

Regulated Subsidy (RS) Provider Study

Final Report

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Executive Summary

Within a collaboration between the Early Learning Division and Oregon State University, a research project was conducted to examine participation and supports for those persons *interested* in becoming listed as a Regulated Subsidy Provider within January 2019 and January 2021. Additionally, we tested the initial effectiveness of two light-touch interventions: 1) a set of supports designed by the OSU and ELD team to assist interested RS providers in navigating the requirements and 2) allow interested RS providers to complete the First Aid (FA)/CPR training at no cost to them. Overall, five CCR&Rs agreed to participate in this study and 44 persons interested in becoming an RS provider. Data was collected through surveys and informal interviews with CCR&Rs.

This report first describes the full sample of participants (those *interested* in becoming RS providers) at baseline—before they were listed as RS providers—focusing on demographics and individual characteristics. We find that on average participants were female (90%), identified as White (86.4%), (50%) lived in households with incomes of \$2,000/month or less, and about one third (34.1%) were unemployed at baseline, where they were starting the process to become an RS provider. About half of them had moved through the process enough to complete fingerprinting, while only 27% has completed the DHS orientation. Regarding supports utilized in the process, they were less aware of the CPR/First Aid waiver (41%) and reimbursement for lead testing.

Second, we describe (using longitudinal data) the paths participants took to be successful in the RS process or not—and if they cared for children served by child care subsidy. **Overall, 22 (63%) completed all requirements and 13 (37%) did not complete requirements by the 12 month survey.** Descriptively, **those who met requirements were more likely to have a two-year or four-year degree, had slightly higher monthly income, lower rates of unemployment, and utilized more supports than those who did not meet requirements.** The two groups were similar on number of barriers, depressive symptoms, and understanding of CCDBG requirements at baseline. Those who did not meet requirements often utilized only one system-level support (and often did not know about the supports available) and experienced at least one barrier during the process. Importantly, only 13 of the 22 who met requirements provided care for children and families receiving subsidy, which means that only **37% of those initially interested RS providers met requirements and provided care to children served by child care subsidy.** The majority of these providers reported high satisfaction with two primary supports at 6 months: CCR&R and DPU phone support.

Third, we describe intervention effects for RS Navigator Model as well as no-cost FA/CPR on key outcomes. The RS Navigator model was perceived as very supportive by participants, but dosage and engagement in the full model was not consistent. Those providers ($n = 14$) the Navigator Model group were slightly more likely to have a Health and Safety inspection at 6 months compared to the control group. Those in the no-cost FA/CPR group were slightly more likely to have a

Health and Safety inspection at 6 months and also more likely to complete the FA/CPR training requirement at baseline.

Based on these findings we offer specific considerations for practice and policy including (1) awareness of and connection to supports for interested providers (e.g., The Listing Form should more prominently recognize CCR&Rs as a source of support for the trainings *and* for technical assistance); (2) importance of 1:1 support to demystify the process for interesting RS providers (e.g., Encourage CCR&Rs to use DHS database to check on the 'progress' for RS provider); and (3) description of barriers that interested RS providers faced (e.g., There was a notable descriptive difference in those who met requirements and did not—more equitable access to support is necessary).

Key Findings

- 63% who completed the requirements to become listed as an RS provider, yet only 37% met requirements *and* provided care to children served by child care subsidy as an RS provider.
- Those who met requirements to become an RS provider more often had a two-year or four-year degree, slightly higher monthly income, lower rates of unemployment, and utilized more system-level supports.
- Both the Navigator Model and FA/CPR groups were more likely to have the Health and Safety inspection at 6 months (but no difference between control group for meeting requirements).

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Study Overview

As part of the OPRE CCDBG Implementation Grant, a collaboration between Early Learning Division and Oregon State University, a research project was conducted to examine if participation in two separate interventions increased the likelihood of successful completion of the requirements to become a regulated subsidy (RS) provider, compared to the control group. This report focuses on the participants working through the process to become RS providers.

Briefly, there were two interventions in this project designed to test the effectiveness of two scalable, feasible supports for potential RS providers. First, the OSU and ELD team created a set of light-touch supports aimed to increase potential RS provider competency to *navigate* the CCDBG requirements; we call this support the *Navigator Model*. The Navigator Model included 1) a café (i.e., interactive group workshops) designed to facilitate support with completing the listing form its requirements in an interactive environment, 2) a brochure describing main concepts and requirements for CCDBG, and 3) and a newsletter tailored to RS providers. These activities were funded with the OPRE grant. In our early conversations with CCR&R staff, financial barriers were cited as a much-needed support for potential RS providers. Additional funds from the ELD allowed for a second, financially-based support which allowed potential RS providers to take the First Aid (FA)/CPR training at no cost to them (see [Intervention Descriptions and Effectiveness](#) section, pages 8-9 for more information).

Overall, five CCR&Rs agreed to participate in this study¹. Two CCR&Rs were assigned to a control group, which supported RS providers as usual in their region. These two offices support rural and suburban and/or urban providers. Two CCR&Rs agreed to implement the Navigator Model and these offices also support rural and suburban and/or urban providers. Finally, one CCR&R agreed to offer the financially-driven support and offered FA/CPR at no-cost to providers; they also support rural, suburban and/or urban providers.

These five CCR&Rs led the recruitment efforts; in other words, they were in charge of recruiting eligible participants as persons who were *interested* in becoming an RS provider likely interfaced with their local CCR&R office to receive support with the trainings (e.g., FA/CPR) required to submit the listing form or through DHS orientation. During these connection points, CCR&R staff would inform eligible RS providers about the study, and if interested, they received a link to participate in the study. Study eligibility was then determined using a brief Qualtrics survey, which would then direct them to the consent form and baseline survey (paper or electronic) if they were determined to be eligible. This information was only available to the OSU research team. After completing their baseline survey, participants received a \$25 gift card compensation.

¹ attempts were made within the research team to 'match' the counties (overall) within each assignment (i.e., RS Navigator, No-Cost FA/CPR, and control) on median county income, number of providers who turned in a listing form in 2017, and population size.

Recruitment and baseline data collection for the Navigator Model and control group began in January 2019 and continued for 12 months. In August 2019, the CCR&R that delivered no-cost FA/CPR to *interested* RS providers was added and continued through January 2020². Follow up surveys with providers were completed on a rolling basis after initial recruitment: participants received additional surveys at 6 months and 12 months after their initial study enrollment, via email (or mail if preferred). Thus, data collection ran from January 2019 - January 2021 and August 2019 - January 2021, respectively. Of note, due to limited grant funds, the surveys and intervention materials were only available in English.

This report first describes the full sample of participants (those *interested* in becoming RS providers) at baseline—before they were listed as RS providers—focusing on demographics and individual characteristics. Second, we describe (using longitudinal data) the paths participants took to be successful in the RS process or not—and if they cared for children served by child care subsidy. Third, we describe intervention effects for RS Navigator Model as well as no-cost FA/CPR on key outcomes. Finally, we close with a summary of findings, limitations and key considerations for practice and policy given these results.

Description of Participants at Baseline

A total of 44 participants enrolled in the study; however, only 42 completed the baseline survey. These 42 individuals represented 12 counties in Oregon within five CCR&Rs, mostly in the mid-Willamette valley, central, and southern Oregon. Of these participants, 90% identified as female. When asked about race/ethnicity, the majority (86.4%) identified as White, 4.5% identified as Black or African American, 6.8% identified as Latinx or Hispanic, and 2.3% as American Indian or Alaskan Native (participants could select multiple race/ethnicities). Educational attainment ranged from 25% with a high-school diploma or equivalent to 31.8% with a two- or four-year degree. On average, providers (50%) lived in households with incomes of \$2,000/month or less, and about one third (34.1%) were unemployed at the time of application. Finally, 61% had at least some prior paid experience working with young children and 50% of those had at least 3 years of experience working with young children.

At baseline, participants were *in the process* of working to become a listed RS provider. They were in a variety of stages of the process: seven (18%) had submitted their listing form and were pending approval, 7 (18%) had approved listing forms, and 23 (60%) had not yet submitted their listing form. Thirty-four (of 42) had completed their ICCHS training, 17 had completed their CPR/First aid training, and 33 had completed their RRCAN training. Due to survey revisions during active data collection, only 26 of the 42 participants were asked about additional aspects of their certification process. Of those 26 applicants, 46% had completed their fingerprinting requirements, and 27% had completed the DHS

² This recruitment period was only 5 months (versus 1 year) due to contract/procurement challenges at the onset.

orientation. At baseline, six (14%) had had a Health and Safety Visit, all had passed on their first visit, and none were listed as RS providers. Of the full sample, a variety of motivations to become a RS provider were reported. **The most common reasons for choosing to become a RS provider included: helping out a friend, family member, or neighbor (52.3%),** an interest in caring for children (47.7%), and needing employment (31.8%; participants could check all that applied). Participants could also write in their own motivations, and common responses included wanting to care for their own children (e.g., “to stay home with my newborn”).

During this time (i.e., baseline) of this study, providers were working to complete the requirements to become a RS provider, and they reported using a variety of supports to help them in the listing process. These include: CPR/First aid waiver³, their local CCR&R office, DPU and OCC phone support, DHS and ELD websites, reimbursement for lead testing, and the Child Care Provider Guide. Of those who knew about *and* used these supports, the DPU and OCC phone supports, the Child Care Provider Guide, and their local CCR&R’s were rated as the most useful. However, a **significant portion of participants were not aware of certain resources, such as the CPR/First Aid waiver** (41%³ were unaware of support), **reimbursement for lead testing** (61% were unaware of support), ELD website support (55%), and OCC phone support (41.5%). Finally, five participants (12%) indicated that they did not feel confident in their understanding of DHS orientation or when they would be able to start providing care.

Finally, participants reported on characteristics that may influence their ability to care for children and/or complete the process. Specifically, we asked about the rigidity of their beliefs about child development and appropriate child behaviors (Schaeffer & Edgerton, 1985), teaching self-efficacy (Tschannen-Moran & Hoy, 2001), self-care practices (Lee et al., 2016), and depressive symptoms (Radloff, 1977). See [Appendix B](#) for a description of these measures. In general, participants reported moderate agreement with child-centered beliefs about child development and high self-efficacy beliefs about their ability to facilitate student/child engagement. They also reported moderate levels of personal self-care practices (such as, “I spend quality time with people I care about”) and professional self-care practices (such as, “I take small breaks throughout my work day”). Finally, on average, participants reported low feelings of depressive symptomology (see Table 1).

Table 1: Baseline characteristics on key constructs

	Mean (SD)	Range
Ideas about Child behaviors	2.72 (.46)	1.69-3.69
Teaching efficacy total (all items)	7.31 (.79)	5.00-9.00
Student Engagement	7.57 (.85)	5.00-9.00

³ Twelve participants did not need the CPR/First Aid waiver, as they were in the CCR&R area that delivered no-cost CPR/First Aid as part of intervention efforts.

Instructional Support	7.22 (1.02)	5.00-9.00
Classroom management	7.30 (.89)	5.00-9.00
Self Care Practices total (all items)	25.19 (6.99)	14.00-44.00
Personal Self Care	18.69 (4.22)	9.00-26.00
Professional Self Care	6.51 (3.67)	1.00-18.00
Depressive Symptomology	6.46 (5.69)	0.00-21.00

Description of Participants at Follow-Ups

As described in the overview, we continued to follow-up with participants from baseline survey point with a 6 and 12 months survey check in. They received a \$25 gift card after completion of each survey. Using the subsample of 35 participants with data at 6 months and/or 12 month follow-up points, we describe who 'completed' all requirements to be an RS provider and who did not. **Overall, 22**

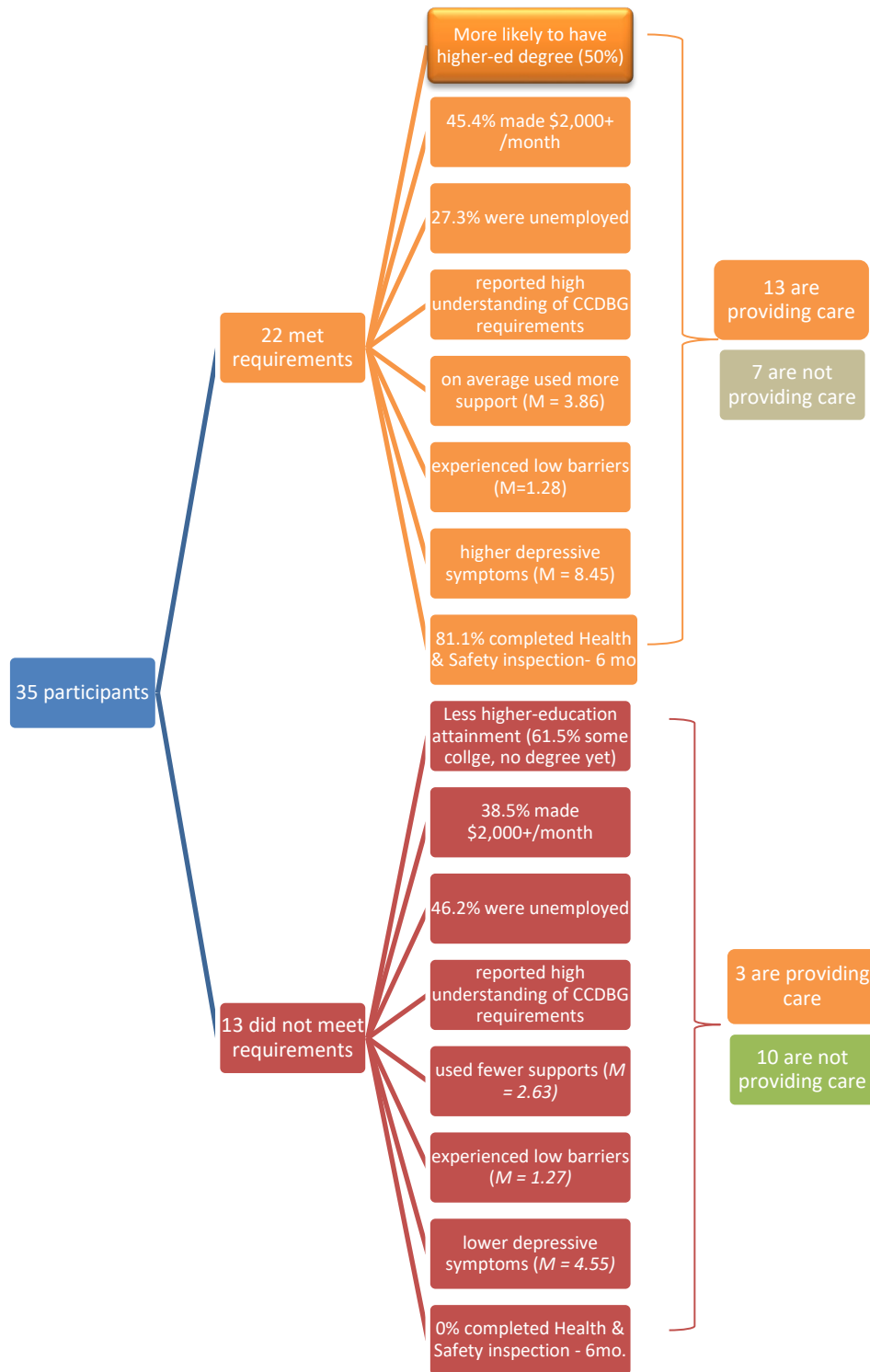
Those who met requirements were more likely to have a two-year or four-year degree, had slightly higher monthly income, lower rates of unemployment, and utilized more supports than those who did not meet requirements.

(63%) completed all requirements and 13 (37%) did not complete requirements by the 12 month survey. Of note, only 13 of the 22 (59%) who met requirements provided care for children and families receiving subsidy. In other words, **37% met requirements and provide care to children served by child care subsidy.** The following sections describes those who had met requirements ($n = 22$) and those who had not ($n = 13$), with available descriptive data from baseline and 6-month survey. Figure 1 (next page) visually depicts the characteristics of the overall groups who either met requirements or did not meet requirements.

37% of interested RS providers ultimately met requirements and provide care to children served by child care subsidy.

Descriptively, **those who met requirements were more likely to have a two-year or four-year degree, had slightly higher monthly income, lower rates of unemployment, and utilized more supports than those who did not meet requirements.** The two groups were similar on number of barriers, depressive symptoms, and understanding of CCDBG requirements at baseline. See Table A.1. in [Appendix A](#) for additional descriptive information (details regarding measures are found in [Appendix B](#)).

Figure 1. Visual Depiction of Differences for 'met' and 'did not meet' requirements to become an RS provider and care status.



Met requirements (n = 22). Of the 22 providers who met requirements (in green in Figure 1) for becoming listed as an RS provider (e.g., completed all training requirements, passed home inspection), 19 met requirements by the 6 month survey, and the remaining three met requirements by the 12 month survey. **Of those 22: 13 were providing care for children whose family received DHS funding**, 7 reported that they were not currently providing care for children whose family received DHS funding, and 1 participant did not respond to that survey item. There were few descriptive differences between those who met requirements and care for children whose family received DHS funding and those who did not care for children (Table A.2. in [Appendix A](#)). Educational attainment and income appear consistent across the two groups, yet the motivation at baseline for 'why become an RS provider?' reveals a notable descriptive difference: **those who were caring for children reported their highest motivation to be 'Interested in caring for children'** (57.1%), while those who met requirements but are not caring for children were more likely to report 'need employment' (42.9%) as motivation. At baseline, those who ultimately care for children at 6 and/or 12 months reported lower understanding of the requirements, higher barriers in the process, and lower use of supports in the process. However, that narrative seems to descriptively change over time in that **those who cared for children reported to engage overall in higher supports and higher-levels of understanding by 12 month survey**. Of note, the majority of those who cared for children reported high satisfaction with two primary supports at 6 months: **CCR&R** (71.4% 'very useful') and **DPU phone support** (57.1% very useful). See the *Snapshot of Success* sidebar for a case-study-like narrative of success for meeting requirements and caring for children whose families receive child care subsidy.

Snapshot of Success: *Providing care for 2-4 children**

At the start of the process to become listed, this successful RS provider^d used a variety of supports, and found the CCR&R and Child Care Provider Guide to be the most helpful. They were unaware of other key supports such as the Office of Child Care and the Lead Testing Reimbursement. They also reported high-levels of understanding regarding the requirements to become listed as an RS provider in Oregon and found the requirements (e.g., fingerprint, CPR/FA) to be 'easy' to complete. Related, they passed their home inspection on the first attempt and the visit lasted no more than 30 minutes. Their primary motivation to become an RS provider was to 'help out a friend/neighbor/family member' & 'interested in caring for children'. They cared for 2-4 children who received subsidy, some with IFSPs, using English as primary instruction, out of their own home in English. They report the misbehavior of the children to be occasional to frequent and received the enhanced rate.

*to protect participants, data from 2-3 participants were merged for this snapshot.

^dHS diploma, control group assignment, low depressive symptoms

Did not meet requirements (n = 13). Thirteen participants did not successfully meet requirements to be a RS provider at 6 and/or 12 month follow-up, and the reasons for not completing are varied. Of note, three of the 13 are caring for children whose parents pay out of pocket and did not proceed with becoming RS as they were already caring for children. Two families no longer needed care so the two

individuals did not pursue it further. At least one individual: a) continued to need support with the listing form, b) was no longer interested, or c) cares for a different age group. The other individuals did not provide reasons for not continuing to meet requirements.

A Dynamic Process:

*Need to elevate available supports**

At the start of the process to become listed, this participant^d had completed both online trainings and had a strong perceived understand of the requirements. They used the DHS website (somewhat helpful) and the Child Care Provider Guide (somewhat helpful), but were unaware of additional supports. They were unemployed at baseline and reported financial barriers, and also reported lower child-centered beliefs and self-care practices.

At 6 months, they had their listing form approved, (not Health and Safety visit yet) and reported using two new supports-- CCR&Rs and the ELD website, which were very helpful.

It is unclear why they did not move forward past the listing form (which was approved) and they did not provide a reason. It is possible, given other data, that the family no longer needed then due to the time it took them to even get their listing form approved.

*to protect participants, data from 2-3 participants were merged for this snapshot.

^dsome college, control group participant, mid-level depressive symptoms

At the 6 month survey, we were curious about the progress of those who ultimately did not meet requirements. About 75% of participants completed the steps leading up to submission of the Listing Form (e.g., RCCAN training, FA/CPR), while about 50% completed the subsequent steps leading to the Health and Safety home inspection (e.g., fingerprinting). Over half (61.5%) had attending the DHS 90-minute Orientation. No participants reported that they had received a Health and Safety inspection at 6 months. For those who completed these requirements, they found them easy or somewhat easy.

Most utilized only one support and experienced at least one barrier at baseline. Most participants did not know about the supports (at baseline) they could use to ease the burden of the listing process. The supports that participants who did not meet requirements reported the **highest unawareness of were: 1)**

Direct Pay Unit phone support, Reimbursement for lead testing, ELD website, office of child care phone support, and the use of other child care providers. The most **commonly used supports were DHS website (which ranged in somewhat to very helpful), CCR&Rs (very helpful) and the Child Care Provider guide** (which ranged in somewhat to very helpful). At 6 months, descriptive data, compared to baseline, indicate that participants grew in their

knowledge of supports, but still did not use them. See Table A.2 in [Appendix A](#) for more information. Finally, **participants reported high financial barriers** (69.2%), such as inadequate funds for the CPR/ First Aid or materials for health and safety visit at baseline. See the *Dynamic Process* sidebar for a case-study-like narrative of the ways in which those who did not meet requirements engaged (or not).

Intervention Descriptions and Effectiveness

CCR&Rs were assigned to one of three groups and attempts were made to match the CCR&Rs on a few key county- and system-level descriptives¹. Of the 44 participants at baseline, there was a relatively even distribution of participants across the three groups: control/business as usual (BAU), Navigator Model, and no-cost FA/CPR (see Table 2).

Table 2. Participants by intervention assignment

	Number of participants	Percent of sample
Control/Business as Usual (2 CCR&Rs)	18	40.9%
Navigator Model (2 CCR&Rs)	14	31.8%
No-cost FA/CPR (1 CCR&R)	12	27.3%

Description of Intervention Supports

Navigator Model. The Navigator Model was built to be a relatively light-touch support to help participants *navigate* the process from listing form preparation all the way through. The primary support was a 2-hour café that offered: (1) an interactive and peer-supported activity designed to assist participants in the listing form process and make connections with other providers in the area and (2) an interactive informational session designed to prepare them for their health and safety visit. These ‘cafes’ were created by the OSU research team and our ELD team members, CCR&R staff were provided materials and the training guide and ultimately lead the cafes⁴. Those in the Navigator Model group also received a checklist brochure⁴ to guide them in filling out the listing form. Starting two months after the participants were recruited (after they were likely to be providing care) they received newsletters⁴ (6 total), which consisted of information and resources designed to support them in their work with children and families.

Regarding dosage and satisfaction with the Navigator Model, overall there was limited use of the supports. However, when they were used the participants mostly

⁴ Café materials, brochure, and newsletters are available upon request. Email bridget.hatfield@oregonstate.edu.

found them helpful. Specifically, only three of the 14 participants attended the 'café' and reported it was very useful to somewhat useful. Eight used the checklist brochure at baseline and found it very useful (57.1%) or somewhat (42.9%) useful. At 6 months, six of the 12 participants in the Navigator Model group with available data reported they used the newsletters and found them very useful (27.3%) to somewhat useful (45.5%).

First Aid/CPR. This no-cost FA/CPR condition emerged, and was funded by ODE ELD, based on initial conversations with CCR&R staff—that the most common barrier for prospective RS providers was the cost of the required FA/CPR training. Thus, this intervention was financial in nature in that is provided the funds for this CCR&R to offer the FA/CPR at no cost to those enrolled in this study.

Effectiveness of Intervention Supports

Independent t-tests (two-sided) were executed for the intervention assignments (=1) and control group/BAU (=0) separately for Navigator Model and no-cost FA/CPR. Interventions assignment was used to predict mean group-level differences in: completed requirements (at 6 or 12 months), number of barriers (baseline and 6 month), understanding of requirements (baseline and 6 months), number of supports used (at baseline and 6 months), and if they had a Health and Safety inspection (6 months) and passed the inspection (6 months).

Navigator Model. Results indicate that there was one trend-level difference between the group that received the Navigator Model supports and those in the control group. Specifically, those in the **Navigator Model group were slightly more likely to have a Health and Safety inspection at 6 months** (a mark of significant progress in the steps to become a RS provider; $t(18.82) = 1.83, p = .08$). No other significant differences emerged. However, recall that the supports in the Navigator Model were not used by all participants in that group (e.g., only 3 of 14 reportedly participated in the 'café'), but our sample size limits further investigation of effectiveness by use of specific components of the Navigator Model.

No-cost FA/CPR. Results indicate that there was one trend-level difference between the group that received the no-cost FA/CPR and those in the control group/BAU. Specifically, those in the **no-cost FA/CPR group were slightly more likely to have a Health and Safety inspection at 6 months** (a mark of significant progress in the steps to become a RS provider; $t(14.82) = 1.75, p = .10$). No other significant differences emerged. Due to the nature of the intervention, we conducted one additional test to see if participants in the no-cost FA/CPR group were more likely to complete the FA/CPR training at baseline. We found a significant difference in that those in the **no-cost FA/CPR group were more likely to complete the FA/CPR training requirement** ($t(26) = 2.12, p = .04$), which was of no-cost to them.

Post-hoc analyses. We also investigated the overall effect of each intervention group against the full sample, regardless of other intervention status to see if the

results held and were unique to the intervention. Specifically, we tested differences in outcomes for those in Navigator Model compared to those in no-cost FA/CPR *and* control group, as well as for those in no-cost FA/CPR compared to those in Navigator model *and* control group. Those in the **no-cost FA/CPR group were more likely to completed FA/CPR training at baseline compared to those in Navigator Model or control group** ($t(20.37) = 2.46, p = .01$), suggesting a unique effect for this model, beyond that of BAU practices or those in the Navigator model. No significant differences emerged for the Navigator Model compared to no-cost FA/CPR or control group.

Summary, Limitations, and Considerations

The aim of this study was to describe a population not yet systematically understood in Oregon—those who begin the process of becoming an RS provider (but may or may not complete requirements and provide care). Of importance, this study was conducted in the wake of the updated CCDBG requirements, which notably increased the requirements for RS providers in Oregon (e.g., health and safety home inspection, additional training hours, required FA/CPR class). In the years following the new requirements for RS providers, Oregon experienced a severe drop in this type of care. Specifically, the number of license exempt providers declined in Oregon from 1,761 in 2014 to just 275 in 2019⁵(inclusive of RS providers and relative providers).

The Navigator Model was created in response to a co-developed (OSU and ELD) logic model. The three light-touch supports (i.e., café, brochure, newsletter) were created to fill in gaps that may be present in understanding and/or process due to the new CCDBG requirements in Oregon. The no-cost FA/CPR intervention was organically discovered in conversations with CCR&R staff and then implemented based on perceived financial barriers for RS providers. Both of these interventions aimed to increase the success of *interested/in process* RS providers to actually become listed with DHS and provide care for children’s served by child care subsidy. Both interventions were designed and implemented in efforts to ultimately increase the supply of this much needed and desired care type to support diverse working families and children in Oregon.

The following sections first provide an overview of key results from baseline, 6/12 month follow-ups (met requirements or did not met requirements), and intervention effectiveness. Then, limitations of the study are identified and discussed. Finally, we close with system and policy considerations based on the results.

⁵ Hatfield, B. E., Pratt, M., & Probert, K. (2020, June 10). *Reauthorization & Oregon’s License Exempt non-relative providers*. Community of Practice Web Conference, CCDBG Implementation Research & Evaluation Grantees, Center for Supporting Research on CCDBG Implementation.

Summary of Results: Participants at Baseline

A unique feature of this study is the ability to understand the characteristics of English-speaking RS providers at the first, initial step of becoming an RS provider. Understanding these characteristics in comparison to the actual RS provider workforce (which was not part of the current study), sheds light on who is making it through the rigorous process to become listed as an RS provider, and who is not. We aim to provide data as to who was interested/started the process to be an RS provider. At that initial step (baseline), participants identified as White (86.5%) and female with 31.8% with a two- or four-year degree and 50% lived in households with incomes of \$2,000/month or less. The most common reason for choosing to become an RS provider was helping out a friend, family member, or neighbor (52.3%) or an interest in caring for children (47.7%). Please see Table A.1. in [Appendix A](#) for further details.

During this initial process, many were unaware of key supports that would help them be successful. A significant portion of participants were not aware of certain resources, such as the CPR/First Aid waiver (41% were unaware of support), reimbursement for lead testing (61% were unaware of support), ELD website support (55%), and OCC phone support (41.5%). They most often used CCR&R and the Child Care Provider Guide and found them useful.

Summary of Results: Met Requirements/Did Not Meet Requirements

Overall, 22 (63%) completed all requirements and 13 (37%) did not complete requirements by the 12 month survey (of note nine did not participate in the 6 or 12 month follow-up, so we do not know their status beyond baseline). Further, only 37% of participants at 6 and/or 12 months (13 of the 35) reported to care for children served by child care subsidy, indicating that about 1/3 of those who started the process to be a RS provider in our study actually succeeded in meeting requirements *and* providing care for children whose families receive subsidy.

Those participants who successfully completed the listing requirements (at 6 or 12 months) to become a RS provider were descriptively more likely to have a two-year or four-year degree, had slightly higher monthly income, lower rates of unemployment, utilized more supports throughout the long process, and reported higher depressive symptomology, than those who did not meet requirements. They reported high satisfaction with CCR&R and DPU phone supports.

Results indicate that many interested RS provider who did *not* meet requirements did not know about key supports offered they could use to ease the burden of the listing process. Most utilized only one support and experienced at least one barrier at baseline (mostly financial). These participants that did not ultimately meet requirements had a variety of paths; for example: two families no longer needed care and three participants care for other children (not those children who are served by child care subsidy). Data reveal that most of these interested RS providers at least completed the steps leading up to submission of the Listing Form (75%; e.g., RCCAN training, FA/CPR), while about 50% completed the subsequent

steps leading to the Health and Safety home inspection (e.g., fingerprinting). No participants who did not meet requirements reported that they had received a Health and Safety inspection at 6 months. Over half (61.5%) had attending the DHS 90-minute Orientation, which comes at different points in the requirement process depending on CCR&R.

Summary of Results from Intervention Programs

The effects of the two intervention programs (Navigator Model and no-cost FA/CPR) on potential RS providers were minimal. Specifically, participation in the Navigator Model or the no-cost FA/CPR increased the likelihood that providers had a Health and Safety inspection by the 6 month mark. Further, those in the no-cost FA/CPR were more likely to have completed the FA/CPR requirement at baseline. The no-cost FA/CPR did assist interested providers in completing that training, but as we speculate above, more supports for providers and an improved coordinated system, also present barriers to interested providers. Overall, the results for the Navigator model should be interpreted with caution, as there was limited participation in the three supports/activities that defined the model—but when the supports were used they were well received. Sample size did not allow for the power to investigate differences in outcomes for providers who fully participated in the Navigator Model activities versus those in the model who did not use any of the supports, but this is a key future direction.

Our post-study structured conversations with CCR&R staff participating in this study revealed supports offered by the control group CCR&Rs that were in line with supports that stemmed from the logic model of the Navigator Model. The two control-group CCR&Rs mentioned a check-list that they gave providers (CCR&R created) to help them through the process, and all of the CCR&S discussed 1:1 individual follow-up, which may have been similar to our check list and individualized supports in the Navigator Model. The intervention groups did indicate that the content of the café was useful for the providers in those initial steps—and that the DHS orientation does not cover that important content in the same way (see also, in Considerations, about DHS orientation moved to earlier in the process).

Limitations

A critical limitation of this study is that is only focused on the English-speaking population of *interested/possible* RS providers. This was due to the approved grant deliverables as well as limited funds. Additionally, participants were mostly White (86.4%), about 50% lived in households with incomes of \$2,000/month or less, and about one third (34.1%) were unemployed at the time of application. Future work should focus on more culturally, racial/ethnically, and linguistically diverse populations as they may have a difference experience interfacing with this system that the current participants.

A major limitation in this survey design is the difference between the language/terms that are used at the state-policy level and that of the interested

provider. For instance, our survey called out 'Child Care Resource and Referral Agencies' as a support in the survey, but many people in Oregon know the CCR&R by the name (e.g., Mid-Willamette Valley Community Action Agency, Eastern Oregon Kids and Care). Future research with this population may consider other methods, such as interviews or focus groups to better understand the nuances and individual differences for RS providers.

Finally, as mentioned previously, we were unable to truly test the effectiveness of the Navigator Model—many participants did not participate fully (or at all) in the supports available. This may have contributed to its limited effectiveness overall.

Considerations

Given these results described in the report and our rich narratives with the CCR&R staff, we offer the following considerations.

Awareness of and connection to supports

1. The Listing Form should more prominently recognize CCR&Rs as a source of support for the trainings *and* for technical assistance. They can navigate the process with interested providers and connect them with system-level supports. This was evident in the data as those who were successfully listed as an RS provider called out CCR&R help as helpful and utilized more supports overall.
2. Offer DHS orientation as an actual orientation as they are getting started in the process (initial stages)—not as one of the last requirements. CCR&R staff indicated that the content of the orientation would help interested providers be more successful, and that the system may consider offering different orientation for RS providers and relatives, since their requirements are different. Our results mirror this recommendation, in that individuals were not able to navigate the steps (e.g., none of those who did not meet requirements had a Health and Safety visit). Related, the CCR&R staff that implemented the Navigator Model indicated that some of the content in the 'café' could be added to an earlier orientation to set people up for success.

1:1 support to demystify the process

1. CCR&Rs should continue to support individualized 1:1 follow-up to assist, answer questions, help with Listing Form, get technology assistance, connect the 'system dots'. This may be especially important gearing up for the home inspection given that our data indicate that step is a stopping point for some. All of the CCR&Rs mentioned this strategy (1:1 support) as one of the ways in which they successfully supported interested RS providers—and recognized the time commitment. Continued support for CCR&Rs should reflect the nature of this work to recruit and support RS providers.
2. Encourage CCR&Rs to use DHS database to check on the 'progress' for RS provider (e.g., fingerprinting status, DHS sends letter) and follow-up with

them individually if they are not going to meet the deadline or need to complete a next step.

Barriers

1. There was a notable descriptive difference in those who met requirements and did not by the 6 and/or 12 month survey in their education and unemployment status (i.e., met requirements: two-year or four-year degree, slightly higher monthly income, lower rates of unemployment). This is critical to note in order to recognize the disparities in those who made it through and those who did not—more equitable access to support is necessary.
2. Many of those who did not meet requirements reported financial barriers; the financial burden of the FA/CPR class, background check, and other costs related to Health and Safety inspection were identified by CCR&R staff as barriers to interested RS providers. CCR&R staff note that many never even start the process as they don't have the funds up front to meet these requirements. Our results with the no-cost FA/CPR intervention indicate that those in the intervention group were more likely to complete that requirement at baseline, but this intervention did not cover other costs associated with the process to become a listed RS provider (e.g., background check, transportation to a site for the fingerprinting, outlet covers for home), which may have been additional financial barriers for interested RS providers.
3. Some RS providers in our study who met requirements were not caring for children as often the family found other child care in the time it took the individual to become a RS provider. This was also evident in the 'did not meet requirements' group as some stopped the process as their assistance was no longer needed. One thought is to create a listed RS providers database to connect RS providers with families receiving child care subsidy. At a minimum, the already listed RS provider could be a temporary placement for the family while the desired RS provider works on the process (maybe even mentored by the current RS provider).

Appendix A

Table A.1. Descriptives comparing 'met' and 'did not meet' requirements to become an RS provider

	Met requirements (<i>n</i> = 22) % or <i>M</i> (SD)	Did not meet requirements (<i>n</i> = 13) % or <i>M</i> (SD)
<i>Baseline</i>		
Education level ^t		
High school diploma or equivalent (e.g., GED)	22.7%	23.1%
Some college but no degree yet	27.3%	61.5%
AA, AS, two-year degree	27.3%	--
Bachelor's degree	22.7%	--
Household income ^t		
Less than \$500/month	13.6%	7.7
\$500-\$999/month	9.1%	30.8
\$1,000-\$1,999/month	27.3%	7.7
\$2,000-\$3,999/month	31.8%	23.1
\$4,000-\$5,999/month	13.6%	15.4
Unemployed	27.3%	46.2%
Number of supports used	3.86 (1.72)	2.63 (2.46)
Understand requirements	3.53 (.58)	3.40 (.76)
Number of barriers	1.28 (.67)	1.27 (.65)
Child-Centered beliefs	2.69 (.51)	2.73 (.46)
Teaching efficacy	7.23 (.81)	7.46 (.73)
Personal self-care	17.55 (3.17)	19.91 (3.91)
Professional self-care	5.00 (2.98)	8.18 (3.31)
Depressive symptoms	14.70 (5.16)	10.64 (3.80)
Why provide care		
Interested in caring for children	50%	46.2%
Helping out a friend/family member/neighbor	54.5%	53.8%
Needed employment	27.3%	38.5%
<i>6 month follow-up</i>		
Have H&S home inspection	81.1%	0%
Passed on first visit	72.7% passed first time	N/A

Enhanced rate	50%	--
Supports (used)	3.81 (2.01)	2.73 (2.41)
Barriers	.81 (.93)	.45 (.52)
Understand requirements	3.79 (.46)	3.71 (.52)
<i>12 month follow-up</i>		
Have H&S home inspection	77.3%	0%
Passed on first visit	63.6% passed	N/A
Supports (used)	4.65 (2.34)	2.00 (1.84)
Barriers	1.23 (.35)	1.00 (0.00)
Understand requirements	3.84 (.34)	3.69 (.53)

t=missing data, % do not add up to 100%; a = full-time, part-time, or on-call.

Table A.2. Descriptives comparing, among those who 'met requirements' (n =22), those who cared for children and those who did not care for children served by child care subsidy

	Care for children with DHS \$ at 6 or 12 months (n = 13)	Do not care for children with DHS \$ at 6 or 12 months (n = 7)
Baseline	<i>M (SD)/%</i>	<i>M (SD)/%</i>
Education level		
High school diploma or equivalent (e.g., GED)	35.7%	--
Some college but no degree yet	14.3%	42.9%
AA, AS, two-year degree	28.6%	28.6%
Bachelor's degree	21.4%	28.6%
Household income		
Less than \$999/month	21.4%	28.6%
\$1,000-\$1,999/month	28.6%	28.6%
\$2,000 or more/month	42.9%	42.9%
Why provide care		
Interested in caring for children	57.1%	28.65%
Helping out a friend/family member/neighbor	50%	57.1%
Needed employment	14.3%	42.9%
Understanding of requirements	3.54 (.62)	3.71 (.47)
Number of barriers	1.33 (.78)	1.00 (.00)
Number of supports used	3.62 (1.69)	4.00 (1.83)
6 months		

Understanding of requirements	3.80 (.53)	3.78 (.31)
Number of barriers	.86 (1.10)	.71 (.49)
Number of supports used	3.93 (2.09)	3.57 (1.99)
Passed Health & Safety (Home inspection) first time	85.7%	57.1%
12 months		
Understanding of requirements	3.89 (.29)	3.71 (.44)
Number of barriers	1.17 (.41)	1.00 (.00)
Number of supports used	5.67 (2.25)	3.44 (2.30)
Passed Health & Safety (Home inspection) first time	71.4%	42.9%

Table A.3. Descriptives for baseline 'supports used' and 'helpfulness of utilized support' for participants who did not complete requirements by 6 or 12 months (n ~ 13)

	Baseline				6 months			
	Didn't know	Knew, didn't use	Used	If used, how helpful	Didn't know	Knew, didn't use	Used	If used, how helpful
CPR/ First Aid short-term waiver	46.2%	30.8%	7.7	Very helpful	46.2%	23.1%	15.4%	Very helpful (46.2%), a little helpful (7.7%)
CCR&R	38.5%	15.4%	30.8%	Very helpful	15.4%	30.8%	38.5%	Very helpful (15.4%), somewhat helpful (7.7%)
Direct Pay Unit phone support	61.5%	7.7%	15.4%	Very helpful	23.1%	53.8%	7.7%	Very helpful (38.5%), somewhat helpful (7.7%)
DHS website	15.4%	7.7%	61.5%	23.1% very, 38.5% somewhat helpful	15.4%	23.1%	46.2%	Very helpful (15.4%), somewhat helpful (7.7%)
Reimbursement for lead testing	53.8%	23.1%	7.7%	Very helpful	23.1%	38.5%	23.1%	Very helpful (30.8%), somewhat helpful (7.7%)
Early Learning Division website	69.2%	--	15.4%	Very helpful	54.5%	9.1%	36.4%	Very helpful (30.8%), somewhat helpful (15.4%)
Child Care Provider Guide (DHS childcare program)	38.5%	7.7%	38.5%	23.1% very, 15.4% somewhat helpful	15.4%	30.8%	38.5%	Very helpful (15.4%), somewhat helpful (15.4%)
Office of Child Care phone support	53.8%	7.7%	23.1%	15.4% very, 7.7% somewhat helpful	--	--	--	--
Other child care providers	53.8%	15.4%	15.4%	Very helpful	23.1%	38.5%	23.1%	Very helpful (15.4%), somewhat helpful (7.7%)

Appendix B

Child-centered beliefs. This construct was measured using the total score of an adapted for educators version of the Parental Modernity Scale (Schaefer & Edgerton, 1985). This measure has been adapted for educators in previous research and has found acceptable reliability (Cronbach's $\alpha = .76$; Mashburn et al., 2006). This measure consists of 16 items, which are rated on a 5-point Likert type scale (with "1" being "strongly disagree" and "5" being "strongly agree", such that higher total scores indicate more child-centered attitudes) and has moderate internal consistency in the current study (Cronbach's $\alpha = .67$). Example items include "children should always obey the caregiver/provider" and "preparing for the future is more important for a child than enjoying today." A mean score of all items was created, in alignment with previous work (Mashburn et al., 2006) and used for analysis.

Understanding of CCDBG requirements. Participants were asked to rate how well they felt they understood seven different aspects of the process to become a listed provider (range 1, "not at all" to 4, "completely understood requirement"). Items included: trainings, health and safety, fingerprinting, background checks, home visits, orientation, and when they would be able to start providing care. This measure was created by the OSU research team and ELD partners and reflects the requirements for LE HBCC in Oregon (Early Learning Division, 2021). The seven items display a strong internal consistency in the current study (Cronbach's $\alpha = .85$). Thus, a mean score was created for each participant to reflect their overall confidence in their understanding of requirements.

Supports used. At each survey time point, participants were invited to indicate if they 'used a support' knew about a support but did not use' or 'did not know about the support. If they used the support, they were then asked to rate how helpful the support was on scale of very helpful (=4) to not at all helpful (=1). Total number of 'I used this support' were tallied at each timepoint. The supports that were identified for participants are listed in Table A.3.

Meeting Requirements to Become a Licensed Exempt HBCC/RS Provider. This variable was measured with a dichotomous indicator created using 6- and/or 12-month data. Participants reported on the progress of completion of the requirements to become listed through Oregon Department of Human Services (administrative data are not available). There were some errors in the reporting identified by research team and lead investigator on this study, thus, the research team created a variable using all available data to represent a strong likelihood that the participant completed all requirements to be listed (e.g., completed home inspection, DHS orientation, training requirements). In other words, if participants met all job-related requirements for becoming listed at either the 6 month and/or 12 month time point, they were considered as having met requirements.

Teaching Self-Efficacy. This construct was measured using the Teaching Efficacy scale (TSE; Hoy & Woolfolk, 1998; Tschannen-Moran & Hoy, 2001), a reliable and valid measure for teaching efficacy

(Hoy & Woolfolk, 1998; Li et al., 2000); some items were reworded to better reflect the home-based care/RS provider situation. It is a 12-item scale (1 to 9, with "1" indicating "not at all," and "9" indicating "very much") assesses teachers'/providers' feelings about their capability to enact desired outcomes with their children and falls into three subscales: efficacy in student engagement, efficacy in instructional strategies, and efficacy in behavior management. The total scale in this study demonstrated strong internal consistency (Cronbach's $\alpha = .88$) and good reliability on each of the subscales (Student Engagement Cronbach's $\alpha = .72$; Instructional Support Cronbach's $\alpha = .72$; Classroom Management Cronbach's $\alpha = .73$). Example questions include "To what extent can you craft good questions for the children in your care?" and "How much can you do to get children to follow the rules?" For this study, each of the subscales are utilized, as well as the overall total score in analysis.

Depressive symptoms. Depressive symptoms were measured via participant report of the Center for Epidemiological Studies Depression scale (CESD; Radloff, 1977). This reliable and valid scale includes 20 items that are measured on a 4-point Likert-type scale (Cosco et al., 2017; Piquart & Sorenson, 2003), and demonstrated acceptable reliability in the current study (Cronbach's $\alpha = .74$). Example items include "Over the last two weeks, how often have you experienced...loss of appetite? ...feelings of loneliness?". All 20 items are summed and the total score is used in analysis, in line with author guidelines (Radloff, 1977).

Financial Barriers. Participants were asked to select from a list the barriers that they experienced at baseline, 6 and 12 months (i.e., financial, not understanding the listing form, home not meeting requirements, trainings not available, materials not offered in preferred language, or other barriers). Participants could check all that applied, and a total number of barriers was computed.

Motivations. Initial motivations to provide care were assessed at baseline; participants could check all that applied: interested in working with children, wanting to help a friend/neighbor, or needed employment. Participants could choose all that applied, and each were recoded into a dichotomous variable (e.g., interested in working with children = 1, or did not choose this option = 0) for analyses, similar to previous work identified in Porter et al., 2010.