first aid training; higher levels of education; entering into partnership with a Head Start or Early Head Start program; completing a nationally recognized accreditation in early childhood education; following a curriculum; and completing more than 24 hours of training in the previous year. Nebraska led the Midwest in the percentage of providers who had completed CPR and first aid training.
4. The study identified ways that Nebraska can improve child care quality. Two of these are to improve pre-literacy environments and to provide

incentives to improve quality to providers who serve children receiving child care subsidies. First, Nebraska child care was deficient in pre-literacy environments. Following the current national emphasis on pre-literacy skills (reading to children, helping them understand and appreciate print media, and encouraging expression), pre-literacy environments are likely to be emphasized in upcoming child care block grant and Head Start reauthorizations in 2003. Few infant/toddler providers were observed reading to children; many family home providers lacked materials to encourage verbal expression. While preschool center-based providers had more books available, many scored only at a minimal level in pre-literacy activities. Second, among providers caring for children receiving subsidies, in some sectors the quality was lower when providers cared for larger portions of children receiving child care subsidies. Incentives for quality among family providers caring for children receiving subsidies are recommended to ensure that low-income children receive quality care.

Nebraska and its neighbors in the Region VII of U.S. DHHS are among the first states in the nation to assess child care quality on a statewide and region wide basis. These baseline data will permit examination of changes over time in quality; for example, as a result of the new Nebraska TEACH program and other new and continuing initiatives.

Research Questions

The initial questions that specifically address child care in Nebraska are as follows.

1. What are the characteristics of the child care work force in Nebraska? How do Nebraska providers compare to those in other states? How do provider characteristics vary according to type of care (whether infant/toddler or preschool center-based, family child care or license exempt care)?
2. What is the quality of care in Nebraska? What is the quality of interactions between providers and children? How do child care quality and teacher-child interactions vary according to different types of care?
3. How well is Nebraska faring in providing early literacy environments for children?
4. Are quality and other features different between providers who care for children whose tuition is paid by government subsidies and those who do not? Further, does quality vary for providers who receive a high proportion of payment by subsidy and a lesser proportion?
5. Do quality and other features vary between Early Head Start/Head Start partnerships and other types of care?

6. Are there relationships between education, training, workplace characteristics, selected practices and observed quality?
7. Is child care for children with disabilities of comparable quality to other care in the state? Who provides care for children with disabilities?

Background

The child care workforce and quality have been studied over the past three decades. Nationwide, from 10% to 40% of child care is reported to be good quality (Cost, Quality and Child Outcomes Study Team, 1995). The policies that support quality in the state and nationwide are complex and the child care market generally does not support high quality or good wages for providers. In Nebraska, the Department of Health and Human Services Regulation and Licensure (HHS R & L) administers child care licensing (which addresses minimum standards of health and safety and requires 12 hours of annual training as well as an annual inspection). The Department of Health and Human Services (HHS) administers the federal Child Care and Development Fund (CCDF) for payment of tuition for children eligible for government subsidies¹. Some quality funds targeted for infants and toddlers are administered by DHHS and are used for Early Head Start and child care partnerships and the other portion is administered by Department of Education for the First Connections project. The Nebraska Department of Education administers slightly less than a quarter of the funds from the Child Care and Development Fund allocated for quality for the training and education of child care providers. The remaining funds allocated for quality are used for subsidy payments; to support the licensing function; and to award grants to providers for start-up, expansion, and to meet requirements for licensing. Many, but not all of Nebraska's quality enhancement projects are carried out through the Nebraska Early Childhood Training Center. A few other funds also contribute to the training center for use in quality-enhancement initiatives. A number of initiatives identified in this report are in place in Nebraska to support quality and to enhance the commitment and professional status of child care providers. Some of these include Heads Up! Reading, First Connections, Early Head Start/Head Start child care partnerships, Special Care, and child care

management training². A number of training initiatives in place in Nebraska are also available in other states and these include High/Scope, CPR/First Aid, Creative Curriculum, West Ed, Montessori, Child Development Associate, and others. A number of conferences and local training events are offered in Nebraska and

¹ Federal Temporary Assistance for Needy Families (TANF) and state funds supplement the federal CCDF subsidy for child care for low-income families.

² For more extensive description of training initiatives available to Nebraska Child Care providers, see Appendix A.

throughout the Midwest. In addition, there are some efforts in place to support higher education efforts of providers, and the TEACH program, initiated after this survey was conducted, promotes education and increased wages.

Methodology

The University of Nebraska’s Center on Children, Families, and the Law and the Midwest Child Care Research Consortium³ contracted with The Gallup Organization of Princeton, New Jersey, and four state universities to conduct a study of child care workforce characteristics and quality in the four states. A survey was developed based on indicators of quality and the workforce from the child care literature and information needs of state child care administrators. Names of approximately 10,000 providers were drawn from lists of nearly 40,000 regulated providers and subsidy-receiving providers in Iowa, Kansas, Missouri and Nebraska. A letter notified the providers drawn that they could be called by Gallup to complete a 12-15 minute survey. Respondents were contacted between April and August of 2001; final survey sample size was 2022 (508 in Nebraska). A subset of approximately 385 (85 from Nebraska) providers was contacted for follow-up observations using well-known assessments of child care quality: the Infant/Toddler Environment Rating Scale (ITERS), the Early Childhood Environment Rating Scale (ECERS), the Family Day Care Rating Scale (FDCRS), and the Arnett Caregiver Interaction Scale, which measures provider-child interactions. Reliability in observations was obtained across states and within states to “gold standard” observers who were “anchors” for their own states. The ITERS, ECERS and FDCRS provide industry-standard measures of child care quality and a score of “5” or above is defined as good quality and less than “3” is poor quality while the zone between “3” and “5” is defined as mediocre or minimal quality. In addition, two quality factors were created from self-reported quality practices; we refer to these as the Reading/Learning Centers factor and the Parent Communication Factor. Data reported here are unweighted. Weighting the data according to the estimated population of Nebraska providers caring for children 5 and under in child care changes the findings slightly, but minimally.

Definitions

The study was completed with several groups of child care providers, including:

³ The Midwest Child Care Research Consortium consists of researchers from Iowa State University, the University of Kansas, the University of Missouri and the University of Nebraska and representatives from state governments in child care and education, health and regulation divisions and resource and referral organizations. This study is a part of a three-year partnership grant funded by the Department of Health and Human Services, Child Care Bureau, and the Ewing Marion Kauffman Foundation, Kansas City, Missouri.

Infant/toddler center-based providers: Licensed center-based providers who care for children from 6 weeks to age 3. Licensing specialists make a minimum of one unannounced visit to center-based facilities each year.

Preschool center-based providers: Licensed center-based providers who care for children from age 3 to kindergarten age. Licensing specialists make a minimum of one unannounced visit to center-based facilities each year.

Family Home I providers: Providers licensed by the state of Nebraska to care for 3 to 10 children in their homes. Licensing specialists make a minimum of one unannounced visit to Family Home I providers each year.

Family Home II providers: Providers licensed by the state of Nebraska to care for 3 to 12 children in their homes. These providers employ a second provider who assists with child care. Licensing specialists make a minimum of one unannounced visit to Family Home II providers each year. In many cases in this report, Family Home I and II providers are referred to jointly as Family Home providers.

License Exempt providers are approved by the state to care for 3 or fewer children from different families, or any number from one family. License exempt providers in this study all receive child care subsidies.

All of the participants in this study—who in their own programs may be identified by a number of titles and terms such as teacher, caregiver, babysitter, or provider—are called providers in this study.

The following terms are used to describe observed child care quality; these quality measures are derived from scales which are widely used in early childhood (see Appendix C for more information):

Good quality care: Scores of “5” or higher on the Infant Toddler Environment Rating Scale (ITERS), the Early Childhood Environment Rating Scale (ECERS) or the Family Day Care Rating Scale (FDCRS).

Mediocre or minimal quality care: Scores of “3” to “5” on the ITERS, ECERS or FDCRS are referred to as “mediocre or minimal” quality.

Poor quality care: Scores of less than “3” on the ITERS, ECERS or FDCRS are referred to as poor quality.

Characteristics of the Child Care Workforce

The Nebraska child care workforce includes a substantial cadre of committed providers who have been providing child care for a number of years and intend to continue to provide child care despite very low earnings. The typical child care provider sampled in Nebraska is female, 38 years old, married, a parent and has a high school degree with some additional training. She works full-time and earns \$14,700 a year and has been providing child care for over 10 years. Of all Nebraska providers sampled, 63% state that child care is

their profession; 57% say that it is a personal calling for them; 60% intend to be a child care provider for five years or longer; and 83% say they would not choose work other than child care. The average provider in the state reported receiving 31 hours of training during the previous year, and 58% of providers have an Internet connection. Nebraska leads the Midwest in the percentage of providers who are current in CPR and First Aid and who have completed High Scope training, but lags behind its neighbors in Child Development Associate (CDA) and Parents as Teachers (PAT) certification; and National Association for the Education of Young Children (NAEYC) membership.

Specific descriptions that distinguish each type of provider groups are provided below:

- *Nebraska infant/toddler center-based providers* led the Midwest in reported practices that lead to continuity of care (referring to a practice of children staying with their providers over time). However, 30% of Nebraska providers in infant/toddler centers had been in their jobs for less than a year, which might make continuity difficult. Infant/toddler center-based providers were the youngest providers in the sample in Nebraska, had somewhat lower incomes, and about half as much training as their preschool center-based counterparts.
- *Preschool center-based providers* were the best educated and received the most training of all providers in the state and 84% of preschool center-based teachers had been in their jobs more than a year. In general, preschool providers were older than infant/toddler center-based providers but were younger than family child care providers.
- *Licensed family home providers* (Licensed Family Home I and Licensed Family Home II) were a dichotomous group with some showing high levels of dedication to child care and education and another group showing low levels of dedication and completing the minimal number of training hours. For example, 26% of Nebraska subsidy-receiving Family Home I providers said they would do other work if they could.
- *License exempt (approved) providers* have no training requirements in Nebraska; however, a subgroup of these providers (34%) reported receiving more than 12 hours of training during the previous year; 60% see child care as their profession; 78% say they intend to provide child care for more than two more years. In addition, 70% said they are helping out a friend or neighbor and 42% are providing care to get a paycheck, the highest rates for these attitudes found in the Nebraska sample.

Key Findings

About 34% of Nebraska’s child care was found to be “good” quality. On the measures of quality used in this study and in most studies, ratings above “5” are regarded as good quality. Thus, with 34% “good” quality, 48% is “minimal” quality and 18% is “poor” quality. The rate of good quality care is generally comparable to that found in Kansas and Missouri but there is more high quality care in Nebraska

than in Iowa (in regulated homes and infant/toddler centers). The rate of good quality care is also comparable to that reported in other studies of child care quality. In general, quality in Nebraska tends to be fairly consistent across types of care, although, as has been found in other studies, quality of license exempt (approved) care is poorer. There was good and poor quality found in every type of care in the state. Preschool ECERS ratings were slightly lower than ECERS ratings for other states, although the difference was not statistically significant.

In Nebraska, the child care *literacy environments* are substandard. The vast majority of programs, whether family daycare or center-based, were judged to be minimal or below minimal quality in providing books and reading materials, promoting language and reasoning, displaying pictures or children's work in a way that promotes conversation, and working towards cultural awareness.

Care in family child care for Nebraska's children who receive *subsidies* is lower quality than care observed in family child care at large. This finding is particularly true among Family Homes I. Subsidy-receiving Family Home I care was of comparable quality to that found in license exempt (approved) homes. Quality of care in Family Homes II was higher but showed a similar though smaller trend for poorer quality among subsidy-receiving providers. This trend for lower quality among subsidy-receiving providers was not found in center-based care. Moreover, in family child care, the higher the proportion of children on subsidies, the lower the observed quality, the lower the provider's education, and the higher the provider's income. Across all types of care, the higher the proportion of children on subsidies, the lower the provider's education level.

Center-based care in Nebraska is relatively available to children on subsidies, and the percent of center providers who accept children receiving subsidies is somewhat higher than for other states. A high proportion of licensed center-based providers in Nebraska provide child care for at least one child whose tuition is reimbursed through government subsidies. In Nebraska, 58% of all licensed center-based providers cared for at least one child whose tuition was paid by subsidies during October of 2000; the next highest among the four states was Kansas with 49%. However, regulated family child care in Nebraska was less open to children on subsidies; in Nebraska, only 32% of all regulated family child care providers cared for at least one child whose tuition was paid by subsidies, less than 42% for Missouri and the same as for Kansas.

Across the Midwest, *Early Head Start child care partners* had higher observed quality care than other providers on average, and, in Nebraska, the relationship held up for infant/toddler center-based partners. Nebraska directs about 25% of the federal infant/toddler quality enhancement funds it receives to Early Head Start programs that partner with local child care programs to provide quality that meets the Head Start performance standards. Kansas and Missouri have similar but more expanded programs. In Nebraska, ITERS quality care of infant/toddler centers partnering with Early Head Start was higher than that of other infant/toddler center-based care in the state. Early Head Start partners completed more training than their Nebraska counterparts (but less than their Early Head Start partner counterparts in Kansas and Missouri), participated in more Heads Up! Reading, training for college credit, CDA, High Scope and Creative Curriculum than their Nebraska child care counterparts, and earned slightly more, but also had more negative workplace

attitudes. These Nebraska providers were no more likely than providers on average to receive paid time off for training.

The relationship between child care quality and high levels of education, found in many other studies, also exists within most groups of providers in Nebraska. This relationship is strong for family child care and less strong for center-based care. Compared to other states in the Midwest, Nebraska has a comparable percentage of providers who have degrees, slightly more with two-year degrees and slightly less with four-year degrees. In the Midwest and Nebraska, high quality was found among one-year child development certificate holders (typically, a CDA, see next paragraph) and somewhat lower level quality than predicted was found among those having a two-year degree. Nonetheless, the tendency is for quality to go up as education goes up so that quality provided by four-year degree holders is considerably higher than that provided by providers with high school or high school plus some training. Nebraska preschool providers with two-year degrees provided lower quality care than their counterparts in other states. Having a teaching certificate was associated with quality in Nebraska and having a child development degree was also associated with overall quality in the Midwest but not in Nebraska. In Nebraska, education is a strong predictor of observed quality among family child care providers.

In Nebraska and the Midwest, there was a strong relationship between having a CDA certificate and quality in all forms of care. Some of the strongest associations found in this study were between receipt of the CDA and quality. Positive significant relationships were found between CDA and quality among infant/toddler center-based care ($r=.34$), preschool center-based care ($r=.24$) and family child care ($r=.28$).

In Nebraska, overall hours of training were associated with higher quality but increments came with 12 and 24 hours. Some forms of training have higher associations with quality than others but many forms seem to associate with quality in small but potentially incremental ways. Training hours reported (31 on average) exceeded state requirements for training, but they were slightly lower than those reported in Kansas and Missouri. In the Midwest several initiatives and certificate programs were associated with observed quality (First Aid; West Ed; Project Construct), even when controlling for the provider's previous level of education. In Nebraska, Heads Up! Reading associated with ECERS quality regardless of the provider's education level. "In-person" training, training which requires interaction within a group or with an instructor, associated more highly with quality than "not in-person" training (videos, self-study materials or distance learning). The positive effects of "in-person" training over "not in-person" training were particularly striking in the Midwest, but also existed in Nebraska. Training involving a mentor was associated with quality in the Midwest sample, as was attending conferences. The relationships were similar but did not reach significance due to sample size in Nebraska. Finally, in the Midwest and the Nebraska sample, there were small and significant relationships between many forms of training and self-reported quality factors leading to the conclusion that most forms of training help quality a little and some forms help more. Training strongly associates with education such that the more education providers have, the more they seem to participate in all forms of training.

In Nebraska, there was a relationship between *provider earnings and child care quality* in center-based care. This relationship was strongest for infant/toddler providers but did not hold up for family child care. In family child care some providers with highest earnings provided some of the poorest quality care. Providers who received subsidies in family homes had higher incomes than their counterparts who did not receive state subsidies. Throughout the Midwest, subsidy-receiving family child care providers cared for more children

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quality, although the relationships did not reach significance in the smaller Nebraska sample. In Nebraska, providers can receive higher subsidy reimbursements if they are accredited.

In Nebraska, about a third of providers reported that they cared for at least one *exceptional child (a child with a disability)* on a typical day. Two-thirds of these providers worked in center-based programs. Quality of observed care in programs that included exceptional children was equivalent to quality in programs that did not. Center-based programs that included exceptional children were of higher quality than other kinds of inclusive programs (family daycare and license exempt homes).

Commendations

Nebraska child care demonstrates a number of strengths that should be noted:

1. Across the Midwest and in Nebraska, there is a sizeable group of child care providers whose training well exceeds minimum state training requirements, have long tenure in child care and who intend to stay in the field longer. Such dedication exists despite, in many cases, poverty-level wages.

2. Nebraska leads the Midwest in percentage of providers who are certified in CPR and First Aid and in High Scope training. Nebraska provides an array of training opportunities, and new initiatives such as Heads Up! Reading and First Connections are showing good uptake rates. Observational findings show that the Heads Up! Reading associates with observed quality in preschool center-based settings.
3. Overall, the quality of child care in Nebraska is comparable to that of two of its neighbors. For every type of care, Nebraska is comparable. Thirty-four percent of care is good quality.
4. Together with Missouri and Kansas, Nebraska is among a few states that have invested in Early Head Start/Head Start partnerships. In Nebraska infant/toddler center-based partnerships with Early Head Start programs appear to be bringing higher quality child care to low-income children.
5. A higher proportion of Nebraska center-based and family child care licensed providers care for children whose tuition is paid by public subsidy than is true in several other Midwestern states. A relatively high proportion of licensed providers caring for children whose tuition is paid by subsidies is one sign that a variety of care is available to children eligible for subsidies.
6. Nebraska has a subgroup of license exempt, approved providers who are invested in child care and are good candidates for more training and development.
7. Infant/toddler center-based providers in Nebraska are significantly more likely than those from other states to have a policy that allows them to stay with their children throughout the infant/toddler years.

Recommendations

While there are many strengths, emphasis should be placed on moving more of Nebraska's child care into the good quality category, recognizing that most care in Nebraska has yet to reach the target of good quality care. It is good quality care that associates with good outcomes for children and helps to provide the foundation needed for success throughout their subsequent education. The following are recommendations for improving quality that stem from the research findings:

1. There is an immediate and urgent need to improve quality among Family Home I providers who care for children receiving child care subsidies and to take steps to improve quality among license exempt providers who receive subsidies. Steps could include: requiring higher levels of training for subsidy-receiving licensed providers and increasing incentives for quality among this group of providers (e.g., removing barriers to accreditation-level reimbursement). As much as possible, target combinations of the USDA Food Program/CDA/Early Head Start/Head Start to this group and make educational opportunities available. Invest in providers who choose to be in child care including those in license exempt care. Prioritize CPR/First Aid training for license exempt providers to ensure the basic safety of Nebraska's children for whom the state provides child care funding.

2. Emphasize improvements in the literacy environments throughout Nebraska child care.
3. Continue to work to raise the very low annual earnings among providers in every form of child care in the state.
4. Continue to augment Early Head Start/Head Start partnerships. Nebraska invests less in these partnerships than is true for Kansas and Missouri. Increase Nebraska funding for this project, allowing local Early Head Start/Head Start programs to use the funds in new and existing partnerships and direct funding of child care partners to enable more resources to reach the frontline program staff. Staff should receive paid time to attend training events and should otherwise benefit by participating in the partnerships.
5. Increase resources within the community college system that are targeted to early childhood programs to ensure that the preparation of child development/early childhood degree holders supports growing quality, across all regions of the state. Embed the CDA within the two-year programs to bring the added rigor of the CDA to two-year preparation and to bring Nebraska up to CDA completion rates in neighboring states.
6. Provide expanded training and educational opportunities:
 - Provide incentives for increased education and training of all types. Increasing requirements for training hours up to 24, especially among providers with less education, would be expected to benefit quality.
 - Build on the contributions of the USDA Food Program. The USDA Food Program has been an important way to augment the quality of programs serving low-income children.
 - Combine Internet and video training programs with “in-person” components. While Nebraska leads in the amount of “not in-person” training completed, the benefits of this type of training are not as great as for “in-person” training. Consider more opportunities for “in-person” training for family child care, e.g., Missouri’s EDUCARE program. However, recognize that for family child care providers, particularly those with less education, all forms of training seem to help to improve quality in small increments.
 - Target training specifically to new and often young infant/toddler center-based providers. Enforce requirements for CPR/First Aid training among infant/toddler providers. Help infant/toddler center-based providers see the potential for intentional planning, creative use of space and other high quality early childhood practices in infant settings. Work to ensure that infant/toddler providers receive employment benefits.
 - Build on success: expand upon and intensify Heads Up! Reading and other programs that associate with quality. Continue to emphasize training that has an outcome, certificate or credit.

- Provide training for providers in implementing a curriculum or a playful approach to their caregiving, as such intentionality appears to be a strong correlate of quality in Nebraska.
- Require providers caring for children with disabilities who are receiving subsidies to enroll in the Special Care program for special instruction for caring for children with disabilities. However, because the care provided for children with disabilities tends to mirror that of all care, provide incentives for providers who care for children with disabilities to achieve higher levels of quality.

7. Expand and empower the TEACH program. This program has led to higher overall quality and higher wages in other states where it has been implemented, and similar success is expected in Nebraska.

Introduction and Methodology

Introduction

The University of Nebraska’s Center on Children, Families, and the Law (CCFL) and the Midwest Child Care Research Consortium⁴ contracted with The Gallup Organization of Princeton, New Jersey, and four state universities, to conduct a study of child care workforce characteristics and quality in Iowa, Kansas, Missouri and Nebraska. The purposes of this research were 1) to determine the prevalence of quality indicators in child care programs in the Midwest, and 2) to determine if there were systematic differences in quality indicators according to whether providers were subsidy receiving or not, according to type of care provided, by state, and whether the provider was an Early Head Start/Head Start child care partner. States were in hope that the quality indicators for those providing care for children receiving subsidies would be comparable to other care in the state and that high quality care would be found across all types of care. Additionally, in three of the states investments in Early Head Start/Head Start partnerships were viewed as a way to improve quality, and administrators wanted to learn whether there were differences between these partnerships and other programs in states. Results of the study are to be used as baseline for tracking quality in the states over time.

Methodology

To accomplish the objectives of this study, researchers from Gallup and the Midwest Child Care Research Consortium prepared a survey consisting of items that predict quality and workforce characteristics and conditions, and obtained files of providers from state child care divisions in the four states as a population from which to select the random sample.

The survey was comprised of 28 general questions, 8 demographic questions and 1 open-ended question. Items were selected according to several criteria: 1) if they had been used in previous studies and had been found to predict observed quality; 2)

⁴ The Midwest Child Care Research Consortium consists of researchers from Iowa State University, the University of Kansas, the University of Missouri and the University of Nebraska and representatives from state governments in child care and education, health and regulation divisions and resource and referral organizations. This study is a part of a three-year partnership grant funded by the U.S. Department of Health and Human Services, Child Care Bureau, and the Ewing Marion Kauffman Foundation, Kansas City, Missouri.

if they had been used in previous studies and had been found to predict positive child outcomes; 3) if similar or related items had been used in previous studies and had been found to predict observed quality or to predict child outcomes; 4) if items tapped into a feature of the labor force found to be predictive of trends or changes in other areas of the country; 5) if state administrators in the Midwestern states had invested in a procedure (e.g., a type of training) or had initiated a policy in order to improve quality and the prevalence of the procedure or response to the policy could be addressed by the survey. As much as possible, questions were written to be consistent with those asked in previous studies so that Midwestern results could be compared with earlier findings.

Prior to selecting the sample it was necessary to define the population. State-level child care division files were used to identify providers and programs that provided full-day child care. These files included all providers who were licensed or registered and all providers who received public child care subsidies from each of the four states in the most recent month for which transactions were complete. In three of the states the files included names of all providers for October 2000 and in one of the states the file contained names current as of November 2000. Altogether these files yielded names of 39,473 providers who were then subdivided according to the study stratification categories, as denoted in the chart below that illustrates stratification for the Nebraska sample.

TABLE M-1. POPULATION OF PROVIDERS BY STRATA IN NEBRASKA OCTOBER 2002⁵

NE	Infant Center	Preschool Centers	Licensed Family Homes	Registered Family Homes or Other Category	License Exempt Homes	Early Head Start/Head Start Child Care Partner
Subsidy	269	292	904	Family Care II-237	1484	39
Non-subsidy	182	210	2080	Family Care II-297	NA	

⁵ Totals add to greater than total number of providers as some providers enter more than one category for purposes of our study (e.g., center-based programs that serve both preschoolers and infants and toddlers and may be an Early Head Start/Head Start child care partner).

The list of providers was sent to a telephone look-up service to maximize the number of providers who could be contacted by telephone. State university and resource and referral agencies also contributed missing telephone numbers.

Additionally, Head Start and Early Head Start programs were contacted to obtain the names of their child care partners, and partnerships were verified with the child care programs by telephone. The following are the categories of care studied across the states: Licensed Infant/Toddler Center-Based Care (Subsidy and Nonsubsidy): 4 States; Licensed Preschool Center-Based Care (Subsidy and Nonsubsidy): 4 States; Licensed Family Child Care Homes⁶ (Subsidy and Nonsubsidy): 3 States—Kansas, Missouri and Nebraska; Registered Family Child Care Homes (Subsidy and Nonsubsidy): 2 States—Iowa and Kansas; License Exempt Family Child Care Homes (Subsidy Only)⁷: 4 States; Early Head Start/Head Start child care partners: 4 States.⁸

Providers received advance information about the study from newsletters published by state child care and education divisions, professional organizations, and resource and referral agencies. Two state child care divisions sent providers notices that they could be called by Gallup, and this letter encouraged providers to participate in the survey. Field staff in child care divisions and resource and referral agencies were informed about the study so they could also encourage providers to participate if contacted. From the large state provider files, Gallup drew a sampling list of five times the number of providers required to fill each stratification cell, and these providers received a letter from Gallup explaining the study and telling them they could be called in the near future. Gallup selected providers at random from the sample files and calls were completed from April through August of 2001. Ninety-nine percent of providers who completed the survey were female.

When contacted by Gallup, the person who answered the telephone was informed about the study and was asked to identify a teacher at random or to respond to the survey if they were the only provider at the number. The respondent was given the option of responding to the survey at the time contacted or the interview was scheduled for a later time. A number of questions were asked in order to verify the eligibility of the program (offering full-day child care) and of the respondent (e.g.,

⁶ A program was classified as a licensed family home if the state conducts inspection visits to the home for purposes of ensuring that regulations are met. A home was classified as a registered home if the state had initiated some quality requirements and required registration but not inspection.

⁷ License exempt care varied somewhat across the states. In Iowa this form of care was referred to as “license exempt care”; in Kansas this category is referred to as “relative care”; in Missouri, the least regulated providers are referred to as “registered providers” and in Nebraska this form of care is called “approved care.” Category inclusion by state varies somewhat, e.g., Kansas relative care providers primarily care for relatives. For purposes of definition for this study the license exempt category refers to the least regulated form of care, generally referred to as informal care but categories are not perfectly comparable. However, by definition, each is the least regulated form of care in the state and is regarded as informal care. These providers are subsidy receiving and have no nonsubsidy receiving counterparts.

⁸ The number of Early Head Start/Head Start partnerships in each state is small. Therefore, a decision was made to contact the entire population of these providers and this category was regarded as one category. These providers are child care providers and therefore were classified for subgroup analyses according to the type of care category and subsidy status groups they enter but for whole group analysis each was only counted once.

full-time teacher or provider) and to verify the classification of the respondent (e.g., infant/toddler or preschool teacher).

Once a provider had been drawn to participate in the study, a seven-call call back design was followed to ensure the integrity of the random design. Providers who indicated their willingness to be re-contacted (about 90%) were put on a list to be drawn for follow-up observations. The final sample consisted of 508 Nebraska providers (2022 in the Midwest sample) stratified according to state, subsidy use, and type of care. The University of Nebraska contacted 124 providers for follow up. There were 85 Nebraska providers observed and 385 observed in the Midwest sample.

TABLE M-2. SAMPLE BY STRATA (Observations are in parentheses)

State	Infant Center	Preschool Centers	Licensed Family Homes	Registered Family Homes	License Exempt Homes	Early Head Start/Head Start Child Care Partner ⁹
Total	N = 436 (114)	N = 460 (113)	N = 449 (68)	N = 287 (28)	N = 260 (12)	N = 130
TOTAL: Sub	302 (70)	321 (69)	254 (32)	162 (14)	260 (12)	50 (25)
Non	134 (35)	139 (35)	195 (36)	125 (14)	NA	80 (19)
NE: Sub	79 (15)	75 (11)	115 (9)	NA	64 (7)	19(7)
Non	41 (12)	41 (9)	93 (13)	NA	NA	6(2)

Data in this report are unweighted. Weighting the data according to the estimated population of Nebraska providers caring for children 5 and under changes the findings slightly, but minimally.

⁹ As previously noted, Early Head Start/Head Start child care partners were also classified according to the type of program and whether they were subsidy receiving or not. Early Head Start/Head Start child care partners could be infant/toddler center-based providers; preschool center-based providers; licensed family homes; registered family homes or license exempt homes and could be either receiving tuition paid by subsidies or not. In fact, this array was found.

¹⁰ In the Nebraska sample, 5 of the Early Head Start partnerships were infant center-based providers; 1 preschool center-based provider; 3 family child care providers.

Detailed Findings

Characteristics and Quality in Nebraska Child Care

1. CHARACTERISTICS OF THE CHILD CARE WORK FORCE

“What are the characteristics of the child care work force in Nebraska and how does Nebraska compare to other states?”

TABLE 1. PROVIDER CHARACTERISTICS AS REPORTED IN THE GALLUP SURVEY

<u>Percent of child care workforce</u>	Midwest	Nebraska	Iowa	Kansas	Missouri
Age	38.7	38.4	37.9	39.8	38.3
Married	72%	74%	74%	70%	70%
Parent	84%	82%	87%	86%	83%
Bachelors Degree/+	15%	14%	17%	14%	16%
2 year Degree	15%	18%	14%	16%	14%
1 year Child Development	7%	6%	6%	8%	8%
Some education + high school	31%	32%	28%	32%	30%
High school	28%	28%	31%	26%	26%
Less than high school	4%	2%	4%	5%	5%
Wage	\$13,900	\$14,700	\$12,410	\$13,250	\$15,390
Experience in child care % > 5 years	72%	75%	71%	72%	70%
In program % < 1 year	16%	14%	14%	16%	18%
Child care as profession	60%	63%	58%	56%	65%
Child care as calling	59%	57%	55%	58%	66%
While children are young	36%	35%	38%	37%	35%
Help someone	42%	41%	43%	44%	43%
CPR	82%	90%	83%	80%	76%
NAEYC	16%	13%	13%	17%	21%
N AFCC	7%	7%	6%	8%	6%
Stay in child care 5 years or more	60%	60%	57%	56%	67%
Chose other work	17%	17%	19%	16%	15%
Have Internet Connection	57%	58%	57%	53%	60%

The average child care provider in Nebraska is experienced with children and with child care. Most providers are women who average 38 years of age, are married, and are also parents. The average provider has a high school degree with some

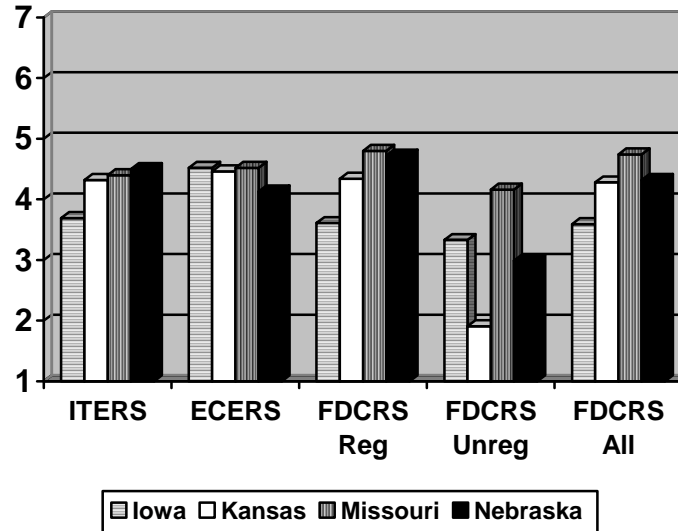
additional training and earns \$14,700 a year. The average Nebraska provider is more likely to have CPR training than providers in the other Midwestern states. In addition, providers in Nebraska reported receiving 31 hours of training during the previous year. Interestingly, providers are fairly well connected to the Internet; 58% have an Internet connection and another 29% aim to get one within the next year.

There is also a substantial cadre of committed long-term providers in the state. The average provider has been providing child care for over five years and over half have been providing child care for over 10 years (51%). They are committed to child care and see it as important work; 63% of Nebraska providers report they agree that child care is their profession and 57% say that it is a personal calling for them. Ninety-three percent say they have had opportunities to learn and grow in the past year and 60% say they intend to be a child care provider for five years or longer. Eighty-three percent say they would not choose work other than child care.

2. QUALITY

“What is the quality of child care in Nebraska? How does child care quality in Nebraska compare to other Midwestern states?”

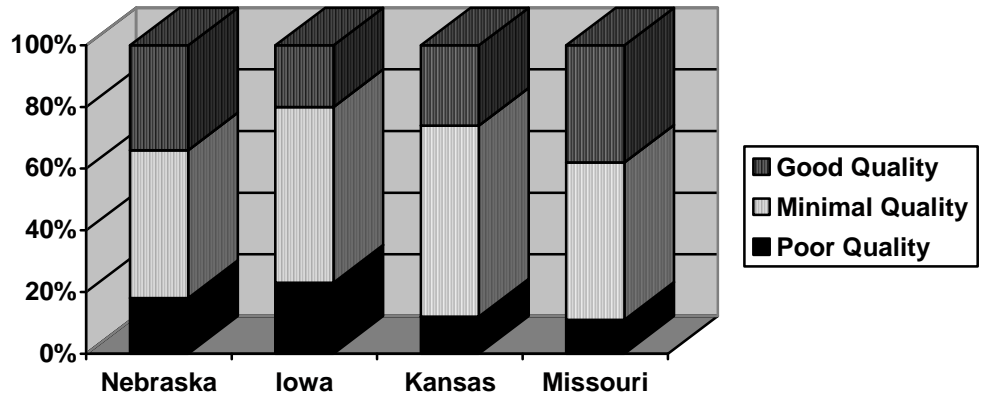
FIGURE 1. QUALITY OF OBSERVED CHILD CARE IN THE MIDWEST BY TYPE OF CARE AND STATE (N= 365)



Average quality of observed care in Nebraska is comparable to that in other states in Region VII, across all forms of care. Quality of observed care was measured using the following assessments: the Infant Toddler Environment Rating Scale (ITERS) for infant/toddler center-based care, Early Childhood Environment Rating Scale (ECERS) for preschool center-based care, and the Family Day Care Rating Scale (FDCRS) for regulated and unregulated homes. By the instrument author’s standards, a score of “5” is rated good quality; a score of “3” or lower is poor quality and scores between are categorized as mediocre or minimal quality. Infant/toddler center-based care, preschool center-based and regulated family child care in Nebraska were comparable in quality to one another, while licensed exempt care in Nebraska, as was true for other states, was rated lower. Infant/toddler center-based care in Nebraska rated 4.50, similar to the quality scores for infant/toddler center-based care in Kansas and Missouri and significantly higher than in Iowa. Preschool center-based care in Nebraska averaged 4.13, which was lowest among the four states but not statistically significantly lower. Licensed family home care averaged 4.71 and was comparable to similar care in Kansas and Missouri, though Missouri’s family child care received somewhat higher quality scores; and all were higher than comparable care in Iowa.

“What percent of Nebraska’s child care is good quality?”

FIGURE 1.2. PERCENT OF GOOD, MINIMAL AND POOR QUALITY CHILD CARE IN NEBRASKA AND OTHER MIDWESTERN STATES¹⁰



About 34% of Nebraska’s child care is good quality or better, rating above a “5” on the ITERS, ECERS or FDCRS, averaging across all forms of care (Figure 1.2). This proportion of good quality care compares well with that of Midwestern neighbors, lagging only behind Missouri. It is comparable to findings of good quality care in national studies (Cost, Quality and Child Outcomes Study Team, 1995). In Nebraska, the remainder of care breaks into mediocre quality care (48%) and poor quality (18%). In past studies, positive child outcomes have been associated with better quality care and negative child outcomes with poorer quality care. When data are weighted to the population of providers providing care for children 5 years of age and younger, the percent of good quality care is 37%; the percent of mediocre care is 44% and the percent of poor quality care is 18%.

“What is the quality of interactions between providers and children?”

The Arnett Caregiver Interaction Scale measures positive interaction, detachment, permissiveness, and punitiveness in provider-child interactions. It is an assessment

¹¹ To determine the percent of good, minimal and poor quality care across different types of measures and different types of care, scores on the ITERS, ECERS and FDCRS were converted to a 7-point index of overall quality.

often used in connection with the ITERS, ECERS and FDCRS to expand the assessment of child-provider interactions.

Correlations indicate that the more total “in-person” training that providers receive, the more positive interaction is observed. Providers who are rated high on positive interaction are also more likely to report frequent communication with parents and using reading and learning centers in their program. When providers are rated high on positive interaction, the quality of observed interactions among children is also rated positively. Infant/toddler teachers tend to be rated higher on positive interaction than preschool teachers, but it is quite possible that this is due to the developmental needs of children, since infants and toddlers require more contact and comfort, whereas preschoolers require more autonomy. Provider positivity was not significantly related to: the type of care (center or home), membership in NAEYC or NAFCC, parental status, having a teaching certificate or CDA, having a major area of study as child development or early childhood education, having an Early Head Start or Head Start partnership, receipt of subsidy, or working in a center that practices continuity of care.

Conversely, the more punitive the provider was, the more negative were interactions between children in her care. There was a significant correlation between the providers’ age and punitiveness, with older providers more likely to be rated higher by observers on punitiveness. There was also a significant correlation between punitiveness and income, with providers reporting higher child care income more likely to be rated high on punitiveness. Similarly, the more detached the provider was, the more negative were the interactions among children. Providers who were detached were less likely to report using reading and learning centers, and were less likely to see child care as a stepping-stone to a related career or profession. Providers who indicated that they would choose different work if they could do so were significantly less warm and supportive in their interactions with children.

3. TYPE OF CARE: CENTER-BASED, FAMILY CHILD CARE, LICENSE EXEMPT CARE

“How do child care characteristics vary according to type of care?”

TABLE 3. QUALITY AND CHARACTERISTICS BY TYPE OF CARE (N = 85-508)

Features of Providers: (n = 85 – 508)	Infant Toddler Center	Preschool Center	Licensed Homes	License Exempt Homes
Observed Quality	4.5	4.13	4.71	3.2
CDA	8%	12%	6%	0%
Training Hours	27.8	46.2	27.6	21.9
Two year degree or higher	35%	42%	28%	20%
Child care as profession	74%	90%	82%	59%
Child care as stepping-stone	62%	57%	34%	21%
Child care as my personal calling	81%	85%	78%	63%
Job with a paycheck	40%	30%	36%	43%
Do while children are young	45%	36%	51%	55%
Child care is to help someone	62%	53%	52%	80%
In current position < 1 year	30%	16%	5%	5%
Would do other work if could	18%	15%	16%	23%
Will be in child care ≥5 years	60%	68%	63%	39%
Age (% < 24)	25%	22%	4%	9%
Wage	\$15,410	\$16,570	\$15,130	\$8,120
First Aid (% current certification)	90%	91%	98%	54%

Infant/Toddler Center-Based Care

Infant/toddler center-based observed quality (ITERS) was comparable to that of other states. Nebraska leads other states in infant/toddler teacher continuity practices; however 30% of infant/toddler teachers have been with their programs for less than a year. Therefore, practicing continuity of care may be impaired by high provider turnover because a sizable percentage of teachers have been with their programs for a short period of time.

Infant/toddler center-based providers are younger and newer to their jobs than other providers. Thirty percent of the infant/toddler center-based providers had been in their jobs less than a year and 25% of the sample was younger than 24, younger than the Nebraska sample at large (43% of all providers in the sample

younger than 24 were infant/toddler center-based providers). Infant/toddler center-based providers have slightly lower incomes than preschool center-based providers.

Infant/toddler center-based providers have less training and education than preschool center-based providers in the state. Fewer have two-year degrees or more education or a Child Development Associate (CDA) credential than is true for preschool providers and they received about half the number of training hours as preschool providers. In addition, 10% of infant/toddler providers were not current in First Aid. Infant/toddler center-based providers were also more likely to say that child care is a stepping-stone to a related career than any other type of provider.

Preschool Center-Based Care

Observed quality in preschool center-based care (ECERS) was comparable to other care in Nebraska and to preschool center-based care in other states. Preschool center-based care in Nebraska was observed to be slightly lower than other regulated care in Nebraska and slightly lower than comparable preschool care in other states, although the differences were not significant.

Across the Midwest, preschool center-based providers are the best educated and receive the most training of any subgroup of providers. In Nebraska, this group received nearly twice as many training hours as any other group of providers. Also, preschool providers included the largest proportion of providers with two-year degrees or greater, including the most providers with CDA's and the most who had completed Heads Up! Reading. Preschool center-based providers had the highest incomes on average of any group. In addition, preschool providers included the highest proportion that regarded child care as their profession and as a personal calling.

Family Child Care Providers

Some of the highest observed quality in Nebraska was found in family child care (FDCRS) but some of the lowest quality was found in this category as well. On average, observed quality of family child care fared very well in comparison with other Midwestern states and averaged the highest of all observed care in Nebraska, though not significantly higher than for center-based care. Family Homes II tended to provide quality care than Family Homes I on average, averaging 5.3 on the FDCRS vs. 4.2 for Family Homes I. The Family Home II average was the only subgroup in the sample that was above the critical "5" signifying good care on average!

Family home providers (I and II) as a group represent a stable group of providers. This group has a high proportion of providers who see child care as their profession, as a personal calling and who intend to stay in child care. This group

does not include many who would choose other work; however, it includes the highest proportion of providers who see the work as something to do while their own children are young.

License Exempt Providers

Nebraska does not require a license for providers caring for three or fewer children together with their own children. On average these providers reported caring for 3.3 children (including their own) during peak periods. **This small group of providers had lower observed quality (FDCRS) than providers in general but there was good quality found among license exempt providers as well.**

There was a subgroup among license exempt providers who received training; 34% reported receiving greater than 12 hours of training. Although they are not required to be current in basic emergency and safety preparation, about half of license exempt providers reported they are current in CPR or First Aid.

Many are committed to child care; 78% say they intend to be a child care provider for two years or longer and 39% for five years or longer. While 80% say they are providing child care as a way of helping out a friend or family member, forty-three percent say they are providing child care for the money. Sixty-three percent regard child care as a personal calling and 59% see child care as their career or profession. More license exempt providers than any other group of providers (23%) say they would choose other work if they could.

4. SUBSIDY AND QUALITY

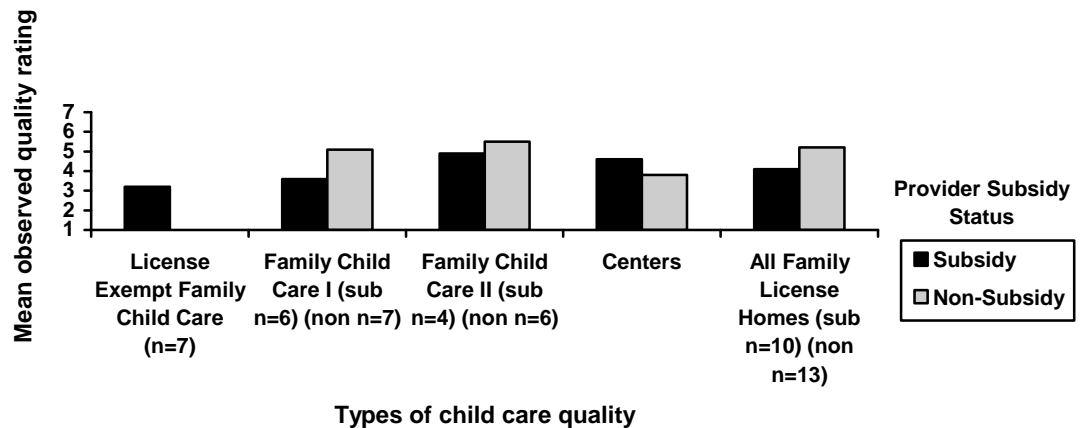
“Are quality and other features different between providers who care for children whose tuition is paid by government subsidies and those who do not? Are quality and other features different between providers who receive a high proportion of payment by subsidy and a lesser proportion?”

A central question of the Midwest Consortium was to determine the quality of child care received by children whose tuition is paid by child care subsidies. There are several ways in which the Consortium attempted to answer this question: 1) by examining the observed quality of subsidy-receiving and nonsubsidy-receiving child care providers; 2) examine the frequency with which child care providers reported engaging in high-quality practices; and 3) by examining teacher qualifications and training hours. Each relationship was examined within different types of providers (licensed center and home providers, and non-licensed providers) and according to the age of the child (infant and preschool, for centers only) because the relationship between quality and subsidy receipt may vary according to type of care.

Subsidy Receipt and Observed Quality

While the mean level of observed quality was lower for subsidized child care providers (4.2) than for providers not receiving subsidies (4.6), this difference was not statistically significant. However, subsidized family child care providers had significantly lower quality than their nonsubsidized counterparts. There were no statistically significant differences between infant and preschool center care for subsidized and nonsubsidized providers. However, there was a large difference between subsidized and nonsubsidized home providers, with substantially lower observed quality scores among subsidized home providers. The latter relationship held up even taking regulation into account; subsidized Family Home I providers were significantly lower in quality than their nonsubsidized counterparts, and subsidized Family Home II providers were lower than nonsubsidized Family Home II providers, though not significantly. Nonsubsidized Family Home II providers had the highest observed quality of any subgroup within this analysis. Of the high quality Family Child Care I providers, fewer enroll children with subsidies. Interestingly, it appears that there is a slight trend towards increased quality among subsidized preschool center-based providers. Subsidy-receiving infant center-based providers were similar in quality to nonsubsidy-receiving infant providers. This trend remained after removing the Head Start/Early Head Start partnership programs (see section 5 of this report).

FIGURE 4.1. OBSERVED QUALITY IN DIFFERENT TYPES OF NEBRASKA CHILD CARE SETTINGS



Subsidy receipt was not associated with quality among center providers, but was very strongly associated with quality among home and license exempt providers. More specifically, we found that among home providers, as the proportion of children receiving subsidies increases, the quality of that facility decreases ($r=-.61$). This relationship remained very strong after removing license exempt providers. However, this relationship was not true for either infant or toddler center-based providers; subsidy ratio had a positive relationship with observed quality in preschool center settings, and there was no relationship between subsidy ratio and observed quality in infant center settings. **It appears that high levels of subsidy receipt may indicate low quality among some home providers, but not among providers in general. Subsidy receipt may even enhance quality among preschool center-based providers. Furthermore, among nonsubsidized providers, 44% of care was found to be good quality or higher, while only 30% of subsidized care met the same standard.**

Frequency of other high-quality practices among subsidy providers

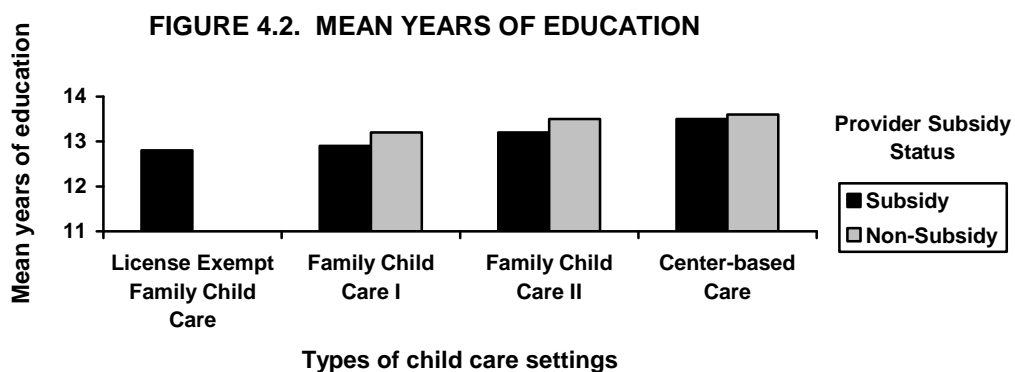
In order to determine whether providers who were not observed were engaging in practices associated with high quality, providers who answered the telephone survey

were asked to report how frequently they read to children, whether they have adequate space and toys for children, whether they greet parents daily and have formal conferences once a year, and whether they use learning centers for children to organize the play space. Scores were then created to indicate how likely providers would be to report engaging in these practices. Subsidy providers were less likely to report reading daily and using learning spaces within their facilities. There were no significant differences reported in adequacy of toys or spaces and whether they greet parents daily and talk formally once a year.

Subsidy receipt may also be associated with less optimal interactions between caregivers and children in licensed and license exempt homes. As subsidy receipt increased, sensitivity decreased among this group of providers.

Subsidy and Provider Characteristics

Education. Overall, subsidy providers in Nebraska have a lower level of education than nonsubsidy providers. However, *center* subsidy and nonsubsidy providers do not differ according to level of education; subsidy home and license exempt providers have a lower level of education than nonsubsidy home providers. More specifically, when looking at licensed and license exempt child care providers, as the proportion of subsidy-receiving children increases, provider education levels decrease. This relationship existed only among home providers; there was no difference between the education levels of high, low and nonsubsidy-receiving center providers. Therefore only among home providers was there a decline in levels of education as subsidy proportion increased. This means that children who are vulnerable because of poverty are cared for by the least educated providers. This strong relationship is exacerbated by the low levels of education among license exempt providers but is reflective of licensed home providers as well.



Earnings. Overall, across all forms of regulated care, there were no significant differences in child care earnings between subsidy-receiving and nonsubsidy-receiving providers. Wages were not significantly different according to the proportion of children receiving subsidies enrolled in the facility. However, license exempt home providers had significantly lower income levels than licensed providers. When we examine licensed home providers separately from other types of care, we find that subsidy receiving Family Home II providers had significantly higher earnings than nonsubsidy receiving Family Home II providers. Among Family Home I providers, those receiving subsidies had higher incomes than nonsubsidy-receiving providers; this relationship was not significant in the Nebraska sample (it was significant in the larger Midwest sample).

Experience. Overall, subsidy providers in our sample have lower levels of education and have less experience than nonsubsidy providers. As the proportion of children receiving subsidies in both centers and homes increases, the level of education of providers decreases. However, this was not a very strong relationship, indicating that there are many providers who have both high levels of subsidy receipt and many years of education, as well as providers who do not serve children on subsidies who are relatively inexperienced.

Desire to be providing child care. Subsidy providers in Family Homes I were much more likely to say they would rather be doing work other than child care than were their nonsubsidy family child care counterparts. For example, 26% of Family Home I subsidy providers said they would choose work other than child care if they could, while significantly fewer (10%) of nonsubsidy Family Home I providers would choose other work; 23% of license exempt providers answered that they would choose other work. Among other types of providers, differences were not significant between subsidy and nonsubsidy providers.

Training. When considering all types of providers, there were no significant differences in the amount of training or type of training reported by providers serving children on subsidies and those not. Breaking the analysis down by type of provider, we found that there were no differences in training reported by center providers, but for family child care homes, subsidy providers received significantly less training than nonsubsidy providers. Subsidy Family Home I providers reported 21 hours of training vs. 32 hours for nonsubsidy Family I providers; subsidy Family Home II providers reported 28 hours of training compared to 32 hours for nonsubsidy Family Home II providers.

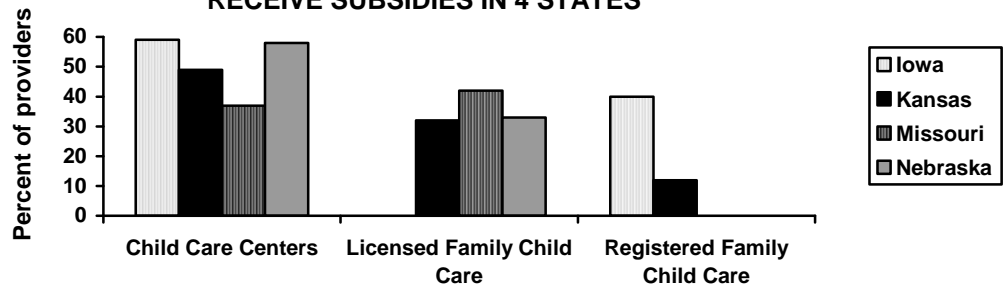
However, some additional differences emerge when considering “in-person” versus “not in-person” types of training. The proportion of children receiving subsidies was negatively correlated with the amount of both “in-person” and “not in-person” training received, after controlling for the provider’s level of education. In other words, the more subsidy-receiving children enrolled in a program, the fewer training hours were received by the provider. It appears that “in-person” training is reliably related to quality when examining level of subsidy receipt. Subsidy providers who received many types of “in-person” training were observed to have higher quality,

and reported engaging in more high quality practices, than high-subsidy providers who had fewer types of “in-person” training. “Not in-person” training did not have a reliable relationship to observed quality. Therefore, subsidy providers may benefit from more opportunities to engage in “in-person” training.

Proportion of All Providers Caring for Children Receiving Subsidies

A higher proportion of Nebraska center-based providers cared for children whose tuition was paid by subsidy than was true in most other states. Nebraska tied for second among states when it came to proportion of providers caring for subsidy receiving children in regulated family child care. The findings indicate that center-based care is relatively accessible to children who receive subsidies in the state.

FIGURE 4.3 PROPORTION OF PROVIDERS CARING FOR CHILDREN WHO RECEIVE SUBSIDIES IN 4 STATES



5. EARLY HEAD START/HEAD START PARTNERSHIPS

“Do quality and other features vary between Early Head Start/Head Start partnerships and other types of care?”

TABLE 5. EARLY HEAD START/HEAD START PARTNERS COMPARED TO OTHER PROVIDERS IN NEBRASKA

	Early Head Start/Head Start Partners (N= 5 - 25)	All Providers (N = 76 - 481)
Observed Quality Overall*	5.4	4.2
ITERS Quality*	5.4	4.3
Arnett Interactions	3.6	3.4
Reading/Learning Centers*	4.8	4.6
Parent Communication	4.6	4.6
Space/Materials	4.8	4.8
Training Hours*	36	24

*denotes a significant difference

The Nebraska Department of Health and Human Services (DHHS) receives approximately \$500,000 in annual funds for quality enhancement specifically for infant/toddler child care. Of these funds, about \$125,000 has been targeted to the eight Early Head Start programs in the state to support partnerships with child care programs in their communities serving Early Head Start children (approximately \$16,000 each). These programs enter into formal contracts (and sometimes informal arrangements) with local child care providers to follow the Head Start performance standards. We asked about both Early Head Start and Head Start partnerships because many of the Early Head Start programs provide services for children from birth to five years of age and because many of the providers these programs partner with also provide care for children birth to five years. Head Start performance standards are higher than licensing standards, specifying group sizes of no more than eight for infants and toddlers, and ratios of no more than 1:3.

There are many more additional requirements known to associate with quality. The Nebraska funding policy follows that of the Head Start Bureau to follow Head Start children into child care and make improvements in child care quality that will affect all the children in a care facility. Kansas and Missouri have made similar but larger investments in Early Head Start/Head Start as partners for child care quality. In Nebraska, nine Early Head Start/Head Start partners were observed compared to 76 providers who were not partners. (Across the four states there were 42 Early Head Start/Head Start partners observed vs. 318 who were not partners). In the Nebraska survey sample, there were 25 Early Head Start/Head Start child care partners interviewed vs. 465 who were interviewed who were not partners. (Across the four states, this figure was 124 vs. 1801 who were not).

Overall Early Head Start/Head Start partners had higher observed quality of care than other providers in Nebraska and across the Midwest. Early Head Start/Head Start partners in Nebraska overall averaged 5.4 on the Environment Rating Scale observed quality of care composite 12 while all other providers averaged 4.2, a difference that was statistically significant. Across the Midwest the corresponding figures were 4.9 and 4.3 respectively, and also statistically significant.

- **Quality of infant/toddler center-based care was higher for Early Head Start/Head Start partners than for other infant/toddler care.** In Nebraska, five of the providers observed were infant/toddler center-based providers and the average ITERS observed score was 5.4 (vs. 4.3, a statistically significant difference). This compared to significant differences of scores of 5.4 for Early Head Start partners vs. 4.2 for infant/toddler center-based care overall in the Midwest sample.
- **There were no preschool centers observed in Nebraska that were Early Head Start partners and in the Midwest only nine such observations were made; these were not significantly different from preschool center-based care at large on the ECERS (4.90 vs. 4.40).** A smaller number of preschool classrooms was expected in this portion of the sample as most state initiatives are targeted to infant/toddler care.
- **Early Head Start/Head Start partners scored significantly higher on the Reading/Learning Centers factor** than other providers in our total Midwest sample but not higher on other quality factors we measured by self-report in the survey. The difference on the Reading/Learning Centers factor tended to go in this direction in the Nebraska sample but did not reach significance.

Early Head Start/Head Start providers completed more training than other providers. Head Start stresses high levels of training for staff and partnerships are expected to provide training opportunities to child care partnership staff. In fact, that is what happened in Nebraska and throughout the Midwest. Nebraska partners averaged 36 hours of training during the previous year vs. 28 hours for other providers (p. = .001, n = 25, 465). Interestingly, Early Head Start partners in other states averaged more training hours than those in Nebraska (59 for the partners in the sample at large vs. 29 for others, p. = .001, n = 124, 1801). Although partners received more training, these providers were no more likely to say they receive the training they need to do their work right, and were no more likely to receive paid time off for professional development.

In Nebraska, Early Head Start/Head Start partners participated in some forms of training more than other providers, e.g., training that was attached to college credit, Heads Up! Reading, CDA, High Scope and Creative Curriculum.

Nebraska partners were notable for high rates of participation in Heads Up! Reading Training (32% vs. 7% for the sample at large); CDA (24% vs. 6% for the sample at large); High Scope (24% vs. 11%); Creative Curriculum (40% vs. 22%). They were more likely to have completed a two-year associates degree (44% vs. 16%), more likely to have a degree in child development or early education (80% vs. 62%) if

¹² Scores on the ITERS, ECERS and FDCRS were converted to a 7-point index of overall quality.

they held a degree at all and to have received college credit for the training they received (64% vs. 41%). Nebraska partners were slightly more likely to have¹² completed West Ed training (4% vs. 1%); CPR or First Aid training (92% vs. 89%); to receive training by a director (82% vs. 75%); to attend workshops or study groups in their communities (88% vs. 74%); and to attend regional or state conferences (64% vs. 51%). In addition, they were no more or less likely than other providers to hold a bachelor's degree or higher (8% vs. 11%), to have completed a Parents as Teachers certificate (4% vs. 3%), Montessori (0% vs. 1%); First Connections Training (4% vs. 11%); receive training by video tape or self-study (80% vs. 78%); to receive training by Internet (16% vs. 19%) or Teleconferencing or ICN Distance Learning (8% vs. 12%). Altogether, partners were more likely to have participated in "in-person" training than others but were not less likely to participate in "not in-person" training. These partners were almost twice as likely to be members of NAEYC (24% vs. 13%).

Providers who were Early Head Start partners were only slightly more likely to receive higher salaries than other providers, averaging \$15,200 vs. \$14,700 overall and are no more likely than other providers to receive paid time for training, despite the fact they receive more training. In Nebraska child care centers there were no earnings differences between Early Head Start and other providers. Partners were slightly more likely to receive some benefits (82% vs. 73%): health insurance (69% vs. 50%); health insurance for the family (57% vs. 40%) and retirement benefits (50% vs. 32%), but no more likely to receive paid vacation days; paid sick days or paid days to attend professional meetings (57% vs. 68%); or reduced child care for their own children. Unlike Nebraska, providers in other states with partnerships reported *higher* rates of paid days to attend professional meetings than was true for the sample at large in those states.

Early Head Start staff do not have better views about their workplace than other staff; in fact, their views are often less positive. Early Head Start partner providers have consistently lower scores than their counterparts on the following items from the Gallup Q12, an interview used across many types of work places to rate the quality of work environments. Results of this interview report that Early Head Start partner providers report the following: they have received praise or recognition for doing good work; they have the materials they need to do their work right; their supervisor or someone at work cares for them; their opinions count; the mission of their program makes them feel their own jobs are important. They were also slightly less likely to say they have the opportunity to do what they do best every day and that their associates are committed to doing quality work. They were no different from other providers in their tendency to say that they know what is expected of them at work, and to say they have a best friend at work. Partners were also more likely to say there is someone at work who encourages their development; that someone has talked with them about their progress; and that they have had opportunities to learn and grow. Except for attitudes that encourage training, these less than positive attitudes about the workplace reinforce the recommendation that more resources and support need to make their way to the front line staff that

participate in the partnership. These trends for more negative attitudes among Early Head Start/Head Start partners were much more prevalent in Nebraska than in Missouri and Kansas where resources for partnership work have been considerably higher. In Nebraska, with fewer funds, it is possible that funds only go to the program or that the total amount for each partnership is not sufficient to support the staff in the extra work they do and higher quality they provide.

Early Head Start/Head Start partners are somewhat more likely to see their work as a profession. They were more likely than the average provider to say that their work was their career or profession (92% vs. 78% agree or definitely agree) and/or a stepping-stone to a related career or profession (72% vs. 43% agree or definitely agree). These providers were no more likely than others to find child care a personal calling; to consider it a job with a paycheck; and were slightly less likely to say it was work to do while their children were young or that they were helping out a friend or relative by providing child care. Partners were slightly more likely than the average provider to say they intended to stay in child care for five years or more (68% vs. 60%) but a small minority was also slightly more likely to say they would be leaving within the year (12% vs. 8%). They were also slightly less likely to say they would choose other work if they could (12% vs. 17% for the overall Nebraska sample).

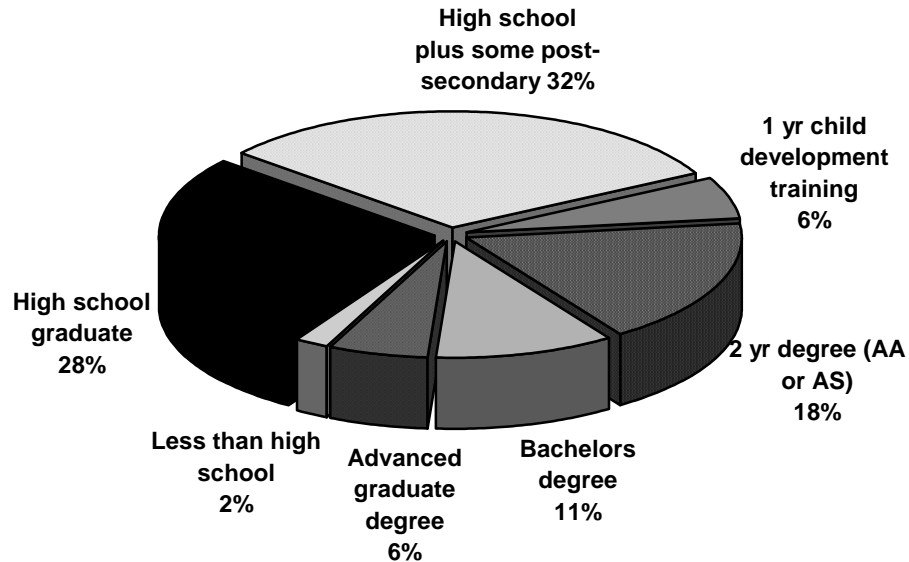
Early Head Start partners included more teachers new to the field and their jobs than was true for the sample at large. The partners' sub sample was only slightly younger in age than the sample at large (35 vs. 39 years of age); included more teachers who had been in their programs for less than 18 months (36% vs. 21%); but also included a group who had been in their programs for three to five years longer (21% vs. 15%). The former group included 12% of the entire sample that had been in the field for less than 18 months, vs. only 4% among providers at large. Thus, the partners' sub sample in Nebraska includes some very new teachers. Partners were also less likely to be parents (68% vs. 83% at large).

Early Head Start partners are more likely to participate in the state's Food Program and were more likely to say their program keeps infants and teachers together throughout infancy (89% vs. 68%), but were no more likely than others to be serving children with disabilities.

6. EDUCATION, TRAINING AND OTHER PRACTICES

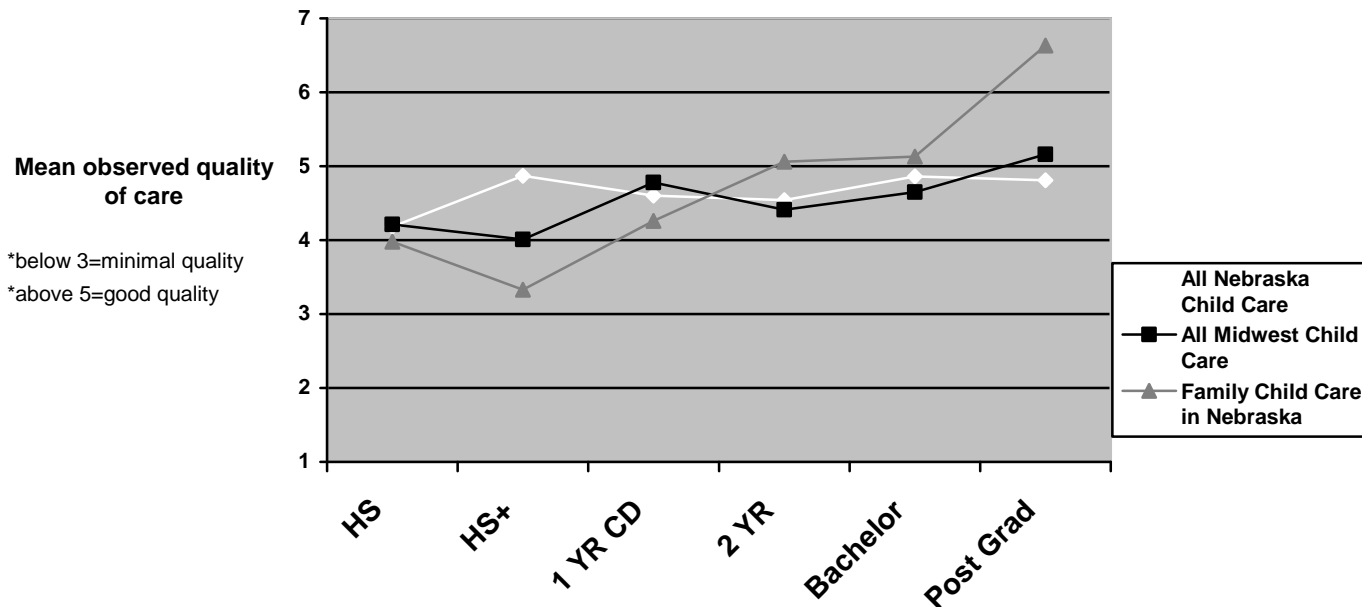
“What is the level of education among Nebraska providers and what is the relationship between education and observed quality?”

FIGURE 6.1. EDUCATION LEVEL OF NEBRASKA PROVIDERS (N = 508)



In Nebraska, as was true for the Midwest overall, the average provider has a high school degree and some training beyond high school but not another degree; 32% of all Nebraska providers fit this category. Additionally, 2% of providers have not completed high school; 28% of providers have a high school degree; 6%, a one-year child development certificate; 18%, a two year degree; 11%, a bachelors degree and 6% a graduate degree. Nebraska had comparable levels of providers with degrees to other states, led in two-year degrees and fell slightly behind in bachelors and post bachelor degrees. Most one-year certificates equate to the Child Development Associate (CDA) and Nebraska lags behind the Midwest in general in CDA completion (7% vs. 13%).

FIGURE 6.2. RELATIONSHIP BETWEEN QUALITY OF CARE AND LEVEL OF EDUCATION AMONG CHILD CARE PROVIDERS IN NEBRASKA AND THE MIDWEST



In general, as can be seen from Figure 6.2, as education increases, so does quality. However, this relationship was significant only for the family child care providers in Nebraska (see gray line). Education level was the strongest predictor of quality for family child care of all factors measured in the study.

Quality of care associated with having a two-year degree was slightly lower than expected, given the higher level of quality found among persons with a one-year certificate (generally CDA). In Nebraska, preschool providers who had two-year degrees had lower quality than their counterparts (preschool providers with two-year degrees) in other states (ECERS quality scores for two-year graduates for Iowa, Kansas, Missouri and Nebraska were respectively, 4.8, 4.5, 4.7 and 4.1; Nebraska ITERS and FDCRS quality scores for two-year college graduates were not lower than those in other states but remained lower than for one-year child development completers). However, in general, having a two-year degree does boost quality over less education.

Providers who had one-year child development training (CDA) showed notably higher observed quality over all types of care in Nebraska and the Midwest. In fact, the quality of care provided by one-year child development holders in center-based settings was comparable to the quality of those with bachelors and graduate degrees, a relationship that held up across ITERS and ECERS observed quality and in both Nebraska and Midwest samples. There was no poor quality for one-year

child development or CDA certificate holders found among center-based providers. FDCRS quality was also slightly higher for one-year or CDA certificate holders but the difference was less striking for homes than centers.

Completing some training (but not including a degree) beyond a high school degree does not seem to increase quality over high school alone in Nebraska or the Midwest. As can be seen from the graph, providers who may be required to complete training but do not advance their formal education do not improve quality beyond that provided by those with a high school education only. The lesson may be that training builds on a base provided by formal education. It is also important to note that the largest proportion of the sample comprised this category (high school with some additional training).

In the Midwest sample there was a positive relationship between quality and having a child development or early education degree but that relationship did not hold up in the smaller Nebraska sample. In the Midwest, as in Nebraska, there were positive relationships between having a state-recognized teaching certificate and quality.

“What training did Nebraska providers receive and what is the relationship between training and observed quality?”

TABLE 6.1. TRAINING RECEIVED BY NEBRASKA AND MIDWEST PROVIDERS

Training	Nebraska	Midwest
Initiatives/Programs		
CDA	7%	13%
Parents as Teachers	3%	7%
West Ed	1%	2%
High Scope	12%	8%
Montessori	3%	3%
Creative Curriculum	23%	31%
Heads Up! Reading	8%	NA
First Connections	11%	NA
First Aid	89%	84%
Types of Training		
“In-person” training	89%	85%
“Not in-person” training	78%	64%
Video tapes or study materials	78%	68%
Training provided in your center	77%	72%
Support person who comes to you	0%	34%
Community support and training	75%	79%
Regional, state, national meetings	52%	48%

Training for credit (CEU or college)	42%	48%
Internet	19%	18%
Teleconferencing/ICN Distance	12%	12%
Total Training Hours	31 hours	35 hours

Nebraska providers have participated in a wide variety of training initiatives.

As can be seen from the table above, Nebraska is ahead of the Midwest average in percent of providers who have completed CPR and First Aid, High/Scope, Heads Up! Reading and First Connections (these two programs are only available in Nebraska). Nebraska falls behind in CDA, Creative Curriculum, Parents as Teachers and West Ed training. However, Nebraska leads in most types of training reported, with the exception of training that involves support persons coming to the provider’s program, community support and training, and in training for credit. Additionally, new programs as Nebraska only Heads Up! Reading and First Connections showed good initial uptake rates and it is anticipated that the impact of these programs will increase over time.

Uptake rates for initiatives and types of training varied considerably by type of care; thus, the selection bias must be recognized.

Infant center-based teachers were more likely to participate in West Ed; preschool center-based teachers in High Scope, Montessori, PAT and CDA, and Heads Up! Reading. Licensed home providers were more likely to participate in First Connections than was true for other types of providers; center and home providers were equally likely to participate in Creative Curriculum. License exempt providers were most likely to report using videos and self-study materials and the Internet for training. Family child care providers were more likely than other providers to participate in community support and training; center-based providers were more likely to attend state, regional and national meetings. Licensed home and preschool providers most often named teleconferencing as a source of training.

Nebraska requires CPR/First Aid training for its licensed providers. Very few family home providers with licenses were deficient; however, 10% of infant/toddler and 9% of preschool providers were deficient in one or the other.

While they are not required to be current in First Aid or CPR, about half of license exempt providers did not have current first aid training. In the Midwest, in general, being current on CPR and First Aid tended to associate in a small but positive direction with observed quality¹¹(e.g., $r = .08$ for First Aid and ITERS quality; for

¹³ Because the provider’s level of education was associated with many variables of interest, such as membership in professional organizations, participation in training and use of a curriculum, statistical techniques which control for the provider’s level of education were employed so that information regarding the unique impact of training, continued education and other variables could be discerned. Correlation statistics are reported to give the reader an indication of the size of the relationship between reported variables. As a general guideline, correlations below .10 are considered small, while correlations of .40 and larger are considered quite substantial. A correlation is denoted by use of the r .

ECERS quality $r = .15$; for FDCRS quality $r = .30$). Relationships in the smaller Nebraska sample did not reach statistical significance.

Nebraska providers reported receiving considerably more training hours than is currently required for licensing (31 hours), and center-based preschool teachers averaged about twice as many hours as other providers. The average number of training hours in Nebraska lagged behind Missouri and Kansas. While there is generally a positive relationship between training hours and quality, improvements seem to come at 12 hours and beyond 24 hours. More educated providers report more training hours, though this trend was stronger for the Midwest than in Nebraska.

Across the larger Midwest sample, there were significant associations between a number of training programs, initiatives and quality regardless of the education level of the provider. Programs that were effectively associated with quality across all education levels and all types of care were Project Construct (MO only); High Scope; CPR and First Aid. In the Nebraska sample, Heads Up! Reading associated with ECERS quality ($r = .41$, a preschool center-based trend in the sample) regardless of education level; however, many did not reach significance due to the smaller Nebraska sample. The analyses controlled for education in exploring associations between training and quality because in the Midwest participation in these training initiatives tended to be stronger for persons with greater education. However, in Nebraska, only High Scope participation was significantly associated with education. Correspondence to education for participants for First Connections and Heads Up! Reading was comparable and participation in both did not seem to be greatly associated with education.

In general, “in-person¹²” training vs. “not in-person¹³” training had higher positive associations with observed quality in the Midwest. Overall, on observed quality across the Midwest, our “in-person” training variable showed higher correlations with quality than “not in-person” training and, consistently specific forms of “in-person” training, for example, attending regional conferences, community support and training and having mentors, also associated with observed quality. Videotape and self-study, Internet training and the summed “not in-person” training factor did not associate significantly with any forms of observed quality measured. These relationships remained true even when controlling for education. “In-person” training, relative to “not in-person” training, seems to be particularly important for family child care providers. For family child care providers in both the Midwest and Nebraska samples, there were strong associations between observed quality and “in-person” training but not for “not in-person” training and observed quality. Additionally, in the smaller Nebraska sample, when controlling for education, the relationship between “in-person” training and quality of provider-child interactions was significant.

¹⁴ (25% = 1 form of “in-person” training; 32% = 2 forms; 26% = 3 or more forms)

¹⁵ (55% = 1 form of “not in-person” training; 20% = 2; and 2% = 3 or more forms)

Associations were examined between “in-person” training and “not in-person” training and the self-report quality factors. When the self-report factors were used, important relationships of smaller magnitude were detected using the full survey sample. Using these analyses and controlling for education, in both the Nebraska and Midwest samples, there were significant positive relationships between the Reading/Learning Centers Factor and “in-person” training (NE, $r = .20$)¹⁴ and specific forms of training leading us to conclude that there are small increments in quality that come with many forms of “in-person” training.

In Nebraska, for the Parent Communication Factor, there was a significant positive association with Internet training ($r = .12$) and “not in-person” training ($r = .10$) and negative associations with Training by Director ($r = -.23$) and “in-person” training ($r = -.08$). In Nebraska, higher-educated providers had a tendency to receive more “in-person” training ($r = .21$, $p = .01$) and less-educated providers received more “not in-person” training (r with education = $.06$). Thus, small increments in quality may be associated with both forms of training, and the value of different forms of training depends on level of education. While “in-person” training shows more association with quality in general than “not in-person” training, “not in-person” training is better than no training at all.

Other Practices and Quality

“What other practices associate with quality?”

TABLE 6.2. OTHER PRACTICES OF NEBRASKA AND MIDWEST CHILD CARE PROVIDERS

<u>Other</u>	Nebraska	Midwest
Membership in National Association for the Education of Young Children	13%	16%
Membership in National Association for Family Child Care	7%	7%
Accreditation (NAEYC or NAFCC or other nationally recognized)	4.7%	2.9%
State Food Program	73%	63%
Use a Curriculum	61%	52%
Follow Developmentally Appropriate Practices, strongly agree	86%	85%

The frequency of participation in the National Association for the Education of Young Children (NAEYC) was low in the Midwest (16%) and lower still for Nebraska (13%). In the Midwest and Nebraska, NAEYC membership associated positively with quality in family child care ($r = .25$ for the Midwest; $r = .27$ for Nebraska) and in the Midwest sample membership in NAEYC was associated with quality of infant/toddler center-based care ($r = .26$), controlling for education. In Nebraska, the relationship with infant/toddler center-based quality was positive but not significant ($r = .15$); ECERS quality did not associate with NAEYC membership in either the Midwest ($r = .09$) or the Nebraska ($r = .02$) samples.

Similarly, membership in the National Association for Family Child Care (NAFCC) was relatively low across the Midwest (7%) and Nebraska (7%). For the Midwest sample, the relationship between membership in this organization and quality in family child care was positive and significant ($r = .21$), and positive and significant in the Nebraska sample ($r = .32$), controlling for education level of staff. In the Midwest, the correlation between Arnett positive interaction scores and NAFCC members was significant ($r = .13$), but the association was not significant in the smaller Nebraska sample ($r = .09$).

National accreditation was significantly associated with quality ($r = .29$). Across the Midwest, only 2.9% of providers worked in a facility that was accredited, whether by the National Association for the Education of Young Children, the National Family Child Care Association or other recognized accrediting bodies. In Nebraska, the percentage was slightly higher (4.7%). Some of the states, including Nebraska, provide higher reimbursement rates for providers who are accredited. Such bonuses seem justified as quality across accredited programs of all types averaged 5.27 compared to 4.27 for programs overall. It was necessary to average across all types of care in the Midwest to attain a quality score for accredited programs, due to sample size.

In the Midwest and Nebraska, participation in the USDA Food Program was associated with quality. This association held true for family child care providers and for infant/toddler center-based providers, regardless of the provider's education level. The correlations for FDCRS quality and Food Program participation were strong for the Midwest ($r = .35$) and for Nebraska ($r = .34$); for ITERS and Food Program participation the relationships were substantial ($r = .20$ for the Midwest and $r = .36$ for Nebraska). There was a significant relationship between USDA Food Program participation and preschool center-based quality across the Midwest ($r = .25$) that was not true for Nebraska ($r = .03$).

In the Midwest and Nebraska, the director's or family child care provider's report of using curriculum was highly associated with all forms of quality, highest particularly for family child care and for infant/toddler center-based care. In the Midwest, following a curriculum and observed quality were significantly related ($r = .38$, $r = .33$, and $r = .17$ for family child care, infant/toddler and preschool center-based, respectively). The corresponding correlations for Nebraska were even higher ($r = .51$, $r = .58$, and $r = .26$).

Most providers (directors for centers and family child care providers) reported using developmentally appropriate practices (86% in Nebraska and 85% in the

Midwest). Use of these practices associated positively with quality only for family child care in Nebraska ($r = .48$) and in the Midwest ($r = .28$). Use of such practices associated positively with quality in center-based preschools in Nebraska ($r = .29$), but the relationship was not significant; neither was the Midwest sample association ($r = .09$). Reported use of developmentally appropriate practices did not have strong associations with ITERS quality.

7. COMPENSATION, WORKING CONDITIONS AND QUALITY

“Are better working conditions associated with more optimal observed quality, and with self-reported quality practices?”

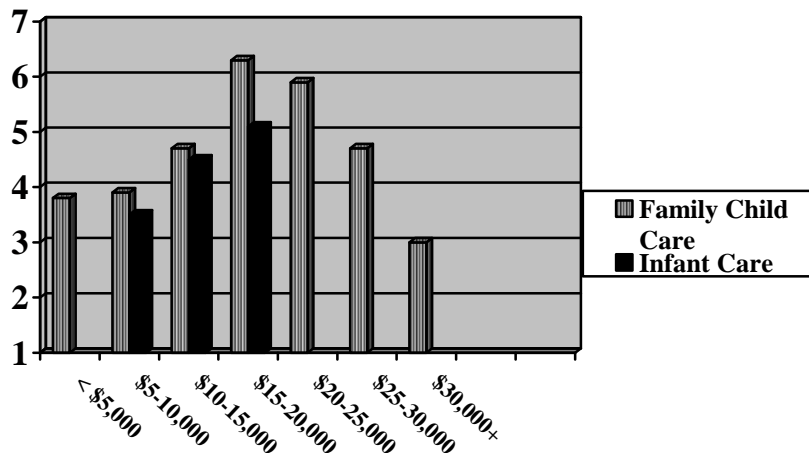
Compensation

The associations between compensation and child care quality were examined in two ways: indicators of quality were compared as a function of child care income and quality indicators were examined as a function of receipt of specific benefits (for example, child care, health insurance, paid sick days) and total benefits (of all types). Providers’ wages in Nebraska and across the Midwest tend to be below poverty.

Providers reporting child care income above \$10,000 per year were more likely to report using reading and learning centers than providers reporting income less than \$10,000 per year.

For family child care providers, there was a curvilinear relationship between observed quality and child care income: the lowest quality was observed for providers reporting \$30,000 or more in annual child care income, and those reporting \$10,000 or less. There was no difference in quality between providers reporting \$10-\$15,000 per year and those reporting \$25-\$30,000 per year. **As can be seen in figure 7.1, the highest quality was observed for providers reporting \$15-\$25,000 per year. Conversely, there was a significant relationship between income and observed quality for infant providers; as income increases so does child care quality.**

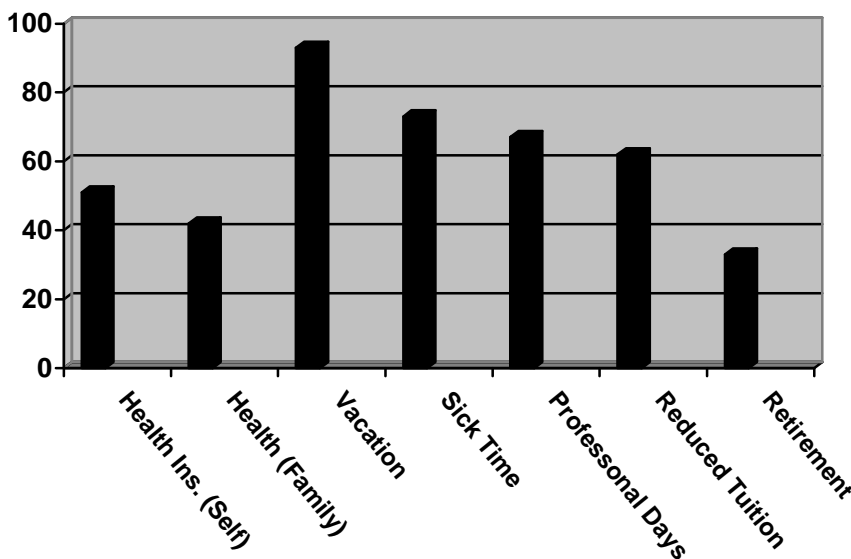
FIGURE 7.1. PROVIDER EARNINGS AND PROGRAM QUALITY



In Nebraska and the Midwest there was a positive relationship between receiving key benefits and observed center-based quality. This is the second strategy for examining the relationship between compensation and quality. A composite benefits score was computed by summing each type of benefit providers reported receiving. Providers were asked whether they receive the following benefits for their child care employment: health insurance for themselves, health insurance for their families, reduced or no tuition for their own children, paid vacation, paid sick days, and paid time off to attend professional meetings. Home child care providers were not asked these questions, because they are self-employed.

Provider responses indicate that approximately half (51.4%) of center-based providers receive health insurance for themselves, and 41.6% receive health insurance for their family. Most providers (93.1%) receive paid vacation days, although only 73% receive paid sick days. About two thirds (67.4%) of providers receive paid days to attend professional meetings, and 62.4% receive reduced or no tuition for their own children. In addition, only one third (33.3%) of providers receive retirement benefits.

FIGURE 7.2. PERCENT OF CENTER-BASED PROVIDERS RECEIVING KEY BENEFITS

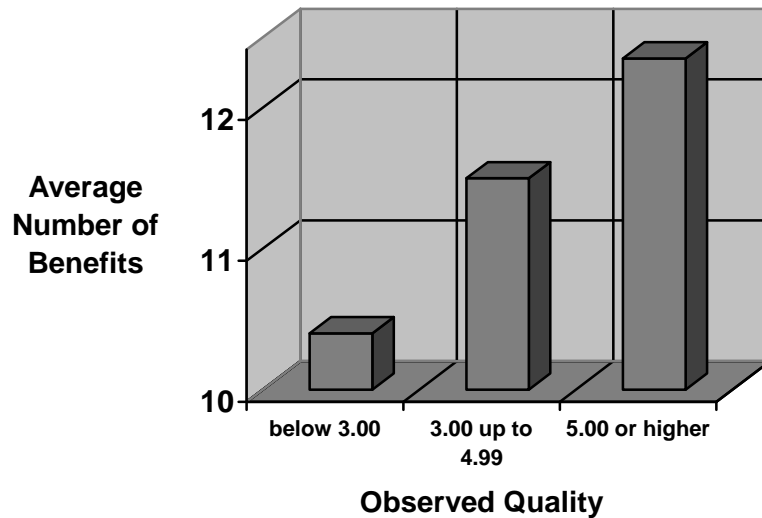


Providers who reported receiving more training, both “in-person” and “not in-person”, and providers reporting higher levels of education receive more benefits. The number of years a provider reported working as an early childhood professional was not related to benefit receipt, nor was the ratio of subsidy-receiving children in her care.

The more benefits a provider receives, the less likely she is to indicate that given the opportunity, she would choose work other than child care. Likewise, the

more benefits a provider receives, the more positively she perceives her working environment as assessed by the Gallup Q12™.

FIGURE 7.3. AVERAGE NUMBER OF BENEFITS AND OBSERVED QUALITY FOR CENTER-BASED PROVIDERS IN NEBRASKA



Benefits are associated with observed quality. The more benefits a provider received, the higher was the observed quality. Providers reporting the highest level of benefits were the most likely to be providing “good” quality care (scoring 5 or above on the observational measure).

Working Conditions

The Gallup Q12™ is a measure of workplace climate used by a wide variety of organizations. We examined the associations between providers’ perceptions of their work environment and several indices of quality in order to determine whether more positive workplace characteristics were associated with higher quality practices.

- **Eleven of the twelve workplace indicators were significantly and positively associated with providers’ reports of having a good environment for children.** Providers were more likely to report having adequate spaces and toys for children when: they have had opportunities at work to learn and grow during the past year; someone has talked to them about their progress at work during the last six months; they have a

best friend at work; they believe their colleagues are committed to doing quality work; the mission of their company makes them feel their job is important; their opinions seem to count; there is someone at work who encourages their development; their supervisor seems to care about them as a person; in the past seven days, they have received recognition or praise; and they have the materials and equipment they need.

- **Five of the twelve workplace indicators were significantly and positively correlated with providers' reports of communication with parents.** Providers reported higher levels of communication with parents when: they have a best friend at work; the mission or purpose of the company makes them feel their job is important; there is someone at work who encourages their development; they have received recognition or praise within the past seven days; and they have the opportunity to do what they do best every day.
- **Four of the twelve workplace indicators were significantly and positively correlated with providers' reports of using reading and learning centers.** Providers were more likely to report using reading and learning centers when: they have had opportunities to learn and grow at work during the past year; someone at work has talked to them about their progress during the past six months; someone at work encourages their development; and they have the materials and equipment they need.
- **Observed quality of preschool environments (ECERS total score) was significantly and positively correlated with two workplace indicators:** observed quality was higher when providers reported that they have had opportunities to learn and grow at work within the past year, and when someone has talked to them about their progress at work within the past six months.

Qualities of observed interactions assessed by the Arnett Caregiver Interaction Scale were not significantly associated with workplace indicators.

A composite score representing overall satisfaction with working conditions was constructed by computing the mean of all Q12™ workplace items (Cronbach's alpha = .82). **The Gallup Q12™ composite score was significantly related to several indicators of quality.** Providers who rated their workplace more positively were significantly more likely to use reading and learning centers ($r=.17$), more likely to frequently communicate with parents ($r=.18$), and more likely to rate their environment for children positively ($r=.42$). This finding was significant for both the Nebraska and the Midwest samples, and remained significant after controlling for providers' education. The Q12™ composite score was not significantly correlated with the overall ECERS or ITERS scores in the Nebraska sample, but was significantly and positively correlated with the ECERS total score for the Midwest sample.

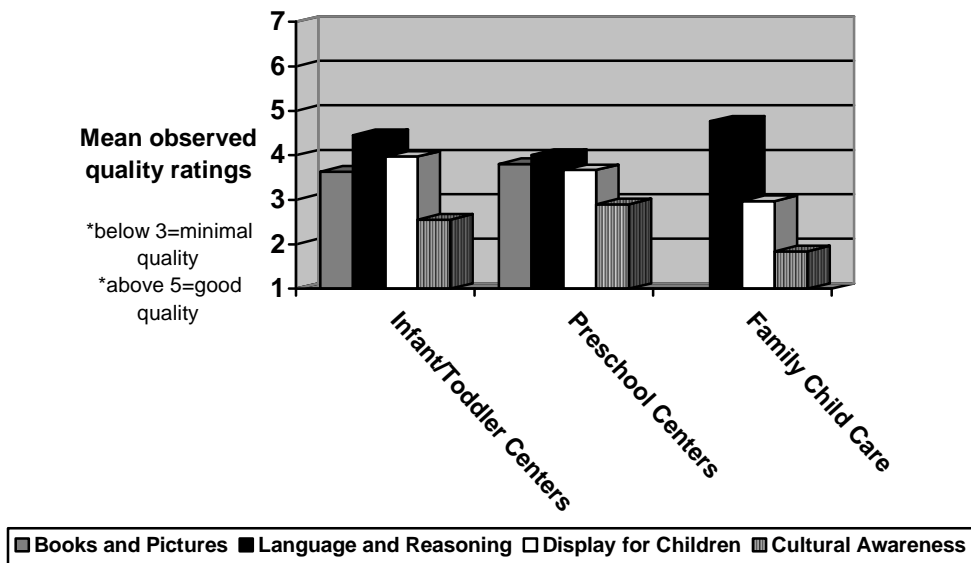
8. LITERACY

“How well is Nebraska faring in providing early pre-literacy environments for children?”

Given the importance of pre-literacy environments for later outcomes, such as school readiness, the quality of pre-literacy environments was assessed through two means: first, by asking providers how often they read to children, and second, by observing the quality of the pre-literacy environment. The 508 Nebraska providers who were interviewed by phone were asked how much they agree with the statement, “Every day, every child in my care is read to,” and 364 (72%) said they strongly agreed.

Further information comes from the observational findings. Four primary areas of literacy were examined from the items and subscales of the ITERS, ECERS, and FDCRS measures of observed child care quality (Books and Pictures, Language and Reasoning, Display for Children, and Cultural Awareness) using the Environment Rating Scales. These observations were supplemented with items from the Informal Child Care Quality Instrument and the means are provided in the chart below.

FIGURE 8. AVERAGE QUALITY OF LITERACY EXPERIENCES IN CHILDCARE



Language and Reasoning is the area in which Nebraska child care programs are relatively strong at all three levels (infant/ toddler, preschool and family daycare). The average score of 4.0 means that children are allowed to talk much of the day, may be encouraged to talk with teachers, and teachers may engage children

in educational conversations. Cultural Awareness is the weakest area, especially for family child care providers. In most programs, there are few culturally diverse items, such as books, dolls or pictures depicting individuals of diverse ethnic background and ages. The subscale, Books and Pictures, was also fairly weak with most programs providing some books and a teacher reading to interested children at least once a day. Displays for Children is also a weak area, especially for family child care providers; the average score of 3.0 on this item means that some colorful pictures (for example, some store-bought or teacher-created pictures) may be displayed. The optimal pre-literacy environment for children includes access to numerous books throughout the day, organized reading times as well as voluntary reading times, colorful and educational displays on the walls of the classroom, and consistent use of new language skills to encourage language development.

However, the mean scores do not tell the whole story on literacy. The literacy scores can also be evaluated against the quality standards of high (5.0 to 7.0), minimal (3.00 to 4.99) and low (below minimal, 1.0 to 2.99). The chart below shows the percentage of programs falling into these categories for each area of literacy.

TABLE 8. QUALITY LEVELS OF CHILD CARE LITERACY EXPERIENCES FOR CHILDREN¹⁵

	Books and Pictures	Language and Reasoning	Display for Children	Cultural Awareness
Infant/ Toddler Centers	Low-50% Minimal-13% High-38%	Low- 22% Minimal-38% High- 40%	Low- 3% Minimal- 72% High-25%	Low- 47% Minimal- 47% High- 6%
Preschool Centers	Low- 10% Minimal- 80% High- 10%	Low- 29% Minimal- 48% High- 24%	Low- 10% Minimal-71% High-19%	Low-38% Minimal-52% High- 10%
Family Childcare	Low-26% Minimal- 19% High- 56%	Low- 19% Minimal- 31% High- 50%	Low- 47% Minimal- 41% High- 13%	Low-78% Minimal- 19% High- 3%

There are a number of actions that child care teachers and providers can take that lay groundwork for literacy. Additionally, environments that support literacy have a wide

¹⁶ The quality scores in Table 8 come from relevant observation items on the ITERS, ECERS, and FDCRS. For books and pictures, the Informal Child Care Quality Instrument (ICCQ) was used because the FDCRS does not include an item about books and pictures. From the ICCQ, a composite of two items related to literacy was created. A mean could not be calculated.

variety of purposes. A love of reading begins early, and among infant/toddler providers, some providers are doing a very good job while another sizable group is doing very little to enrich pre-literacy environments. **Half (50%) of infant/toddler center-based providers were rated as deficient in making books and reading available to children but 38% were doing a good job while 40% were rated as doing a good job in offering language rich environments and 20% in offering display to stimulate conversation.**

Among preschool center-based providers, only 10% were rated good in making books and reading material available to children, only 24% offered environments rich in language and reasoning, and only 19% featured displays that promote symbolic learning and stimulate deeper conversation and social knowledge, a critical medium for language development. **Given how important pre-literacy is for children of preschool age, the performance of Nebraska preschool center-based care is not optimal.**

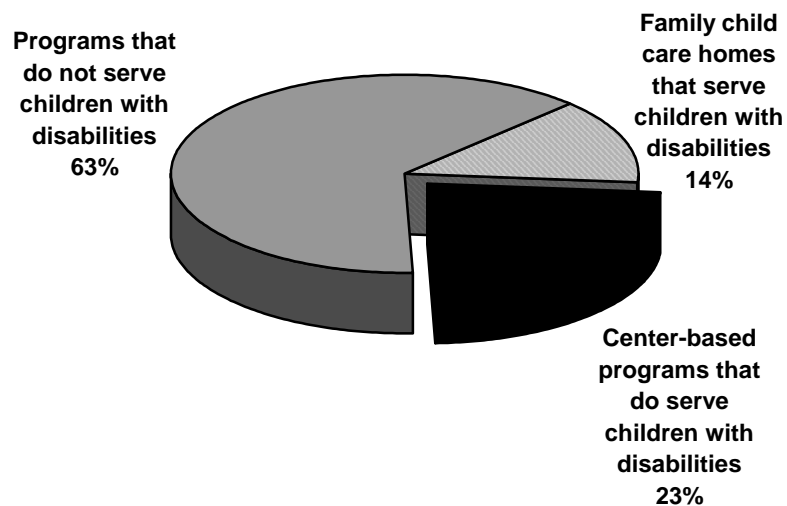
Family child care providers fared better in some respects but not in others, with 26% rated as deficient and 58% rated good in providing reading materials but on a different scale¹⁵. Half of family providers were rated as good in providing a language rich environment but only 13% offered display that would stimulate language. Support for diversity and cultural awareness also support language understanding. Most family child care providers scored as deficient in providing books, displays and activities that would support cultural awareness.

9. CHILDREN WITH DISABILITIES

“Is care for children with disabilities comparable to other care in the state?”

FIGURE 9.1. ACCESSIBILITY OF CARE IN NEBRASKA TO CHILDREN WITH DISABILITIES

Percentages of programs reporting care for at least one child with a disability



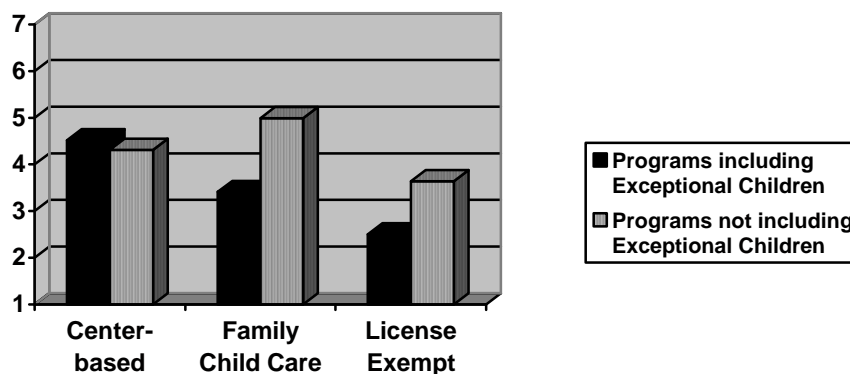
In Nebraska, 37% of providers interviewed reported caring for a child with a disability. Twice as many center-based providers reported caring for a child with a disability as home-based providers.

Providers caring for children with disabilities are not substantially different from providers not caring for children with disabilities. Educational level and work history in caring for children is not significantly different for teachers who report working with exceptional children. In terms of teacher characteristics, 73% reported training beyond high school, with 36% reporting attainment of a two-year degree or beyond. The educational level of teachers who reported working with disabled children was not significantly different than those teachers who did not report working with exceptional children. Additionally, 60% of the teachers who reported working with exceptional children have cared for children for three or more years, while 16% reported working with children for less than one year.

When a sub sample of programs was observed, the overall quality of centers and homes serving exceptional children was found to be in the good range: 37% of the 38 programs were evaluated to be of good quality, 47% of minimal quality and 16% poor quality.

The quality of care for exceptional children was of equivalent quality to that provided other children. The mean level of quality in programs serving exceptional children was as high as that in programs that do not serve any exceptional children. Furthermore, programs serving exceptional children were as likely to be rated high quality as those who did not serve exceptional children. For example, 37% of programs serving exceptional children were evaluated to be good quality and this was similar to the percentage of good quality care overall in the state.

FIGURE 9.2. AVERAGE QUALITY OF OBSERVED CARE FOR PROGRAMS THAT INCLUDE CHILDREN WITH DISABILITIES AND THOSE THAT DO NOT



In general, center-based care seemed to provide the highest quality environment for children with disabilities. Mean overall quality ratings in family care environments serving children with disabilities were lower than that of centers. License exempt care seemed to provide even lower quality services to exceptional children.

Next Steps

The Midwest Child Care Research Consortium has been funded as a three-year project. The data reported here are from Year One of the project and the Nebraska 2002 report, seen here, is one of several products that the project will produce. The reader may be interested in seeing subsequent reports from the Year One project.

These will include:

- Report of Child Care Quality and Provider Characteristics in Iowa
- Report of Child Care Quality and Provider Characteristics in Kansas
- Report of Child Care Quality and Provider Characteristics in Missouri
- Midwest Child Care Research Consortium Report: Report of Child Care Quality and Provider Characteristics in Four Midwestern States

During Year Two of the project, the focus of the child care research work is on parents and their perceptions of child care quality and choice. Data are being collected in two ways—through a paper survey to parents of providers who participated in the quality observations and through a telephone survey of parents whose children’s tuition is paid through federal and state subsidies. There will be state reports and a Midwest report pertaining to findings about parents in 2003.

During Year Three of the project, the focus of the Midwest Child Care Research Consortium will return to quality and provider characteristics, enriched with findings from Years One and Two. During Year Three, we will again study the quality of child care in the Midwest, tracking change from Year One to Year Three. Many initiatives have begun or continued even since the Year One study was begun and changes may be expected. The study will attempt to develop a shorter list of more predictive factors for the study of quality.

Reports from the Midwest Child Care Research Consortium can be found at <http://ccfl.unl.edu/projects/cprojects/childcare.html>

Appendix A

Training Initiatives

Many child care studies have found that education, training and wages are important descriptors of the child care workforce and that they are important predictors of quality.

In our survey, we asked about level of education, type of degrees, special certificates and participation in training initiatives. There are a number of initiatives available in Nebraska: some of these are unique to Nebraska and some are also available in other states in the Midwest. In Nebraska, the Early Childhood Training Center oversees a multitude of state and regional training efforts, and Regional Training Coalitions coordinate training according to training priorities. In the current study we use the following definitions:

Early Childhood Training Center (ECTC): Nebraska's centralized training and technical assistance center for early childhood education. The ECTC is located in the Educational Service Unit #3, 6949 South 110th Street, Omaha, NE. The ECTC coordinates training throughout the state of Nebraska and works closely with Regional Training Coalitions in promoting and providing training.

Child Development Associate: an intense one-year credentialing program for early childhood education providers. In Nebraska, most community colleges provide for articulation of CDA.

One Year Child Development Program: a one-year program that is generally equated with the Child Development Associate.

Heads Up! Reading: a new national program being piloted in Nebraska that emphasizes reading to children and literacy among providers. This project involves a successful combination of pre-service, in-service and technology to expand knowledge of early literacy and offers a college credit option. Heads Up! Reading is being evaluated by Monroe Meyer Children's Rehabilitation Institute, University of Nebraska Medical Center through a US Department of Education Early Childhood Educator Professional Development Grant that is co-administered by the Nebraska Department of Education and the Early Childhood Training Center.

First Connections: an Internet-based project with an interaction component targeted to infant/toddler teachers. First Connections offers in-service and college credit. First Connections is being evaluated independently through Monroe Meyer Children's Rehabilitation Institute, University of Nebraska Medical Center and Nebraska Educational Television. Although we asked about participation in First Connections, it is important to note that no participants have completed the First Connections training yet.

Special Care: a relatively new program of training for providers who will be better prepared to serve children with special needs. Information about Special Care training in the current study was not requested because of initiative timing; ability to do so will be in the next assessment in 2003.

Early Childhood Management Training: is offered through the ECTC to provide training for child care managers of homes and centers. No inquiries were made about management training in the current survey; we will be able to do so in the 2003 survey.

Taking the Lead: provides leadership to new and existing leaders in the early childhood field in Nebraska. To date, 70 persons have completed this training. No inquiries were made about Taking the Lead in the current study, once again because of timing; ability to do so will be in the 2003 survey.

Parents as Teachers: an initiative that began in Missouri that trains home visitors and others in child development and parenting.

Creative Curriculum: a developmental curriculum for child care.

High Scope: an approach to curriculum, environment and philosophy for early childhood.

Montessori: a program that extends on the philosophy of Italian educator Maria Montessori with a structured approach to environment and philosophy.

CPR and First Aid: basic safety and emergency response training programs.

West Ed: a training program that targets high quality services for infants and toddlers. West Ed training was developed by the West Ed company, LaJolla, California.

TEACH: a new program to Nebraska offered in other states that supports provider continuing education and guarantees wage increases upon completion. TEACH was not instituted at the time of the current survey; we will be able to ask about TEACH in our 2003 survey.

Early Head Start Infant/Toddler Initiative: Nebraska Department of Health and Human Services earmarks federal funds to Head Start and Early Head Start programs to partner with community child care providers to meet the Head Start Performance Standards. Funds are used for staff training, facility and program improvements and coordination needed to meet the standards.

Missouri Training Programs referred to in this report:

Project Construct: a program offered only in Missouri that provides training in pre-literacy and language following the philosophy of Jean Piaget.

EDUCARE: a program offered only in Missouri where providers are visited in their facilities, often family child care homes, by a mentor/traveling resource van.

Appendix B

SURVEY ITEMS

- S1. State: Iowa, Kansas, Missouri or Nebraska
- S2. Child Care Strata: Center-Based Infant Subsidy; Center-Based Infant Non-subsidy; Center-Based Infant & Preschool Subsidy; Center-Based Infant & Preschool Non-subsidy; Center-Based Preschool Subsidy; Center-Based Preschool Non-subsidy; Center-Based Licensed Exempt Infant Subsidy (Missouri only); Center-Based Licensed Exempt Infant Non-subsidy (Missouri only); Center-Based Licensed Exempt Preschool Subsidy (Missouri only); Center-Based Licensed Exempt Preschool Non-subsidy (Missouri only); Center-Based, Don't Know Whether Infant or Preschool Subsidy; Center-Based, Don't Know Whether Infant or Preschool Non-subsidy; Center-Based, Licensed Exempt Infant & Preschool Subsidy (Missouri only); Center-Based, Licensed Exempt Infant & Preschool Non-subsidy (Missouri only) (for analysis only); Licensed Family Child Care Subsidy; Licensed Family Child Care Non-subsidy; Licensed Family Child Care II Subsidy (Nebraska only); Licensed Family Child Care II Non-subsidy (Nebraska only); Registered Family Child Care Subsidy (Kansas and Iowa); Registered Family Child Care Non-subsidy (Kansas and Iowa); Approved/Exempt/Relative Homes Subsidy; Approved/Exempt/Relative Homes Non-subsidy (Missouri only) (for analysis only); Part Day (for analysis only/not part of quotas); School Age (for analysis only/not part of quotas); Duplicate (for analysis only/not part of quotas); Other (for analysis only/not part of quotas)
- S3. Head Start Type: Head Start Center, Early Head Start, Head Start Collaboration, Early Head Start Collaboration, None of these, Don't know, Both Early Head Start and Head Start, No longer participating/Inactive
- S4. Facility Type: Licensed Center, Licensed Home, Registered Home, Group Home, Licensed Exempt Center, Approved Home/Relative/Exempt Home, Other
- S5. Ages of children in centers: Infant/Toddler, Preschool, Both infant and preschool, Other
- S6. Subsidized?
- S7. Early Head Start or Head Start Partnership?
- S7a. Does this center provide full-day child care for at least eight hours each weekday?

- S7b. How many regular, full-time teachers work at this child care center?
- S7c. How many children is this child care center licensed to care for?
- S8. (After a random, qualified teacher has been chosen): Are you a regular, full-time teacher or child care provider at the center?
- S9. Do you **PRIMARILY** care for infants and toddlers, or preschoolers? If you mostly care for preschoolers, but have some two year olds, we would like you to consider yourself as primarily caring for preschoolers.
- S10. Quotas: Iowa Center-Based Infant Subsidized (n=70), Kansas Center-Based Infant Subsidized (n=70), Missouri Center-Based Infant Subsidized (n=70), Nebraska Center-Based Infant Subsidized (n=70), Iowa Center-Based Preschool Subsidized (n=70), Kansas Center-Based Preschool Subsidized (n=70), Missouri Center-Based Preschool Subsidized (n=70), Nebraska Center-Based Preschool Subsidized (n=70), Iowa Center-Based Infant Non-subsidized (n=40), Kansas Center-Based Infant Non-subsidized (n=40), Missouri Center-Based Infant Non-subsidized (n=40), Nebraska Center-Based Infant Non-subsidized (n=40), Iowa Center-Based Preschool Non-subsidized (n=40), Kansas Center-Based Preschool Non-subsidized (n=40), Missouri Center-Based Preschool Non-Subsidized (n=40), Nebraska Center-Based Preschool Non-Subsidized (n=40), Missouri Center-Based Infant License Exempt Subsidized (n=40), Missouri Center-Based Preschool License Exempt Subsidized (n=40), Iowa Registered Home Subsidized (n=70), Iowa Registered Home Non-subsidized (n=55), Kansas Registered Home Subsidized (n=50), Kansas Registered Home Non-subsidized (n=50), Nebraska Family Child Care Home II Subsidized (n=40), Nebraska Family Child Care Home II Non-Subsidized (n=40), Kansas Licensed Family Home Subsidized (n=70), Kansas Licensed Family Home Non-subsidized (n=50), Missouri Licensed Family Home Subsidized (n=70), Missouri Licensed Family Home Non-subsidized (n=50), Nebraska Licensed Family Home Subsidized (n=70), Nebraska Licensed Family Home Non-subsidized (n=50), Iowa Licensed Exempt Homes (n=55), Kansas Relative Homes (n=50), Missouri Registered Homes (n=50), Nebraska License Exempt Homes (n=50), Iowa Head Start/Early Head Start (n=30), Kansas Head Start/Early Head Start (n=50), Missouri Head Start/Early Head Start (n=50), Nebraska Head Start/Early Head Start (n=40)
1. Currently, at peak time for you on a typical day, how many children are under your care? (Peak time is the time when the child caretaker is caring for the greatest number of children)
 2. Of the children under your care at peak time on a typical day, how many are: Birth up to twelve months of age, Twelve months up to 18 months of age, 18 months up to 24 months of age, 24 months up to 36 months of age, 36 months up to 48 months (four years) of age, 48 months up to 60 (five years) months of age, 60 months (five years) of age and older
 3. On a typical day, other than someone who has or might replace you when you are done, do other **ADULTS** work along with you in caring for these children? (adult is

anyone “18 or older”)

4. How many adults, in total, usually work along with you on a typical day?
5. Not including your own children, are any of the children you care for related to you?
6. Other than your children, how many are related to you?
7. Please respond to the following statements about your present work situation. (Used a five-point scale, where "5" means that you strongly agree with the statement, and "1" means you strongly disagree with the statement:

I know what is expected of me at work

I have the materials and equipment I need to do my
work right

At work, I have the opportunity to do what I do best every day.

In the last seven days, I have received recognition or praise for doing good
work.

My supervisor, or someone at work, seems to care about me as a person.

There is someone at work who encourages my development.

At work, my opinions seem to count.

The mission or purpose of my company makes me feel my job is important.

My associates or fellow employees are committed to doing quality work.

I have a best friend at work.

In the last six months, someone at work has talked to me about my progress.

This last year, I have had opportunities at work to learn and grow.

8. In your center, is it typical for one main teacher to stay with a child throughout the infant and toddler years?
9. Currently, on a typical day, how many children with verified disabilities or developmental delays, who are under five years of age, are in your care?
10. Do you/Does your center participate in your state's Child Care Food Program?
11. Do you/Does your center have a formal agreement or contract to provide child care for:

Early Head Start children, those aged zero through three or Head Start children, those aged three to five

12. Please use a one-to-five scale for your answers to the following statements, with "5" meaning the statement definitely represents why you work in child care, and "1" meaning it definitely does not represent why you work in child care (can use any number between one and five):

My career or profession

A stepping stone to a related career or profession

A personal calling

A job with a paycheck

Work to do while your children are young

A way of helping a family member, neighbor, friend,
or other adult out

13. How much longer do you plan to be a child care provider? Would you say it will be less than six months, between six months and one year, one year up to two years, two years up to five years, or five years or longer?

14. How much do you agree with different statements that relate to child care? (Used a one-to-five scale, with "5" meaning you strongly agree with the statement, and "1" meaning you strongly disagree with the statement):

Every day, you are able to greet each parent and child you care for when they arrive

Every day, every child in your care is read to or receives picture book experiences

At least once a year, you are able to talk formally with each parent about their child's development

In the child care setting you work in, there are areas that are set up to encourage different forms of learning and play

Your child care facility/The center where you work has good indoor spaces for caring for children

Your child care facility/The center where you work has good outdoor spaces for children

Children have daily access to a good supply of toys and materials in your child care setting

At least twice a week, you are left alone with too

many children

15. Do you have access to an Internet connection?
16. Are you planning to get an Internet connection within the next year?
17. What is your highest level of education?
18. Was your major area of training or education child development related?
19. Do you currently hold any of the following certificates: Teaching certificate from your state, CDA (Child Development Associate), Montessori, Parents as Teachers, or Childnet
20. Do you have any special endorsements from your state, including any in early childhood education, special education, or elementary education?
21. Have you completed a training program for any of the following: West Ed, High Scope, Montessori, Creative Curriculum, First Connections, Heads Up! Reading, Project Construct, CPR within the past two years, or First aid within the past two years
22. How long have you been caring for children in your home/at this center? If you have stopped and started caring for them again, please answer from the time you started again to now.
23. Since you were 18, how long, in total, have you worked in child care?
24. If you could do so now, would you choose work other than child care?
25. From January through December of 2000, how many total hours of child care-related training would you say you received? In your total, include all sources of training. These range from videotapes, the Internet, and study materials to study groups, professional meetings, conferences, and course credits. Please answer in terms of actual hours of time spent, not in terms of any hours of credit you may have earned.
26. Were any of the hours of training you received in 2000 from:
 - Videotapes and study materials in your home/center
 - Training provided in your center by the director or other staff
 - Support person who comes to your home/classroom; these are sometimes referred to as Educare, Project Reach, or a traveling van with a support person
 - Support, study groups, workshops, or training within your community

Regional, state, or national professional meetings or conferences

Training or course work for which you received college credit, CEU credit, or a certificate from a state or nationally-recognized certifying group

Internet, Teleconferencing or ICN distance learning

27. Now, please tell me how much you agree with this statement: "In general, I receive the kind of training I need to do my work right." (Used the one-to-five scale, with "5" meaning you strongly agree with this statement, and "1" meaning you strongly disagree with it).

28. Please tell me if you are currently a member of the association or not.

National Association for the Education of Young Children, or NAEYC

National Association for Family Child Care, or NAFCC

Division of Early Childhood, or DEC

Council for Exceptional Children, or CEC

National School Age Child Care Alliance

MO Care

D1. What is your age?

D2. Is your marital status: Single, never married; Single, living with a partner; Married; Divorced; Widowed

D3. Which of the following classifications best describes your ethnicity or race: White Hispanic or Latino, Black Hispanic or Latino, Black or African-American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, or White

D4. What are your annual earnings from child care, before taxes? (home-based) What are your annual earnings from child care, before taxes, but after you subtract expenses for your child care business, such as purchased equipment and other business expenses?

D5. Do you receive any benefits from your child care work, such as insurance or vacation days?

D6. Do you receive: Health insurance for yourself, free or reduced, Health insurance for your family, Paid vacation days, Paid sick days, Paid days to attend professional meetings, Reduced or no tuition for your own children to receive child care, Retirement benefits

- D7. Are you a parent?
- D8. Are any of your own children cared for along with the other children you care for in your home/at the center where you work?
- D9. What do you think are the two most important issues facing child care today? What other issue?
- D10. Gender
- D11. Is it okay to contact you again to help tell the story of child care?

