Colorado Thriving Providers Project: Final 18-Month Evaluation Report

THRIVING PROVIDERS PROJECT

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SUGGESTED CITATION:

Suggested Citation: Silver, C., Yang, F., Fortet, J., Mustafa, L., Docking, J., Beauchamp, K., Stewart-Kahn, A., Fisher, P. (2024). *Colorado Thriving Providers Project: Final 18-Month Evaluation Report. Home Grown and Stanford Center on Early Childhood.*

Stanford Center on Early Childhood

The Stanford Center on Early Childhood (SCEC) is an initiative of the Stanford Accelerator for Learning, which seeks to accelerate solutions to the most pressing challenges facing learners. The SCEC leverages the current moment of revolutionary science and deep, omnidirectional collaboration across sectors to change the way that research in early childhood is conducted, communicated, and utilized, with the overarching goal of ensuring that *each and every child thrives from the start.*

HOME GROWN

Home Grown is a national collaborative of funders committed to improving the quality of and access to home-based child care (HBCC). Home Grown launched the Thriving Providers Project (TPP) in 2022 after seeing the success of direct cash transfers provided through the HBCC Emergency Fund in helping HBCC providers survive the pandemic. Home Grown is committed to creating sustainable pathways for HBCC providers to earn a living wage, recognizing that economic instability is an underlying issue impacting the availability and quality of child care.

IMPACT CHARITABLE

Impact Charitable is a non-profit focused on directing philanthropic and investment resources towards individuals, entrepreneurs, and institutions who face the greatest systemic barriers. Impact Charitable has run a dozen direct cash transfer programs across the United States, distributing $44 million in direct cash transfers to over 26,000 individuals. Impact Charitable designed and led the Thriving Providers Project in Colorado, alongside a network of aligned community-based and philanthropic partners.

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Executive Summary

In 2022, Home Grown, a national collaborative of funders committed to improving the quality of and access to home-based child care (HBCC), launched a first-of-its-kind direct cash transfer (DCT) program specifically for HBCC providers, The Thriving Providers Project (TPP). TPP arose in response to stark data from the RAPID survey project about providers across the country experiencing high rates of material hardship, as well as the need to acknowledge and better compensate this critical workforce, particularly HBCC providers, for their essential contributions to our country's economy and families. Home Grown spearheaded TPP to support local organizations serving HBCC providers as they implement direct cash pilots to support the economic well-being of HBCC providers and, therefore, ensure that the children in their care can thrive.

In partnership with Impact Charitable and five community-based organizations (CBOs), the first pilot of this national initiative began in Colorado in July 2022. One hundred HBCC providers throughout the state of Colorado enrolled in TPP, receiving $500 monthly for 18 months, in addition to mental health and peer support services through community-based intermediaries, as well as financial coaching. All participants met TPP's definition of Family, Friend, and Neighbor (FFN) caregivers, though some may have become licensed during the program and others may not have self-identified with that term.

Over the past two years, the Stanford Center on Early Childhood (SCEC) served as the learning and evaluation partner for TPP. Grounded in a Theory of Impact and in rapid-cycle evaluation methods utilized in the national RAPID survey, the SCEC conducted a longitudinal, mixed-methods formative evaluation of TPP participants, parents/caregivers, and CBO staff members. Of the 100 TPP participants, 54 consented to participate in the evaluation, completing brief monthly surveys. The evaluation also utilized a non-representative comparison group of national RAPID participants with key similarities to the TPP participant sample. The SCEC frequently engaged in conversation with all evaluation partners, as well as TPP participants, applying a community-based participatory research approach to all elements of the study.

In this report, we provide information on the background and origin of TPP, the initiative's Theory of Impact, methodology including research design and participant details, quantitative and qualitative findings organized by the Theory of Impact for the full 18-months of TPP implementation in Colorado, and a conclusion with lessons learned for future TPP implementation sites, key research takeaways, and policy recommendations. We include additional methodological details around data sources and analysis at the end of the report. Our evaluation points to the notable potential for temporary DCTs to increase HBCC providers' financial and psychological well-being, as well as the urgent need for systemic, sustainable solutions for improving HBCC provider compensation and payment mechanisms to foster long-term workforce stability and strength.

Key Learnings

1. **TPP participants in the evaluation found the process of enrolling in the program easy and accessible, and they reported receiving their payments reliably and on time.** These findings provide proof of concept for this mechanism of cash distribution that may have relevance as states consider implementation strategies for the new Child Care and Development Fund (CCDF) rule that requires timely and reliable methods for paying HBCC providers.
2. **Qualitative reports from focus groups and open-ended survey responses indicated that many evaluation participants experienced more stability in their income month to month due to the DCTs provided through TPP and used the extra money to pay for necessities.** These qualitative findings bolstered the subtle patterns found in quantitative data on financial indicators, which were less conclusive due to high variance in survey data from month to month. Overall, these findings point to the potential for time-limited DCTs to reduce HBCC providers' experiences of income volatility and material hardship.
3. **Many FFN caregivers in the evaluation qualitatively reported that the DCTs allowed them to purchase educational and material resources for the children in their care, while also allowing them to be more present in their caretaking and engage in more training.** As one focus group participant shared, *"[TPP] helped me to want to keep updating myself as a provider, to keep informing myself and to keep taking courses to give the best of myself."* Each of these

findings points to the fact that children may benefit from HBCC providers' enrollment in TPP, since FFN caregivers use the funds to invest in increasing the quality of their services. This sentiment is captured in the following quote from a focus group participant: *"I believe that the work of a provider is not only taking care of children, we are raising them. And these children are going to grow. And much depends on our care, on our stability, both emotionally and economically as well as mentally."*

4. **According to multiple FFN caregivers who participated in focus groups, the DCTs made them feel a greater sense of financial stability, lower levels of stress, and that their work as a child care provider was valued.** One FFN caregiver noted how TPP affected her care in this regard: *"[TPP] made a big difference in me for the care of the children, it kept me calmer, more relaxed, and that is reflected in the care of the children."*
5. **Some evaluation participants reported that receiving the DCTs made them feel more confident that they could stay in the early care and education field, indicating that support like that provided by TPP could be a stabilizing force within ECE.** As one FFN caregiver stated, *"When I started receiving the TPP, not only did I stay, as my colleagues say, but it also helped me to pay for the most essential expenses."*
6. **Evaluation participants reported increased comfort with CBOs, which is a critical first step in bolstering this workforce's access to public benefits.** However, rates of benefit utilization for evaluation participants remained low throughout TPP, indicating that these relationships alone are not sufficient to increase FFN caregiver use of public benefits. There are likely other barriers outside those addressed by TPP that limit FFN caregivers' use of benefits. TPP implementation partners will continue to use these findings to support the important advocacy work happening in Colorado to eliminate barriers preventing FFN caregivers – many of whom are immigrants – from receiving public benefits.

Glossary

- **Community-Based Organization (CBO):** An organization, typically non-profit, that works at the local level to provide services to improve a community's health and well-being. CBOs are driven by community needs, inputs, and solutions. Within the context of all TPP locations, participating CBOs have existing, trusted relationships with home-based child care providers and serve as an intermediary between Home Grown, Stanford, and participants.
- **Direct Cash Transfer (DCT):** An intervention that provides money directly to individuals or households in the form of unrestricted payments. Oftentimes, DCTs are referred to as "no strings attached" payments.
- **Home-Based Child Care (HBCC):** Refers to any nonparental care for children, in a provider's own home or the child's home. HBCC providers may care for mixed-age groups, and they may be paid or unpaid. HBCC is an umbrella term that encompasses both unregulated and licensed care providers in the home context.
- **Family, Friends and Neighbor (FFN):** A broad term encompassing many types of caregivers, typically those who have a previous relationship with the children for whom they care. Family, friend and neighbor care makes up the majority of home-based child care. They are the grandmothers, nanas, aunties, abuelitas, family, friends and neighbors who care for children. Most states allow FFN caregivers to be legally license exempt, or legally unlicensed, meaning they are not required to pursue licensure to serve the (usually smaller) number of children they care for. These caregivers may be paid or unpaid and may not view themselves as FFN caregivers.
- **Licensed Family Child Care (FCC):** Licensed providers are home-based child care providers who hold a license from their state to operate and are paid for their services. Some states use the terms regulated or registered rather than licensed. Licensed FCC programs typically have much smaller capacities than center-based programs.

Background of the Thriving Providers Project

The Thriving Providers Project (TPP) was born out of the acknowledgement that early childhood educators, and particularly home-based child care providers (HBCC), are inadequately compensated for their critical work for our nation's economy and families.

The RAPID survey, a national, longitudinal survey created by the Stanford Center on Early Childhood (SCEC) to investigate the lives of families with young children and child care providers, demonstrated the dire financial situation of many caretakers in the US during the COVID-19 pandemic, with staggering proportions of this workforce experiencing material hardships on a monthly basis. During the pandemic, one in three child care providers who responded to the RAPID survey experienced at least one material hardship (e.g., food, housing, utilities), with significantly higher rates reported among Family, Friend, and Neighbor (FFN) providers. These material hardships resulted in elevated emotional distress among providers, families, and children (RAPID, 2021). An HBCC provider from California shared in the RAPID survey: *"The biggest worry my family is experiencing at the moment is whether or not we can afford to pay the mortgage and bills"* (RAPID, 2023).

Simultaneously, while HBCC providers earn poverty wages and struggle to feed their own families, families with young children struggle to find and pay for child care. National experts and families alike have voiced concern about the lack of affordable and accessible child care for young children. RAPID data further support this reality, highlighting the fact that parents responding to the RAPID survey report that child care has been increasingly difficult to find and inconsistently available since the start of the pandemic (RAPID, 2022). As one parent/caregiver in Illinois shared: *"Our biggest concern is lack of affordable child care (or even unaffordable child care - [there is a] major shortage of child care spots in our large metro area!)"* (RAPID, 2022).

The child care crisis in this country has been the result of a perfect storm of several economic factors, including insufficient workforce investment. Policymakers throughout the nation are clear that the current, largely privately-funded child care system in the US suffers from multiple market failures (e.g., liquidity constraints, positive externalities) that make it a prime candidate for additional, robust government investment (US Department of the Treasury, 2021).

Given these realities, Home Grown sought to employ direct cash transfers (DCTs) as a strategy to support the underpaid home-based child care workforce and provide proof of concept to motivate policy shifts on this critical issue of compensation. Home Grown's first iteration of this work, launched in April 2020, was an HBCC Emergency Fund to catalyze the development of regional funds that provide direct financial support to HBCC providers across the nation.

DCTs in the US have been on the rise in recent years (Stedman, 2023). The fundamental philosophy behind DCTs is that providing ongoing, unrestricted cash transfers to individuals – particularly those who are socioeconomically disadvantaged – will offer a predictable fixed income that may result in more stability, thereby giving them the bandwidth to think beyond meeting their basic needs each week. As DCT programs in the US begin to accrue research findings, experts refer to the meaningful DCT evidence base generated in low- and middle-income countries over the past few decades (Bastagli et al., 2018). These international studies have shown that DCTs to households result in significant improvements in their education, health, nutrition, employment, and poverty outcomes. Further, DCTs to parents/caregivers of young children have meaningful and dramatic impacts on the positive development of infants and toddlers, based on a cost-benefit analysis of a US child allowance (Maxfield & Thomson, 2023; Garfinkel et al., 2022). A notable gap in the growing DCT evidence base is the lack of scholarship examining the impacts that providing DCTs to educators may have on the children in their care. TPP provides an opportunity to test whether the well-established intergenerational benefits of providing DCTs to families are also found when giving unrestricted cash to members of the ECE workforce – specifically HBCC providers. FFN caregivers in particular represent a unique subset of HBCC providers who, like the households and individual parents/caregivers included in the DCT literature above, are often socioeconomically disadvantaged, relationally close to the children in their care, and unlikely to access benefits from public systems. Given these shared characteristics between the typical beneficiaries of DCT programs that have been evaluated and FFN caregivers, DCTs thus represent a promising mechanism to positively impact both HBCC providers and the children in their care.

As the first DCT program specifically for HBCC providers (and specifically FFN caregivers in CO) in the nation, TPP seeks to address compensation and economic stability as a foundational step in building effective early childhood programs and quality experiences for children and families. It is important to note that the DCT strategy is different from other compensation approaches that policymakers used during the pandemic to provide income increases to ECE educators. Whereas a DCT is usually unconditional, a bonus is a strategy that acts as an incentive by rewarding recipients with additional compensation for taking specific action. At the same time, a DCT is similar to other periodic supplements to salaries in that, as "added income… independent of a worker's regular pay[, it] does not provide an ongoing wage increase for the duration of employment" (Whitebook et al., 2016, p. 45). Another compensation strategy that is more rarely used than wage supplements is raising the base salary of ECE educators; some states have explicit requirements to ensure parity between ECE educators' salaries and those of their counterparts in K-12 education settings.

To further contextualize the research findings and policy implications that we outline in this report, it is helpful to consider the impacts of other wage supplement programs for ECE educators that evaluation studies have found. For example, the District of Columbia created the Early Childhood Educator Pay Equity Fund in 2021 through raising local revenue. An efficacy study by Mathematica found that this initiative – which provides annual pay increases to ECE educators in licensed programs – had a statistically significant, positive impact on the number of ECE educators employed in DC, and also increased workforce retention and stability (Schochet, 2023).

In 2020, Virginia used federal relief dollars through the Preschool Development Birth through Five Initial Grant (PDG) to provide $2,000 in financial incentives to educators in child care centers and family day homes who remained employed at their sites over a 6-month period; this compensation strategy is known as the Teacher Recognition Program (TRP). In a pre-post outcome study, the University of Virginia found that the payment through the TRP made participants feel happy, like their work was valued, more excited about their job, and less stressed; furthermore, participants reported that the TRP payment helped them pay for basic needs (e.g., housing, food, bills) and stay in their position longer than they otherwise would have (Bassok et al., 2021).

Both of these examples of alternative compensation strategies are more directly tied to HBCC providers' workplaces than TPP is; the bonuses through DC's Early Childhood Educator Pay Equity Fund are administered by eligible programs themselves and Virginia's TRP is dependent on HBCC providers' duration of employment. Given that these employer-related characteristics do not apply to TPP, some of the findings of the impact of this program may be unique to the DCT strategy (e.g., the reliability and accessibility of the payments). Alternatively, given that DCTs build on what HBCC providers already earn, other outcomes that we examine in this report may be applicable to other wage supplement strategies as well (e.g., maintaining the supply of the workforce, improving HBCC providers' financial and psychological well-being, strengthening HBCC providers' trust in CBOs). As states work to pilot compensation strategies for HBCC providers, lessons learned from TPP and DCTs can help them implement compensation approaches that address the sufficiency, reliability, and accessibility of payments to HBCC providers.

When creating this initiative, Home Grown identified the following guiding principles and values of TPP:

- **Value Providers and Communities:** We value HBCC providers, their opinions, and the work they do. We believe that HBCC providers should be adequately compensated for their work, even when the families of the children they care for cannot afford to pay. We trust HBCC providers to make decisions for themselves and seek to give them power and agency to do so. We will affirm the assets and strengths of each community. We will make space to elevate the voices of participants in decision-making. We trust caregiver and parent/caregiver reports on the well-being of themselves and their children.
- **Learn by Doing:** We aim to continuously test, learn, and iterate, and to be practical and pragmatic in our program design.
- **Open Source:** Our learnings and resources will be freely available to practitioners, funders, HBCC providers, and policymakers.
- **Leverage Direct Cash Transfer (DCT) Best Practices:** We use the principles of DCT (unconditional, unrestricted, cost-effective, minimal administrative burdens) to demonstrate sufficient pay for HBCC providers.
- **Mitigate Unintended Negative Consequences:** Whenever possible, we will anticipate where DCTs may lead to negative consequences such as income/benefits cliffs. We acknowledge those risks and work to make plans to address them.
- **Commitment to Equity:** We aim to promote racially and economically equitable communities. We acknowledge that America's history of racism,

discrimination, prejudice, and bias has disenfranchised and marginalized segments of our society, denying them access to basic rights, social goods, and the means to build wealth.

Nationally, TPP is focused on HBCC providers, with each geographic location specifying their inclusion criteria further. In Colorado, TPP specifically targeted FFN caregivers during the planning phase. All participants in the Colorado sample met TPP's definition of FFN caregivers at the start of TPP, though some participants became licensed during TPP (based on our qualitative data) and others may have never self-identified as FFN caregivers despite matching the TPP definition. When we present demographic data on "provider type," we urge readers to remember that HBCC providers may have conceptualizations of their identity different from the terms the research field has defined.

Terminology for the various participants in the workforce across different ECE setting types is an ongoing topic of discussion among researchers, advocates, policymakers, educators themselves, and other stakeholders; we acknowledge the need for consensus-building outside the parameters of this study and TPP. For the purposes of this report, we use the terms "TPP participants" and "FFN caregivers" interchangeably to discuss research findings and analyze data about the caregivers who received DCTs and participated in this evaluation of TPP in Colorado.

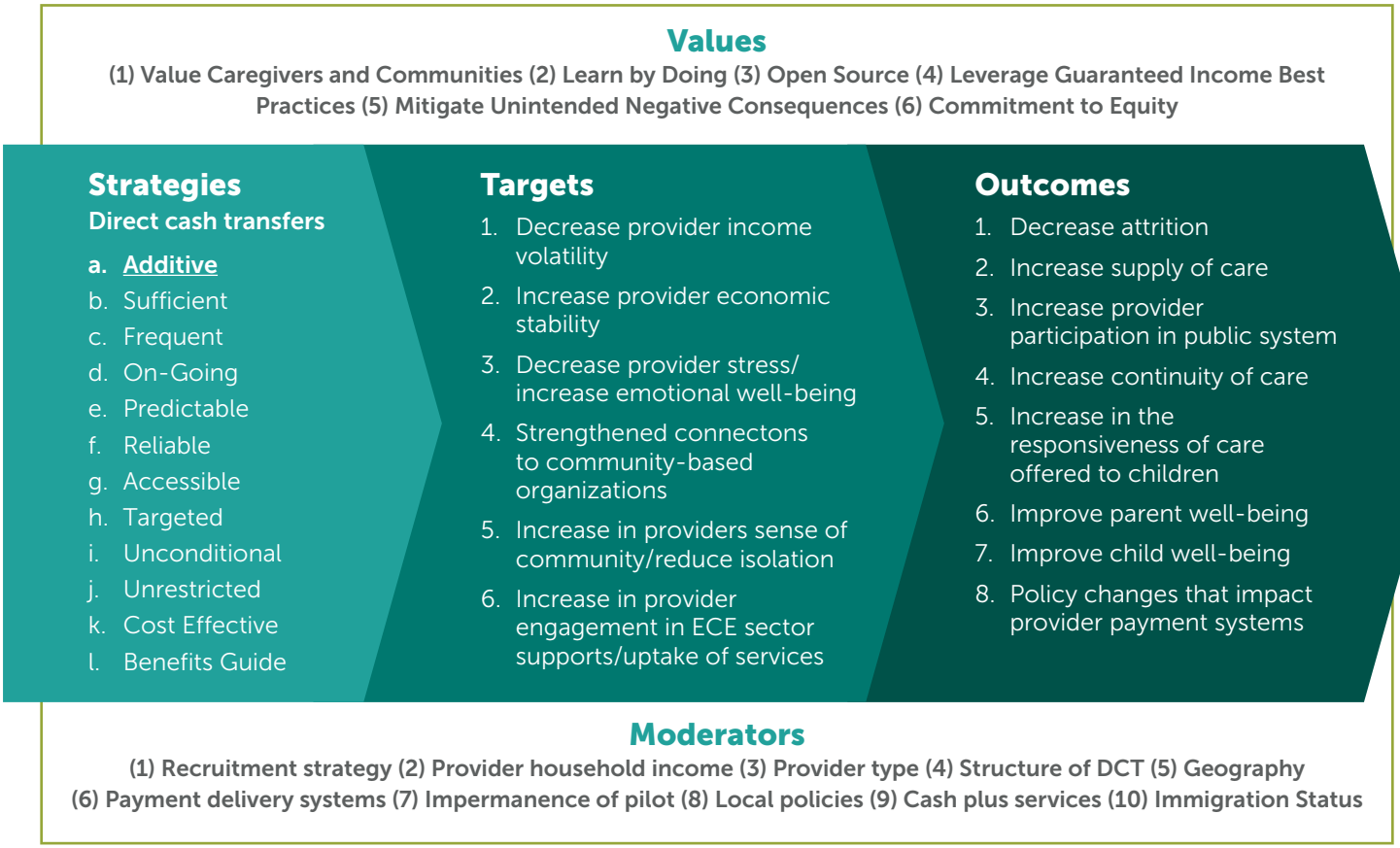
In this pilot, two cohorts of FFN caregivers enrolled in TPP for 18 months of DCTs, through which they received $500 per month delivered in two payments. Cohort 1 began in July 2022 and Cohort 2 began in November 2022. TPP participants also had access to additional linguistically accessible and culturally responsive "cash plus" resources throughout the intervention, including a bi-weekly group-based therapy session on Zoom hosted by a graduate student clinician and supervised by a PhD-licensed psychologist with specialization in early childhood mental health and development. The groups were supported by a peer navigator (an experienced child care provider) who connected them with linguistically accessible, vetted community resources. Lastly, at the end of the program, FFN caregivers enrolled in TPP had access to linguistically accessible and culturally responsive financial coaching through the Savings Collaborative, which offered them savings products, emergency loans, and individualized financial coaching and planning. Colorado is the first implementation site of TPP in the country.

This evaluation report documents the full implementation of TPP in Colorado, presenting data from 18 months of DCTs for both cohorts. The SCEC utilized a rapid-cycle, mixed-methods study design grounded in a Theory of Impact and employed community engaged methods to understand the implementation and outcomes of the program. Data from TPP participants, parents/caregivers, and CBO staff are used to illustrate a robust analysis of TPP's strategies, targets, and outcomes.

Theory of Impact

The SCEC and Home Grown use a Theory of Impact to articulate how TPP impacts HBCC providers and their respective ecosystems (see Figure 1; last updated January 2023). A Theory of Impact is a visual representation of program activities (strategies), what results are expected because of these activities (targets), the broader goals of these program activities (outcomes), and the factors that will affect who benefits most or least from the program (moderators). In April 2022, the SCEC conducted a series of workshops with Home Grown to identify key programmatic elements and related goals of TPP across all implementation sites, ultimately resulting in the national TPP Theory of Impact. This Theory of Impact informed program decisions and evaluation plans for Colorado and future replication sites. In this report, the SCEC organizes TPP's evaluation learnings from the Colorado implementation by the constructs outlined in the TPP Theory of Impact.

Figure 1. Thriving Providers Project Theory of Impact



Methodology: Research Design and Participants

Key Players

This evaluation was a collaborative effort across multiple teams and organizations. Throughout the report, we refer to the following key players who contributed to evaluation design, implementation, and analysis.

Home Grown

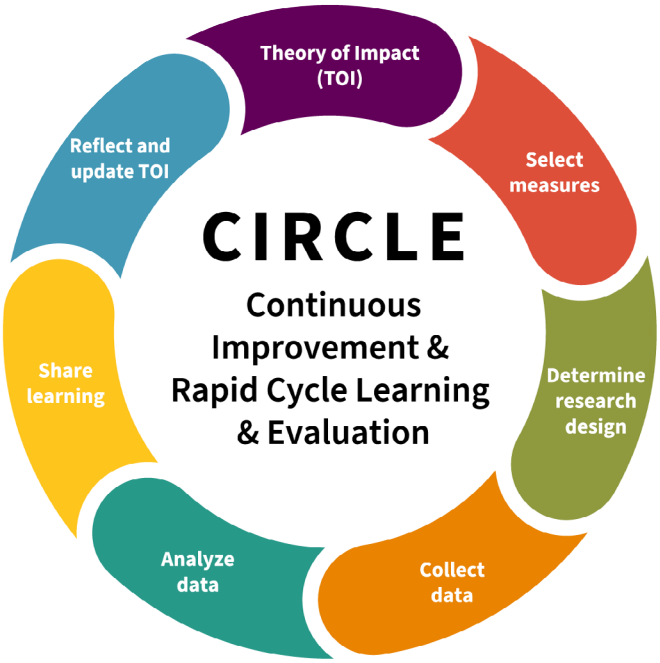
Home Grown is the creator and programmatic lead of TPP nationally. In partnership with private and public funders in local communities, the organization leads the national funding for the initiative. As local communities establish their programs, Home Grown provides the following supports: project management and integration, evaluation, policy strategy and advising, payment and data collection tools, coaching, peer learning support tools such as the Benefits Protection Toolkit, and backbone funding and fundraising support.

Stanford Center on Early Childhood (SCEC)

After collaborating with Home Grown on the national RAPID survey, the SCEC was chosen by Home Grown to serve as the learning and evaluation lead for TPP. Within the SCEC, two teams are involved in the TPP evaluation: the Continuous Improvement and Rapid Cycle Learning and Evaluation (CIRCLE) and RAPID teams.

The CIRCLE Team's robust approach to learning and evaluation is based on continuous improvement. The CIRCLE Team's goal is to move beyond asking whether programs "work" and instead to identify "how" and "for whom" programs are working. The CIRCLE Framework (see Figure 2) guides CIRCLE Team engagements like this TPP evaluation and is effective in driving improvements at the program and systems level.

Figure 2. The CIRCLE Framework



RAPID is a survey project based at the SCEC originally created in response to the COVID-19 pandemic. The RAPID survey provides actionable data on the experiences and well-being of the important adults in young children's lives to inform immediate and long-term program and policy decisions. In the current evaluation, we utilized RAPID survey methodologies and data analyses.

Provider Consultants

Throughout each stage of this evaluation, the expertise and lived experiences of three HBCC providers, two of whom were enrolled in TPP, informed decision-making. Home Grown compensated these consultants for their time and invaluable contributions to this evaluation.

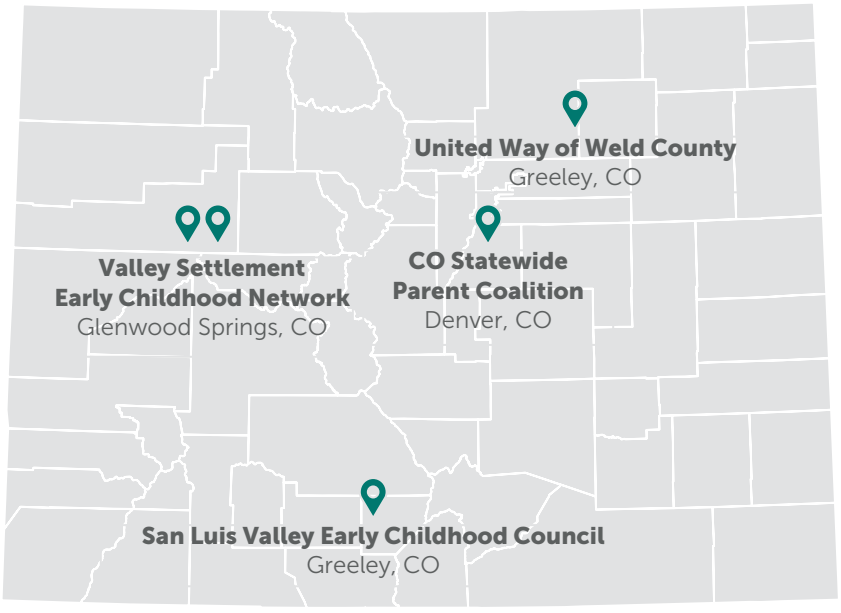
Impact Charitable

In Colorado, Impact Charitable was the implementation lead responsible for designing and administering the DCTs to HBCC providers. Within Colorado, TPP is one of several DCT programs that Impact Charitable implements. Impact Charitable raised implementation funds and oversaw both the cash and additional supports and services (e.g., psychological support, peer support groups) that TPP participants received. To recruit participants to TPP, Impact Charitable partnered with five CBOs (see Figure 3): Colorado Statewide Parent Coalition, Early Childhood Network, San Luis Valley Early Childhood Council, United Way of Weld County, and Valley Settlement. For the delivery of DCTs, Impact Charitable partnered with AidKit, a Denver-based social impact company providing technology to power guaranteed income and direct cash programs at scale. A network of philanthropic and funding partners provided financial support for TPP in Colorado, including the Aspen Community Foundation, the Colorado Health Foundation, Colorado Gives Foundation, the CIRCLES award, and other anonymous foundations within the state.

Research Design

The current evaluation utilizes a longitudinal, mixed-methods rapid-cycle methodology. TPP participants were given the opportunity to complete monthly surveys. The team conducted quantitative trend analyses, comparisons to national provider data, and qualitative thematic analyses. This methodology allowed for quarterly data analysis, interpretation, and improvements. While randomized controlled trials (RCTs) are a celebrated evaluation method, this evaluation approach offers several unique advantages (e.g., faster, actionable data; flexibility to be responsive to community needs; see "What are the strengths of the rapid-cycle survey approach employed in the evaluation of the Thriving Providers Project?" for more detail).

Figure 3. Map of Community-Based Organizations in Colorado



What are the strengths of the rapid-cycle survey approach employed in the evaluation of the Thriving Providers Project? In contrast to conventional experimental approaches that rely on RCTs alone, the rapid-cycle survey approach has unique advantages. First, using rapid-cycled surveys to assess program impacts allows researchers to rely on nearly real-time data for program decision-making, enabling a fast "bench to bedside" translative process. Second, frequent survey assessments, along with iterative program refining processes, can create more flexibility for researchers to test out different components, pinpoint an intervention's "active ingredients," and continuously optimize a program. Third, in the context of disruptive crisis events, such as the COVID-19 pandemic, in which marginalized populations are disproportionately impacted, this survey approach allows researchers to design and test initiatives without withholding potentially critical resources from involved participants, thereby employing ethical and equitable research practices. Lastly, the iterative design-test-refine process better enables listening to, learning from, and co-designing with directly impacted community members (through stakeholder engagement and participatory research activities such as focus groups and interviews), which creates more opportunities for community self-determination and also helps ensure that programs incorporate the expertise, lived experiences, and priorities of those who have the most at stake.

Community-engaged research exists along a continuum (see figure 4). Through consultation, involvement, collaboration, and shared learning, a small subset of FFN caregivers within the TPP community engaged in the evaluation process at various points to support a community informed approach. The SCEC team facilitated open communication and accessibility throughout the research process by ensuring the consistent availability of translation and interpretation services to communicate effectively in FFN caregivers' preferred languages. FFN caregivers were consulted during advisory board meetings and their input on the wording of questions helped shape some survey items (e.g., how best to capture certain domains and appropriate language). In addition, FFN caregivers supported data interpretation to ensure that conclusions drawn were grounded in their lived experiences. Findings from specific survey items were presented to a subset of FFN caregivers, who then gave their perspectives on the potential factors influencing particular patterns. FFN caregivers were compensated to acknowledge their expertise and time. Furthermore, to encourage a bidirectional exchange as TPP was ongoing, findings were shared with HBCC providers through newsletters available in English and Spanish to ensure inclusivity and cultural responsiveness. As part of our internal ongoing improvement process, the SCEC team continues to work toward greater community engagement and move along the continuum to progress from a "community informed" position to "community involved" with future iterations of TPP implementation and evaluation.

Figure 4. Continuum of Community-Engaged Research

Sources: Adapted from The Community-Engaged Research Framework by Petry Ubri, Anmol Sanghera, Sabrina Avripas, Ashani Johnson-Turbes. NORC at the University of Chicago

Recruitment

In this evaluation, we utilized data from several distinct groups of people, necessitating the use of unique recruitment strategies, as detailed below.

1. **FFN Caregivers:** In Colorado, TPP participants were full-time residents of Colorado, providing child care services to children who were not their biological children or in their custody and at least one child under the age of five, operating as a license-exempt provider (though they could apply for licensure throughout the course of TPP), low income (as defined as below 80% area median income (AMI), compliant with Colorado's stipulations regarding the adult child ratio in license-exempt settings, and providing care for at least 20 hours per week.

   CBO staff recruited eligible FFN caregivers, screened applicants, and if approved, enrolled them in TPP. As such, in July 2022, the SCEC team met with CBO staff to prepare them to share information about the TPP evaluation during the application process. As part of the "unconditionality" clause of TPP, TPP participants were not required to participate in the evaluation. During the enrollment process, FFN caregivers could select whether they consented to the SCEC team contacting them about the evaluation. Through a data sharing agreement, AidKit provided the SCEC team with a contact list of enrolled TPP participants who consented to contact sharing. For those participants, the SCEC team sent a link via SMS to a landing page with basic information about the study and what it entailed. If a program participant was interested in proceeding, participants advanced to the consent form section of the Qualtrics survey. After providing consent, participants were immediately directed through Qualtrics to their first survey.

   For every survey they completed, study participants received $5 electronic gift cards sent via email. Starting in February 2023, participants received a $20 gift card bonus for every 3 surveys they completed to combat survey fatigue and promote retention.

   Out of 100 total TPP participants, 54 consented to be part of the evaluation study. Unfortunately, we do not have data to compare the TPP participants who agreed to participate in the evaluation and those who did not. Of note, nine TPP participants dropped out of the program entirely, five of whom were part of our evaluation sample. The majority of participants who dropped out did so due to concerns that they would be then earning too much to qualify for some of their existing benefits (e.g., benefits cliff). These participants only completed surveys while they were still enrolled in the program.

2. **Parents/Caregivers of Children Under TPP Participant Care:** When recruiting parents/caregivers to the study, it was imperative that the nature of TPP was kept private for the sake of the FFN caregivers in the program. FFN caregivers shared with us their concerns that if families knew they were receiving DCTs, this could jeopardize the amount/consistency of payments from families. Parents/caregivers were asked to participate in a study about their child care experiences. The SCEC recruited parents/caregivers to the study in two indirect ways:

   - Asking FFN caregivers to share parents'/caregivers' contact information with us so we could reach out to parents/caregivers directly, or
   - Sharing a link with FFN caregivers so they could forward it to parents/caregivers.

3. **CBO Staff:** During the training that CBO staff received to learn about the process for screening and enrolling FFN caregivers into TPP, the SCEC team shared high-level details of the evaluation and why it is important. The SCEC team asked each CBO to nominate a point person to make contact with the SCEC team during the week following the initial round of enrollment. At that time, the point person at each CBO provided contact information (name, phone number, and email) for each staff member who recruited at least one FFN caregiver. Using this information, the SCEC team sent an initial survey participation link. CBO staff survey participants received $5 electronic gift cards via email for completion of the survey.

Consent: In accordance with ethical standards of the Stanford University Institutional Review Board (IRB), all participants were provided with the same consent process. Participants were shown an electronic consent form in Qualtrics. The consent form provided details about the study, why it was being conducted, what participants could expect to do if they chose to participate, the risks and benefits of participating, and what they would receive for participating. Participants had the option to save or print a copy of the consent form to keep and were encouraged to reach out to the SCEC team (contact information provided) if they had any questions before deciding whether to participate. At the bottom of the consent form, participants could indicate whether they agreed to participate or not.

Participants

The TPP evaluation in Colorado included three types of participants. The inclusion criteria and subsequent sample of each group are listed below:

1. **FFN Caregivers:** FFN caregivers participating in the evaluation were enrolled in TPP, 18 years or older, and spoke English and/or Spanish. The table below demonstrates that the majority of participants in our sample self-identified as Hispanic/Latino(a), female, and FFN caregivers. Nearly all participants reported a household income below 200% of the FPL, and more than three-quarters of them preferred participating in the study in Spanish. How participants self-identified in terms of provider type aligned with TPP's definitions in some cases and did not align in others. The table below reports data according to participants' responses.
2. **Parents/Caregivers of Children Under TPP Participant Care:** Parents or caregivers in this study had to have children cared for by TPP participants. As of September 2023, nearly all (95%) of our parent/caregiver respondents identified as Hispanic/Latino(a) and female.

Table 1. TPP Participants in the Evaluation (N=54)

	N	Percent of Total Responses
Race/Ethnicity		
Hispanic/Latino(a)	43	79.6%
Other Race/Ethnicity	1	1.9%
No Response	10	18.5%
Preferred Language		
Spanish	45	83.3%
English	9	16.7%
Gender		
Female	41	97.6%
Male	1	1.9%
No Response	12	22.2%
Household Income		
Below 200% FPL	21	38.9%
Above 400% FPL	1	1.9%
No Response	32	59.3%
Provider Type Identity		
Babysitter/nanny	5	9.3%
Center teacher	1	1.9%
Family, Friend, Neighbor (FFN)	34	63%
Home-based	3	5.6%
No Response	11	20.4%

3. **Community-Based Organization (CBO) Staff:** To participate in the CBO survey, staff at the five CBOs described in the prior section recruited or enrolled FFN caregivers into the TPP program.

   CBO Staff Sample: Eight participants (7 English, 1 Spanish) completed the initial CBO staff survey, representing all TPP partner organizations who enrolled FFN caregivers in Colorado. As the survey is about the organization itself, and not about individual staff members, we did not collect additional demographic information on survey respondents. In the follow-up CBO staff survey, there were five participants (4 English, 1 Spanish), but a large amount of missing data.
4. **RAPID National Data Providers:** Inclusion criteria for the TPP comparison sample of RAPID provider participants included: identifying as an HBCC or FFN caregiver and reporting a household income of 200% below the FPL. We decided to include self-identified HBCC and FFN caregivers in this comparison group given the variations in definitions of these terms that exist throughout the country. The national comparison data for TPP included 1,559 responses from 486 providers who were either FFN caregivers or HBCC providers with an annual household income below 200% FPL and who provided data between June 2022 and April 2024.

Table 2. RAPID Comparison Sample (N=486)

	N	Percentof Total Responses
Race/Ethnicity		
Hispanic/Latino(a)	110	22.6%
Other Race/Ethnicity	374	77%
No Response	2	.4%
Geographic Region		
West	129	26.5%
Other Region	357	73.5%
Gender		
Female	384	79%
Male	90	18.5%
Other Gender	7	1.4%
No Response	5	1%
Household Income		
Below 200% FPL	486	100%
Provider Type Identity		
Family, Friend, Neighbor (FFN)	142	29.2%
Home-based	344	70.8%

Findings

In this section, we report on both quantitative and qualitative data. First, we describe what we have learned about the sample of TPP participants who have participated in the evaluation and/or completed focus groups or interviews, including demographic comparisons with the national RAPID sample of providers. Next, we present data from TPP participants who participated in the evaluation (referred to as "TPP participants" or "evaluation participants" throughout this section for readability), CBO staff, and AidKit, organized by the components and variables of the Theory of Impact, including strategies, targets, and outcomes. Of note, graphs depicting quantitative trends appear in two formats: 1) by month of TPP with aggregated data across Cohort 1 and Cohort 2 (to demonstrate TPP impacts with the largest possible sample size), and 2) by calendar month with each cohort represented separately (to allow for clear comparisons with the RAPID national provider sample). When relevant, we reference other important work throughout the Findings section to aid in interpretation.

Colorado TPP Participants

To ground our presentation of the data on participants' experiences with TPP, we will first describe what we have learned about these participants, all of whom met our definition of FFN caregivers at the time of enrollment. These secondary qualitative data come from focus groups at two time points held by Impact Charitable.

1. Many participants became FFN caregivers to care for their own children.

A primary factor motivating entry into the field of child care was FFN caregivers having their own children, as one FFN caregiver described:

"I became a child care provider because I have twins. They are six years old. My previous career was as an accountant in Venezuela, and when I came to this country, this opportunity came up."

Many focus group participants had their own child/ren and could not afford child care. Economically, it made more sense to stay at home and look after their own children and other children at the same time. One participant elaborated on this concept with the following:

"I started to look after children when my own children were little... I was paying for child care, and I couldn't afford it anymore. So one of my sisters told me, let's go to my house, you look after my children, I pay you to look after mine and you can look after yours too. And I said, ok, sounds good. That's how I started, and then people would bring more children, and I was looking after more kids and earning more money."

Multiple FFN caregivers also mentioned the commonality of becoming an HBCC provider when they were no longer able to afford child care for their own children. These FFN caregivers described their stories and perspectives as mothers earning for their needs through providing child care:

"When I had my third child, I couldn't afford child care anymore."

"I started to look after children when my own children were little. I had a rough time in my marriage and I ended up alone with my two small children. So I was paying for child care, and I couldn't afford it anymore."

"I liked being with my own children and earning extra money."

2. Caring for children is a passion.

Most participants in focus groups described child care as their vocation and work that addresses a real need. All focus group participants spoke positively about their role and the children they care for. There is intrinsic motivation in this role, and it clearly brings joy to FFN caregivers despite other challenges they face. One FFN caregiver stated:

"Everything I learn about caring for children, education and so on, I honestly feel excited about it, I love it, and I love offering support for families, helping them with the children's routine when they can't sleep."

The majority of FFN caregivers expressed loving what they do, describing this sentiment with the following:

"Children bring joy to our lives,"

"Children often give us life lessons, to put it this way. They can change our mood in a second, and they are very naive and intelligent."

3. Many experience stress related to economic hardships, both their own and those of the families they serve.

Most focus group participants indicated some level of financial hardship simply because they "don't earn much." As one FFN caregiver described:

"When you take care of children, what you earn is very little."

Many FFN caregivers also reported understanding the economic situation of the families for whom they provide care, too. For example, one participant commented:

"The immigrant families do not earn much, how can I charge them so much?"

Low wages are a risk factor for FFN caregivers considering leaving the profession:

"There was COVID and we had a rough time financially speaking. Honestly, I was about to quit doing what I like, which is to care for children."

Another sub-theme that emerged was FFN caregivers negotiating families' needs with their own, and FFN caregivers' tendencies to emotionally connect and empathize with the families they serve. While this emotional connection allows for deep relationships with families, it also may undermine FFN caregivers' ability to receive fair compensation, ultimately increasing their stress. Several participants discussed that they are often caring for children whose families cannot afford to pay them more, or who cannot contribute to the costs of supplies (e.g., food, diapers, materials). One FFN caregiver shared:

"It's a funny thing that happens to me, because I almost always get single moms and I feel bad."

For these reasons, some FFN caregivers did not feel comfortable asking for more from their families. For example, one FFN caregiver stated:

"We as providers, at least myself as a home-based child care provider, do struggle because I usually work with families in great need of child care. So, I can't expect to receive a very high payment from them."

A few FFN caregivers also suggested that they avoid conversations around compensation entirely to preserve the positive relationships they have with families. One FFN caregiver summarized this sentiment by sharing that,

"There is a good relationship if we don't talk about prices."

When FFN caregivers did talk about entering into negotiations with families for adequate compensation, they often shared stories of failed negotiations. As such, many FFN caregivers acknowledged:

"This job is not well compensated."

However, many FFN caregivers remain in this field because they have chosen to prioritize families who really need this support, knowing that they could earn more in a center-based job. As one FFN caregiver stated:

"The need is greatest, and we, as home-based providers, know that we need more than what families can contribute financially to us."

Some FFN caregivers mentioned negotiating with parents on the cost of their child care services as critical to their balance of affording their needs while providing their services at a rate that families are willing and able to pay. One FFN caregiver shared her observation of each family navigating this negotiation differently, with variations in willingness to financially support their care, by describing that:

"Many people feel bad about paying what is fair, what it is, many say it is too much, [but] many say, 'Okay, I am even going to give you something extra so you can keep buying what you need,' but there is a little bit of everything."

A few FFN caregivers also mentioned that some of the families they serve are not financially capable of paying higher amounts for child care, and some of their families view the existing amount they pay for child care as already substantial. One FFN caregiver described this negotiation from a moral perspective by sharing:

"Who am I to force this family to pay me for something they can't afford to spend? And besides, the one who gets hurt is the child."

4. **When FFN caregivers are financially able, they may seek to enhance their quality of care**

   Regardless of their own economic situation, most FFN caregivers reported a strong commitment to providing what they could for the children in their care including basic necessities, materials, and activities. TPP funds helped facilitate this, as one FFN caregiver shared:

   "We keep buying the materials we need to continue working with the children in our care. That money [TPP funds] came in handy for me."

Strategies

Strategies are the activities of a program designed to achieve its desired goals. In this section, we describe each of the strategies in the TPP Theory of Impact and present evidence on their implementation in Colorado. In this section we describe data that provides evidence of the successful implementation of various programmatic strategies that are critically important for future implementation and informing policies and programs related to payment systems. The CIRCLE Framework emphasizes data collection and reporting around strategies to ensure that all elements of the Theory of Impact are supported by data and continuously improved.

TPP Participants were Recruited Based on *Eligibility Criteria*

TPP participants were intentionally recruited from communities most likely to benefit from a DCT and through a trusted source. In Colorado, all participants were recruited through five CBOs (Colorado Statewide Parent Coalition, Early Childhood Council San Luis Valley, Early Childhood Network, Valley Settlement, United Way Weld). CBO staff surveys showed that TPP participants were recruited via the following methods: electronic messages (e.g., email, newsletter), phone calls or text messages, and talking about the opportunity in person, both individually and as a group. Staff shared that FFN caregivers had a range of preferences regarding how they wanted to learn about TPP, and staff tried to accommodate all of them. Ninety seven percent of participants were considered low-income, as defined by 200% or less than the Federal Poverty Line.

Cash Transfers were *Unrestricted* and *Unconditional*

In accordance with best practices in DCTs, there were no restrictions for how the TPP DCT could be spent, as evidenced by agreements between each CBO and Impact Charitable. Similarly, DCTs were intended to be unconditional, meaning that there were no behavioral conditions for receiving the DCT (e.g., FFN caregivers did not need to attend trainings, respond to surveys, etc.). Every Colorado CBO in TPP had these two contingencies (unrestricted and unconditional DCTs) outlined in their Memorandum of Understanding (MOU) agreements with Impact Charitable.

Enrollment Incorporated a *Benefits Guide*

One of the important values of TPP was that CBO staff made all prospective applicants aware of potential impacts that receiving DCTs could have on their public benefits. Prospective participants were told that the increase in their income from TPP could reduce their eligibility for certain public benefits. In order to assist with this, CBO staff were instructed to use a Benefits Guide created by Impact Charitable and were referred to their respective benefits administrator for case-specific questions related to their benefits. All CBO staff shared that the Benefits Guide helped guide their conversations with TPP participants about the potential impact of DCTs on benefits.

CBO staff were asked to report whether any FFN caregivers chose not to participate in DCTs because their access to public benefits would be reduced or lost if they did so. Six staff replied "no," while 2 replied "yes." For the respondents who indicated yes, one staff member shared that 10 potential participants chose not to participate because of the benefits cliff.

Participants Found the Direct Cash Transfers to be *Accessible* & *Reliable*

TPP was intended to be accessible, meaning that the application, screening process, and delivery of DCTs were simple, easily accessible, and took no longer than 15 minutes to complete. TPP was also intended to be reliable, such that participants felt confident that the DCTs would consistently arrive, with little to no effort (i.e., no need to submit an invoice, provide paperwork, etc.).

The FFN caregiver survey revealed that 91.5% of participants felt that the application to sign up for the DCTs was simple and easy. Relatedly, 91.7% of participants reported the process of receiving DCTs felt effortless, on average over time. Unfortunately, the participants who did not find the process effortless did not complete related open-ended questions.

When CBO staff were surveyed about the application and enrollment process, they echoed what the SCEC team heard from FFN caregivers. All CBO staff surveyed indicated that they felt that FFN caregivers found the application and enrollment process to be simple and straightforward. They shared certain strategies that helped with the ease and accessibility of this process:

- "Texting them prior to let them know what documents I was going to need from them"
- "Building trust, having relationships, transparency"
- "Kept notes of what was needed and training videos handy"
- "Give myself the time to get to know and ask questions to people about their specific situations in order to help them more efficiently based on their individualized situation"

Regarding their own challenges with the enrollment process, most CBO staff said they did not encounter any challenges, but some shared that their greatest challenge was the collection of documents from participants. Two staff members also shared that technology was a challenge for them in some instances.

Once FFN caregivers started receiving their payments, they responded to a survey item about their confidence that their DCT would arrive consistently. Over 97% of FFN caregivers agreed or strongly agreed with this sentiment, on average.

Administrative Data from AidKit Demonstrates that Payments were *Frequent*, *Predictable*, & *Ongoing*

The amount of money delivered to TPP participants each month was intended to be sufficient enough to weather a financial shock or, when combined with earnings from caring for children, be above the current local reimbursement rate for child care. In Colorado, this amount was determined to be $500 per month, and this was reflected in all MOU agreements with the CBOs and Home Grown.

The question still remains as to whether $500 was sufficient, and the amount of cash delivered across future TPP implementation sites will continue to be an important point of discussion and inquiry.

DCTs were also intended to be frequent, predictable, and ongoing. Based on AidKit data, we confirmed that payments were delivered each month, on the 1st and 15th of the month, for 18 months.

In Addition to: Direct Cash Transfers were In Addition to CashPlus Resources

Home Grown designed TPP such that the DCTs were additions to services already being offered by organizations or within a community. In Colorado, CashPlus services consisted of mental health support and resource navigation. Additionally, the CBO partners provided professional development, training, navigation, and other support resources that were accessible to all TPP participants.

All focus group participants described how much they learned from their peer support groups, provided by TPP specifically. Participants described how much they learned from one another and the ways that this community contributed to their well-being. When talking about her colleagues from her peer support group, one FFN caregiver shared:

> *"These girls are my inspiration."*

A common sentiment among participants was also the ability to learn from what other FFN caregivers did to improve their own provision of care. One FFN caregiver stated:

> *"And little by little, we got to know each other more, and become more united. And sure, we respect each other, our privacy. As I said from the beginning, we don't judge. On the contrary. We learn."*

TPP was Cost Effective, as Defined by Less Cash Spent on the Program than to Participants Directly

Other DCT programs vary in the amount spent on non-cash costs. For every one dollar spent on DCTs, similar programs in Colorado range from $0.31 to $0.66 spent on non-cash costs (i.e., program administration, community-based partner support, outreach, payment platform and distribution, etc.). TPP in Colorado fell at the upper end of this range, with $0.66 spent on non-cash costs for every $1 in cash distributed. The larger the number of program participants, the lower the non-cash costs were, as the program efficiency increased significantly with scale. TPP in Colorado was relatively small compared to comparable programs which enrolled upwards of 800+ participants. Additionally, TPP was longer than comparable programs (18 months in duration versus 12 or 15 months) which increased costs. One-time cash transfer programs tend to

expend between $0.05 and $0.21 in non-cash costs per $1 in cash distributed, given that the period of administration and management of these programs is far shorter.

Targets

Targets are the direct results expected to follow after successful implementation of strategies. In this section, we present each of the Targets from the Theory of Impact, grouped by three broader categories: FINANCIAL, SOCIAL-EMOTIONAL, and ENGAGEMENT.

Financial

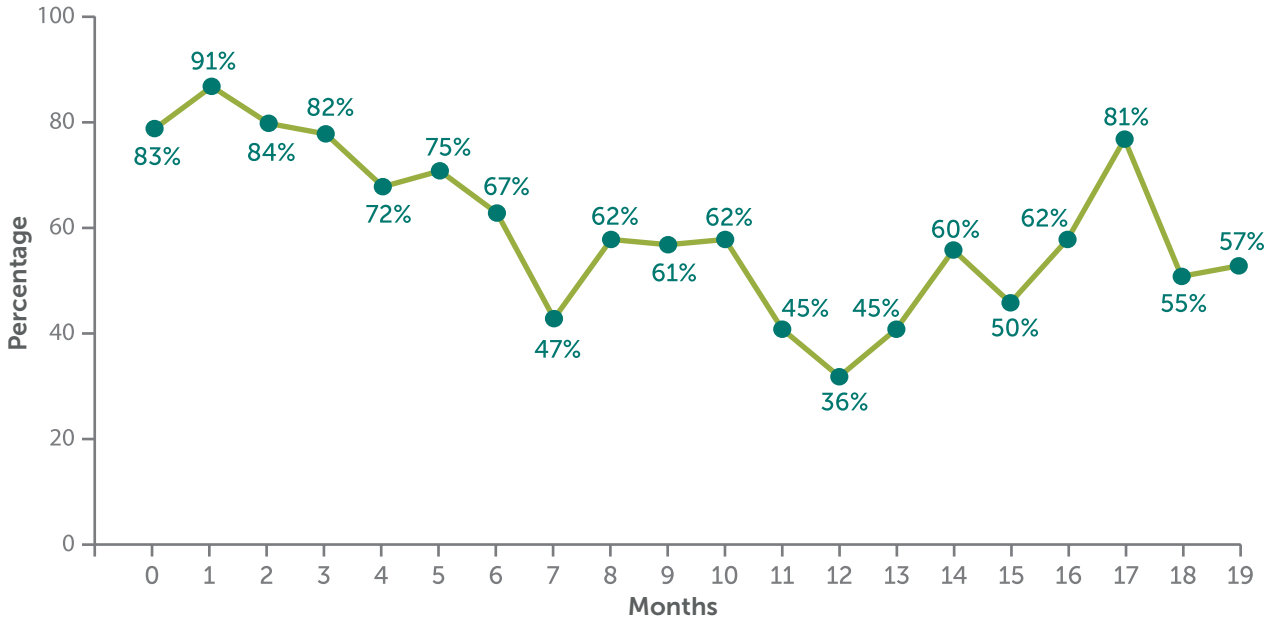
1. Decrease FFN caregiver *income volatility*

Each month of the survey, FFN caregivers were asked what happened to their household income in the prior month, using a 5-point Likert scale from "decreased very much" to "increased very much." Responses indicating a change were aggregated. While reported increases in income in the prior month were likely positive for FFN caregivers, these data provided insight into the fact that FFN caregivers' incomes were not steady over time (as shown in Figure 4 and detailed below), likely resulting in challenges related to budgeting and saving.

Before TPP began, 83% of TPP participants reported a change in their income the month prior. In the first 12 months of TPP, this percentage trended downward, indicating less income volatility over time (see Figure 5). In the final six months of TPP, FFN caregivers' reported income volatility began to increase. Given this pattern in the months leading up to the end of DCTs, we hypothesize that this change could have been due to FFN caregivers pursuing other sources of income to prepare for TPP's end.

LESSON LEARNED: One of the most documented impacts of DCT initiatives is reduction in income volatility (Maag, 2022; Neighly et al., 2022). Income volatility is defined as the variance of income or the amount of divergence from one's average income (Smith-Ramani et al., 2017). Other DCT studies have calculated income volatility manually using participant income reports. While the SCEC team intended to do the same, in the first several months of our survey, we consistently experienced very low response rates on the income report survey item. Survey participants would often complete all survey items, with the exception of the question about their income. Upon observing this phenomenon, we continued to improve this survey item, asking participants to select their income from a range of response options rather than report it in a free response item. Recently, we observed that, since we asked about overall household income (to allow comparison to federal indicators of poverty), we had to increase the upper end of potential response option amounts. We are using these learnings to improve our measurement of income volatility in future TPP sites. In the present report, we utilize other survey data that speaks to the construct of income volatility.

Figure 5. Percentage of TPP Participants Reporting an Income Change in the Past Month Across 18-months of TPP



Of particular note, when FFN caregivers who had experienced income fluctuations in the past month were asked to rate the extent to which they agreed with the following statement: "Over the last month, the direct cash transfer has helped me to manage fluctuations in my income," 82.1% agreed or strongly agreed.

Qualitative data also provided some evidence that the DCTs were helping to offset variability in participants' income. In an open-ended follow-up to the item about managing fluctuations in income, one FFN caregiver wrote,

> *"I feel relief knowing that I have that income assured, because what I receive for taking care of children varies greatly. Some days they come and others they don't."*

Several FFN caregivers echoed this sentiment in focus groups and open-ended responses, noting that their payment depended on unpredictable child attendance and that the DCTs helped them to weather the unpredictability in the profession. One FFN caregiver spoke to the sense of security that came from the steady payments, sharing that she was grateful for the program because,

> *"Sometimes with child care we have a very distorted income, I mean, weeks we have a little less coming in, other weeks more. And knowing that we had this monthly help was something that gave us peace of mind, that helped us to supplement our monthly expenses, because we all have different types of expenses, right?"*

2. Increase FFN caregiver *economic stability*

Economic Stability

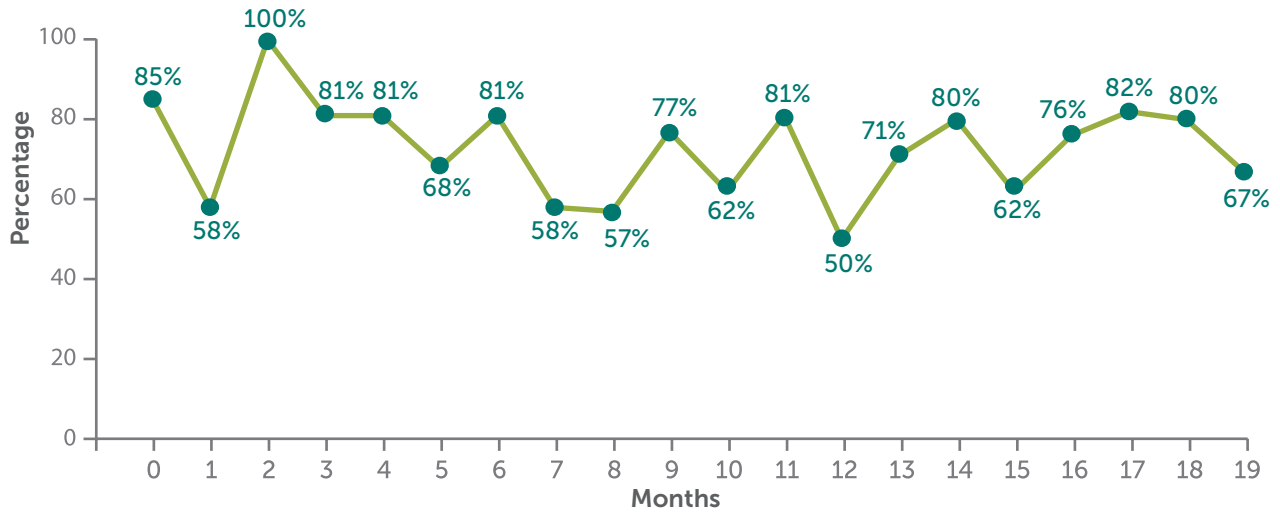
While related to income volatility, economic stability is a broader term that pertains to an individual's ability to access essential resources to live a healthy life. We explored TPP participants' experiences of both stability and material hardship.

When asked to rate the degree of stability that participants have in regards to their employment and housing, TPP participants' responses remained relatively stagnant over time. On a 4-point scale, with a 4 being "very stable," responses across both items ranged from 2.4 to 3.9. TPP participants reported the most stability in employment and housing during the final months of the initiative, though it is important to note that only Cohort 2 was part of the sample beginning in February 2024.

Material Hardships

As shown across Figures 6 through 8, patterns of change in different measures of material hardship over the course of TPP were complex and not always consistent or conclusive. Compared to a retroactive baseline of 85% of TPP participants finding it very hard, hard, or somewhat hard to pay for the very basics like food, housing, medical care, and heating, only 67% of FFN caregivers in April 2024 reported the same. As seen in Figure 6, reported material hardship levels also fluctuated from month to month, potentially indicating continued complexity in the financial situations of FFN caregivers despite the $500 monthly DCT and/or the insufficiency of this DCT amount for these FFN caregivers.

Figure 6. Percentage of TPP Participants Reporting Material Hardships Across 18-months of TPP



To better understand the volatile nature of this material hardships graph, we directly asked a group of TPP participants what might be explaining the fluctuations in their ability to buy basic needs on a monthly basis. These FFN caregivers spoke to the seasonality of income and expenses, noting that things like heating and utilities are more expensive in the cold months, and that sometimes their work, as well as their spouse's work, is seasonal in nature. One FFN caregiver said *"I think the graph could also go up or down because of the seasons the children we take care of go on vacation."* As has been reiterated throughout other data sources, these FFN caregivers also mentioned that in CO, *"prices were rising dramatically,"* putting economic strain on FFN caregivers, even despite the DCTs. One FFN caregiver mentioned that her rent increased, but she was not taking care of more children than before, so despite the existence of material hardships, *"the money helped [her] a lot."*

To further investigate material hardships, participants were continuously asked to select all of the basic needs that were hard to pay for in the past month for their family. In their retrospective baseline survey and each monthly survey, participants selected all that applied from the following list: food, housing, utilities (electric, water, trash, etc.), health care, wellness activities, and child care.

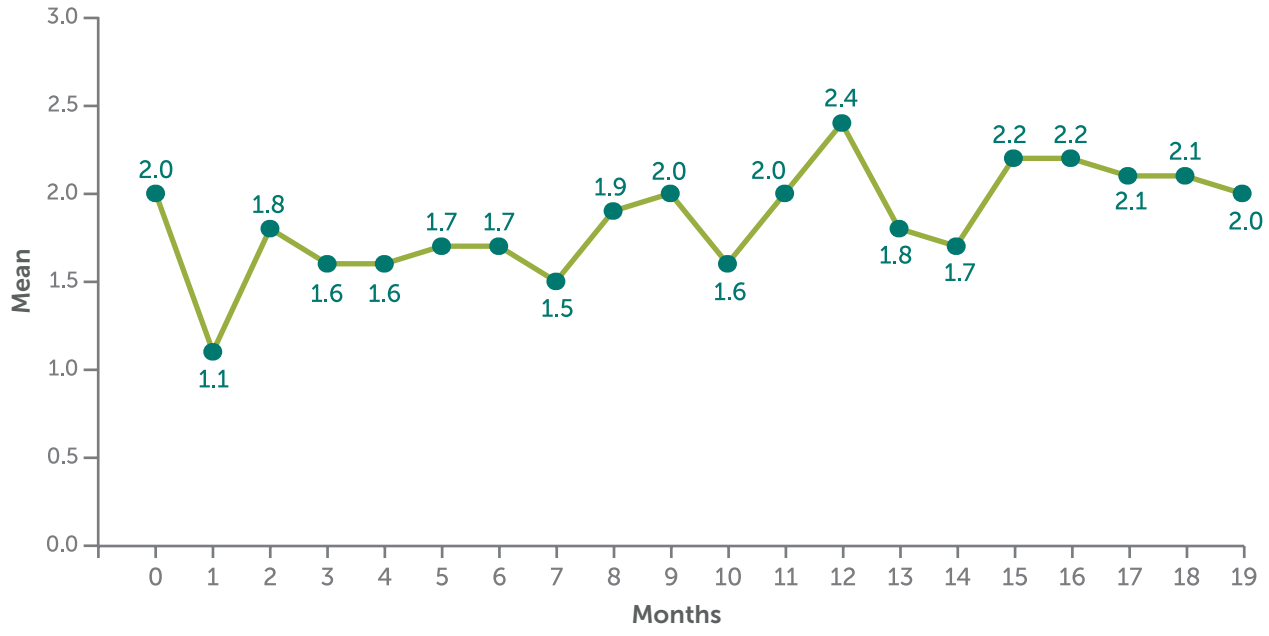
Changes in the mean number of hardships reported (i.e., ranging from 1 to 6 based on basic needs selected from the list above) over time were small and largely inconclusive (see Figure 7). Visual inspection of the data revealed an initial small but sustained decrease followed by fluctuations and a small sustained increase for the last 6 months of TPP.

In terms of reported material hardship types, changes over the course of TPP were mixed (see Figure 8). Housing was the most frequently selected material hardship pre-TPP, with nearly 40% of participants indicating that they found paying for housing to be a challenge. However, by April 2024, this number dropped to half of what it was, below 20%. TPP participants also reported low rates of material hardships related to child care. While child care continues to be a major source of economic stress for most Americans (Annie E. Casey Foundation, 2023; Bragga, 2022), our qualitative data analyses (*see Colorado TPP participants section*) revealed that many TPP participants entered the field of child care in order to care for their own children. In contrast, visual inspection of the trend lines for material hardship types revealed that healthcare and food material hardship both appeared to increase over the course of TPP.

Taken together, these inconclusive quantitative material hardship findings likely underscore the complexity of the financial reality of TPP FFN caregivers particularly in the context of a time-limited DCT program.

Qualitative analyses clearly revealed that participants used the DCTs to help afford basic necessities, such as groceries, housing, and medical bills. The overwhelming majority of FFN caregivers shared that they used the additional income to *"buy food for the month."* One FFN caregiver expanded upon this, saying that TPP "helps me to pay medical or

Figure 7. Mean Number of Material Hardships Reported by TPP Participants Across 18-months of TPP



grocery bills and it allows me to spend time with my children." In a similar vein, many participants also raised that cost of living increases have outpaced their wages, leading to financial stress. One FFN caregiver described,

> *"Everything has gone up, everything is very expensive, now even eating eggs is very expensive because you get scared when you go to the supermarket and with any little thing it is $100, $200. In other words, you go to buy a few things, the basics, what you need, so since everything has gone up so much, you get scared."*

Fortunately, some FFN caregivers mentioned that DCTs were particularly helpful given inflation and the rising cost of all basic household items, as one FFN caregiver summarized,

> *"Things are getting more expensive by the day and that [TPP cash] gives me peace of mind because I know I will receive it at the beginning and middle of every month."*

Saving

In addition to purchasing basic necessities, a few FFN caregivers shared that they were able to save more money each month thanks to the DCTs. One FFN caregiver said in a focus group,

> *"It was a great help because before I had not had the opportunity to save a little for my 18-year-old son who just graduated from high school. My big dream is for him to go to college. So, now I don't spend all of that money."*

Another FFN caregiver wrote in an open-ended survey response, *"I'm happy because I'm saving a little."* While a small number of participants spoke about saving, quantitative data from the exit survey revealed that only 13.3% of participants were able to save more money as a result of the TPP payments.

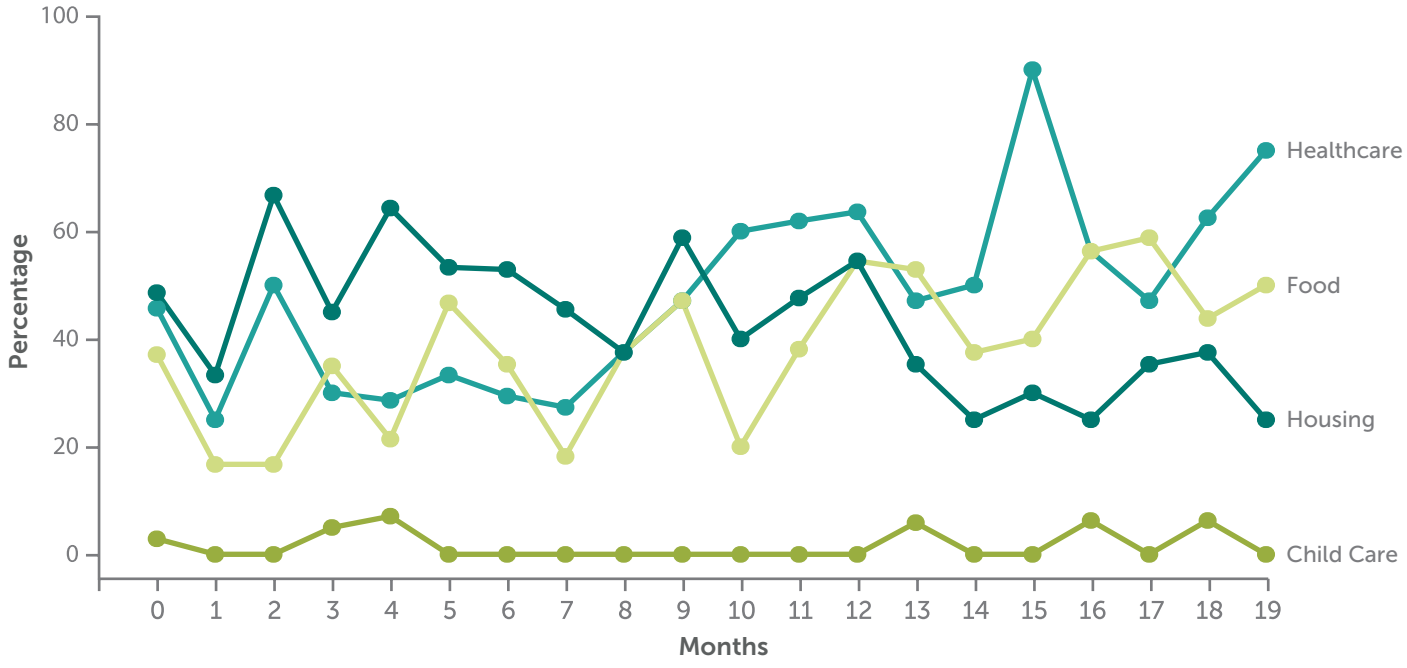
Exit survey data found that 100% of participants who engaged with the Savings Collaborative – a program offered at the end of TPP aimed at teaching FFN caregivers strategies to save money in their final months in the program – found it to be somewhat useful or very useful. In a focus group, one FFN caregiver articulated that this program was moderately helpful, sharing that,

> *"Currently, I am in the Savings Collaborative, I have one automatic debit per week and I think it has helped me a little bit."*

Some participants did articulate, however, that they lacked information on how to enroll in the Savings Collaborative or would have liked this resource to be available to them earlier on in their TPP participation.

> *"Well, in my case, I didn't participate. I think that maybe if it had been from the beginning, because they did explain the whole process to us, maybe I would have been able to. But when it*

Figure 8. Percentage of TPP Participants' Material Hardship Types Across 18-months of TPP



started, maybe I missed the first meeting, so after that, it was a little bit too late for me. The truth is, the biggest barrier was that we had so many expenses that I couldn't take out that little bit to save it."

While some FFN caregivers were able to save some money, there is a future opportunity for the Savings Collaborative to support more FFN caregivers earlier on so that they are empowered to save money throughout TPP.

Spending Patterns

FFN caregivers used their monthly DCTs to fund their own needs, as well as expenses related to the children in their care. The expenses that FFN caregivers used the TPP funds for include:

- Food for themselves, their families, and the children in their care, such as milk, snacks, or fruit;
- Toiletries and hygiene items for the children in their care, such as baby wipes and toilet tissue;
- Health care such as medical bills incurred from FFN caregivers' health difficulties;
- Transportation costs, such as paying car bills; and
- Utility bills for gas, electricity, and water.

One FFN caregiver described purchasing diapers to meet children's hygiene needs as a health issue for children who were sent with fewer diapers than they would need while in the FFN caregiver's care:

"It's very hard to see a child who only has two or three diapers for the whole day. I have three babies and I was almost always half full, but not anymore with this, I buy two boxes for each of my children and I bring an extra one in case I need it. That has been the main thing, the children's hygiene."

Food

The most popular theme from the qualitative data around food was participants using DCTs to purchase food for the children in their care. Most FFN caregivers said that they purchased food with the money, with several noting that they could buy higher-quality, healthier food for the children they were taking care of thanks to TPP. One FFN caregiver remarked,

"I have the security of the transfers and can offer good quality snacks, fruit and vegetables. This summer we visited the local farmer's market."

Another caregiver mentioned that she could buy a larger quantity of healthy food for the children she was taking care of, sharing that because of the DCTs:

"We no longer get only two strawberries because I used to buy the little box and give two strawberries to each one. Now I can buy two or three little boxes and give them more."

Social-Emotional

1. Decrease FFN caregiver stress and increase FFN caregiver well-being

As a result of the DCTs and additional psychological services provided to CO TPP participants, we posited that TPP participants would experience less stress and have improved well-being over time. Our measurement of these constructs evolved over time, in response to participant feedback.

Beyond the financial benefits of TPP, several evaluation participants expressed that the DCTs made them feel appreciated for their work taking care of children. One FFN caregiver stated that the program,

"Made me feel valued as a provider, and that it made me understand the importance of my job."

In addition, a few participants mentioned that this program made them feel a renewed sense of passion for their profession. When asked about the impact of the program, one FFN caregiver shared *"this motivates me more."* Another FFN caregiver reiterated this point by saying, *"I feel more motivated in my work."* One participant built on this by saying that the DCTs made her *"feel more comfortable and confident."*

Another participant spoke to the impact of the program on her cohort of FFN caregivers, saying that,

"It has helped us a lot because they have helped us, for example, to become empowered."

The following FFN caregiver quote illustrates how TPP made her feel seen, along with encouraging her to continue building her skills and support others in her profession as well:

"In this career with child care, when I started receiving TPP, I felt... very valued... I said if someone is thinking about me and my job, I want to train myself to do the best I can, to continue looking for resources for me and for the other providers around me."

The TPP participant sample consistently reported relatively low emotional distress symptoms compared to the RAPID national comparison sample (as shown in Figure 9 below). In the last six months of TPP, reports of emotional distress increased modestly for both cohorts; in their exit survey responses, about a quarter of participants indicated that *"The thought of the TPP cash payments ending makes me feel very stressed."*

In an advisory meeting in Spring 2023, we looked closely at the emotional distress scores of TPP participants compared to HBCC providers in the RAPID national sample. After noting the nearly 20-point difference in distress (TPP participants had much lower scores), we sought feedback from our provider consultants.

In May 2023, we heard reports that CO TPP participants might culturally be less likely to indicate their experiences of clinical-sounding mental health symptoms. In addition to stigmas around mental health in the Hispanic/Latino(a) community, participants explained to us that TPP participants are so grateful to be part of the program and would not want to sound as though they were complaining. In response to this feedback, we decided to add a new measure to the survey, the Warwick-Edinburgh Well-Being Scale. As opposed to the original items that framed well-being as the absence of distress, this scale simply asked about the prevalence of certain feelings and thoughts over the last 2 weeks. We found that, even when items were positively framed, TPP participants indicated high levels of well-being. This helped to bolster the reliability of the distress items that we continued to use in addition to the Warwick-Edinburgh Well-Being Scale. It is important to note, however, that reported energy levels (e.g., *"I have had energy to spare"*) and optimism (e.g., *"I have been feeling optimistic about the future"*) were the least consistent over time.

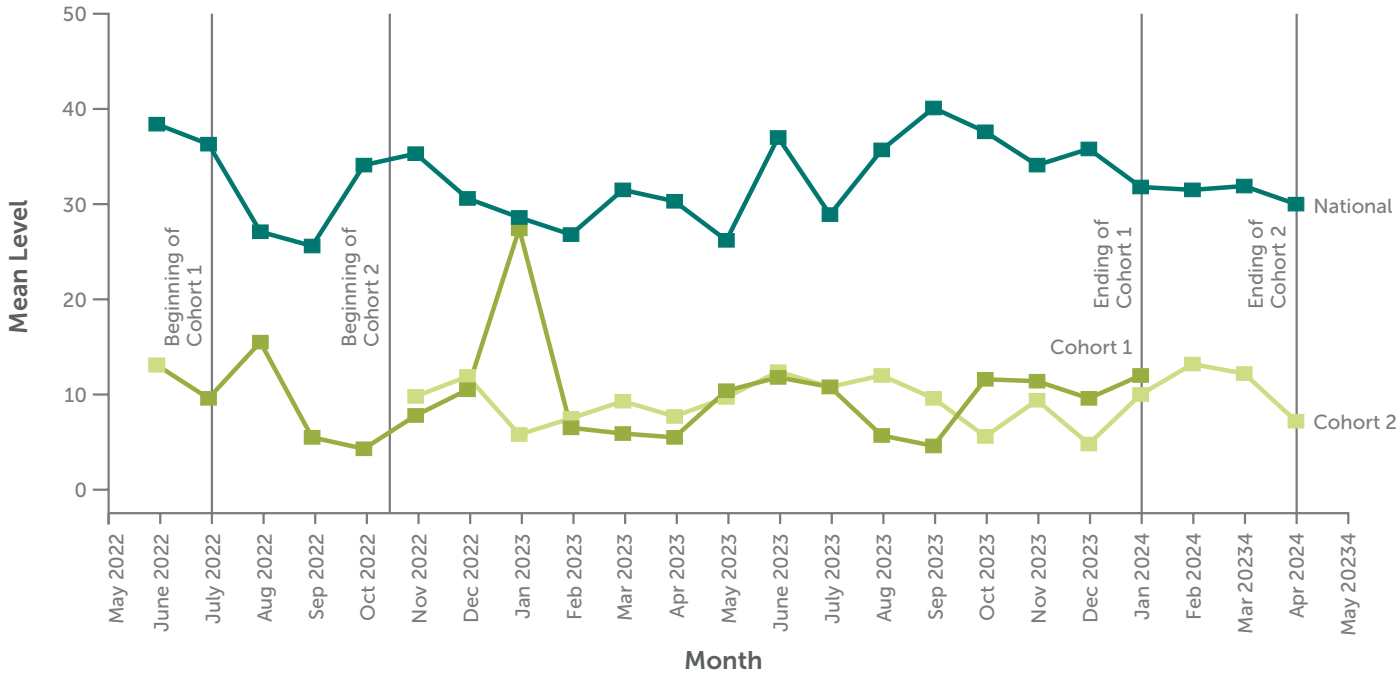
In addition to quantitative findings, it is important to mention that throughout the program, TPP participants qualitatively reiterated the fact that the monthly DCTs eased their stress and improved their mental well-being. In an open-ended survey response, one FFN caregiver said that the additional cash *"helps me not be so worried about expenses."*

Another wrote that because of the DCTs, *"I can have peace of mind about my financial situation."* This sentiment was echoed in focus groups, as one FFN caregiver explained that, *"knowing that money was there gave me a lot of emotional and economic stability."*

One FFN caregiver elaborated on the direct impact of the cash on her mental health in a focus group by sharing that,

> *"Sometimes my husband tells me 'stop thinking, stop thinking.' And I told him, 'I can't. It's something that is there'...but having this financial help was a great relief for me."*

Figure 9. Mean Level of TPP Participants' Emotional Distress Symptoms with RAPID National Comparison



Several FFN caregivers continuously articulated that this emotional stability also benefited the children they care for. One FFN caregiver summarized this sentiment, sharing at the end of a focus group,

> *"I believe that the work of a provider is not only taking care of children, we are raising them. And these children are going to grow. And much depends on our care, on our stability, both emotionally and economically as well as mentally, so that these children will be good people in the future, good citizens. So, thank you, and I hope this support can continue."*

The following quotes from two FFN caregivers signal that the temporary nature of TPP had an impact on their well-being:

> *"I tried to prepare myself to save some of the cash transfer, to use for resources such as going to get some food and continue to take care of the kids... We were getting a heads up and all the support."*

> *"We were all very sad because we were all counting on that money for rent, for food, for kids... So I was very sad... They helped us to kind of prepare ourselves for when it was coming to an end."*

For these two FFN caregivers, the end of the program was a hard adjustment – despite their preparation and offboarding support from their CBOs – because of how much these FFN caregivers depended on the DCTs to meet their needs.

2. Increase FFN caregiver sense of *community* / reduced isolation

Across all focus groups, participants shared what contributes to their well-being. As was discussed in the previous section, these FFN caregivers often described the peer support groups as an activity that positively impacted their mental health. Many participants shared feeling a sense of community in these groups, learning that they were not alone in their experiences. They also learned about meditating and the importance of prioritizing their own well-being. Several participants shared that they had a desire for this type of peer support to continue after TPP ends. Some even mentioned that they desired these continued supports "regardless of the [cash] bonus." One FFN caregiver captured the sentiment of several others in her focus group by saying:

> *"And I would really like [peer support groups] to continue, so that you can keep helping us with our doubts, and with the emotional support, as it's really nice to be here."*

The majority of participants expressed that the peer support groups did not only benefit them professionally, but also benefited them emotionally. One caregiver stated that,

> *"The job is also like very lonely...those meetings helped me to take care of myself, to get away a little bit, to relax and to have that time for me. It was very good."*

Many participants additionally expressed that the emotional support in these groups went beyond just formal sessions on self-care, with one FFN caregiver saying,

> *"I imagine that all of us at some point have suffered from those lows of depression. This project is very helpful; it helps us a lot. Although sometimes we have already talked about it in training, when I talk with my teammates I say, 'I am not the only one going through problems or difficulties.'"*

One FFN caregiver reiterated that the peer support groups helped her handle the loneliness of caretaking; after sharing a list of challenges in the field, she said,

> *"But when I listened to my classmates, I said to myself, 'but it happens to them too. It's not my fault. It happens to all of us.'"*

In short, a common sentiment was that the TPP supports made participants feel that they had a network to rely on; as one FFN caregiver stated,

> *"It made me feel like there was someone, or many people, who supported me."*

Engagement

1. Increase in FFN caregiver engagement in ECE sector supports/uptake of services

Administrative data from Impact Charitable indicates that it is likely that many TPP participants were connected to ECE sector supports and services throughout the course of the program by peer navigators employed by Impact Charitable. Between October 2022 and November 2023, peer navigators held 102 peer support groups for TPP participants. Peer navigators made hundreds of referrals throughout the program to a vetted list of services in the

community. Each referral included a warm handoff with a specific contact from this list of services/organizations. The most common referrals were for training and professional development (270), resources such as clothing and rental assistance (227), nutrition training and food resources (221), and early childhood education events and programs for young children (212).

While we do not have data about uptake of referrals, the qualitative data demonstrate that several participants spoke highly of the experience of receiving referrals through TPP. Focus group participants shared that they were more "motivated" and "feel more capable" to take advantage of resources in the community. One participant was particularly effusive when describing her experience of being more connected to more resources:

> *"I really liked the self-care, and also that led me to meet more people and meet more resources, learn about more resources that could serve not only me, but more people. I always say that one thing leads you to another, and another to another thing, and to know so many resources that exist and you don't know about, I really liked that, and it was very useful for me, to be able to learn from other people and other organizations, to connect with other people. That helped me a lot, it helped me a lot."*

Another core theme among qualitative data was participants' commitment to growing their knowledge as child care providers and spending TPP funds on additional professional development opportunities. Nearly all participants described their deep commitment to providing quality care by references to seeking out child care-related classes, getting licensed, and engaging in the non-monetary supports offered through TPP. With their growing knowledge of child development, several FFN caregivers reported implementing these principles into their businesses, sometimes at their own expense. For example, several participants learned that keeping group sizes small, purchasing materials and food, and participating in additional training could improve the quality of their services, and these participants also reported implementing these practices even though doing so could impact their financial well-being. One FFN caregiver shared:

> *"And since [training], I don't look after so many children now because I can't. It's better to have fewer children but to offer them more quality."*

In addition to purchasing tangible items and services, several FFN caregivers specifically mentioned using the TPP funds to pay for their professional development. Notably, one FFN caregiver said:

> *"The first investment I made with that money was paying the CDA certificate."*

Many FFN caregivers also shared that they had a desire to keep learning and improving their care-taking abilities in the future. When asked whether she had any questions about TPP, one FFN caregiver responded,

> *"The only thing I would like is information about any upcoming courses that we can take. The more knowledge we have about everything related to children, the more it benefits us. It greatly contributes to the work we do."*

Of particular note, several FFN caregivers expressed that TPP's financial assistance gave them the time and financial security necessary to engage in professional learning. In an open-ended survey response, one FFN caregiver wrote,

> *"I'm more relaxed regarding my expenses and payments and I can give myself time to take a class."*

Another shared,

> *"the money has helped me to...invest my time in training."*

When asked about the impact of the program, a focus group participant remarked that the money has continued to impact her professional trajectory; she stated that TPP has,

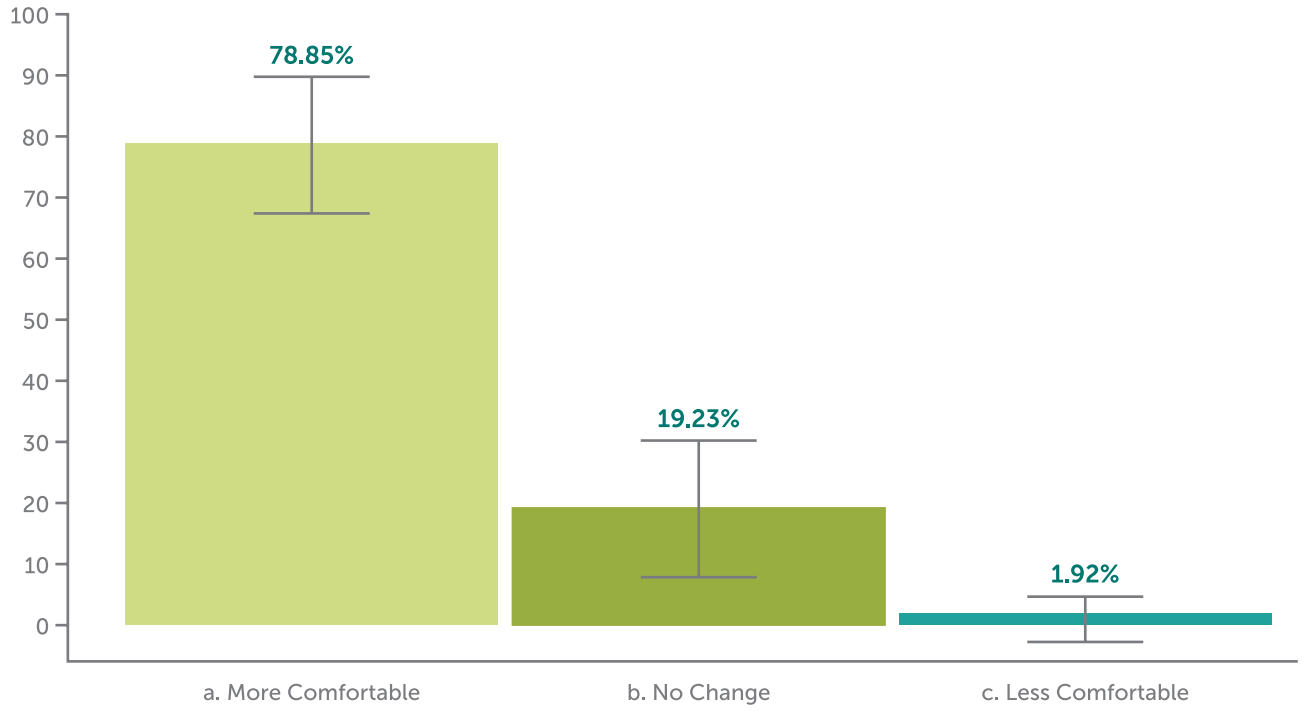
> *"Helped me to want to keep updating myself as a provider, to keep informing myself and to keep taking courses to give the best of myself."*

2. Strengthen FFN caregiver connections to community-based organization

Nearly 80% of participants felt more comfortable seeking assistance from their CBO after being enrolled in DCT and receiving the funds (see Figure 10). About 20% of participants noticed no change; these individuals may have begun TPP already having close relationships with their CBOs.

While interpreting this finding, we draw on relevant literature from international contexts. In 2010, the Tanzania Social Action Fund began a randomized, locally-managed conditional cash transfer program. Data from this study revealed that cash transfers increased participant trust in leaders and perceptions of leaders' responsiveness and honesty (Evans, Holtemeyer, & Kosec,

Figure 10. Percentage of TPP Participants Comfortable Seeking Assistance



2019). Though we did not ask specifically about these constructs in our study, it is reasonable to assume that they are related to feelings of comfort seeking assistance.

Outcomes

Outcomes are the broader, or more distal, goals that we anticipate as a result of program strategies and targets. In this section, we present findings related to outcomes in the TPP Theory of Impact, organized into four categories: WORKFORCE, QUALITY, FAMILY BENEFITS, and POLICY & PUBLIC SYSTEMS.

Workforce

1. Decrease *attrition* of FFN caregivers

In monthly surveys, 27.9% of FFN caregivers reported that prior to the DCTs, they considered leaving their job as a child care provider due to economic concerns. Qualitative data also captured similar sentiments, as one FFN caregiver shared how she almost left the field of child care, particularly with the financial strain of the COVID-19 pandemic by stating:

> *"In my experience, I was about to stop doing child care, because my husband lost his job, he found a new one, but he wasn't earning the same amount of money. So, I had to help him with what I was making with child care. Before that, there was Covid and we had a rough time financially speaking. Honestly, I was about to quit doing what I like, which is to care for children. But when TPP came out, I was very motivated. And I repeat, I'm very grateful."*

Another FFN caregiver shared a similar sentiment of nearly having to leave the field due to economic reasons:

> *"Last year I had a very difficult time financially, which is why I was at the point of leaving my job as a childcare provider. Because of TPP, I continue to work in what I like."*

2. Maintain the *supply* of child care

Increasing the supply of child care is dependent on keeping current HBCC providers in the workforce. TPP survey findings revealed that 74.4% of participants reported that they felt confident they would be able to stay in the field of child care while receiving DCTs, and 83.7% of participants agreed with the statement "receiving DCTs has allowed me to remain a child care provider."

Financially, TPP helped many FFN caregivers continue to care for children, as evidenced by the following FFN caregiver quote:

"I like my job, supporting children, and with the monetary transfers it is easier to continue caretaking because I have enough to cover the expenses of my nursery."

3. Increase continuity of care

In their final exit survey, participants were asked to rate their likelihood of continuing to work in the field of child care for the foreseeable future (even after cash payments ended), and 78.6% of respondents indicated likely or very likely.

Another key indicator of FFN caregivers' ability to maintain their continuity of care was their ability to forgo second jobs while receiving DCTs. Second jobs may limit a FFN caregiver's ability to provide uninterrupted, continuous care to children. In qualitative data, several FFN caregivers indicated that the cash from TPP prevented them from having to seek out additional part-time employment. One FFN caregiver stated,

"Just at the time that I started receiving the TPP everything changed: my husband's job changed, everything went up a lot. So that [TPP] helped me to stay. Because I was looking for another job because, the truth is, with the little they paid us in child care, I couldn't help my husband at home. When I started receiving the TPP, not only did I stay, as my colleagues say, but it also helped me to pay for the most essential expenses."

Another FFN caregiver said that she did not have to seek out supplementary income because of the program, sharing that,

"It has helped me with my bills without having to go out and work beside doing daycare."

One FFN caregiver reiterated this, stating in a focus group that because of the monthly cash,

"I don't have to work elsewhere. I'm not stressing out so much about monthly bills."

Quality

1. Responsiveness of care offered to children

We acknowledge that quality in early childhood care is difficult to define, particularly in HBCC settings. As such, we do not seek to define quality as part of this evaluation. Rather, we are interested in several factors that contribute to overall care quality: responsive care actions and attentiveness to/engagement with children. It is important to note that in accordance with the values of TPP, we trust and value participants' self-reports of their own care actions.

Participants were asked to indicate in the last 30 days, how often they engaged in the following activities as a child care provider (Never / Rarely / Often / All the time):

- I create activities that build on the child/ren's interests (activity)
- I read to the child/ren (read)
- I sing to the child/ren (sing)
- I tell stories to the child/ren (stories)
- I prevent challenging behaviors (challenge)
- I engage in a back-and-forth exchange with the child/ren's verbal and nonverbal communication (exchange)

Since the onset of TPP, we saw a modest increase in TPP participants' reports of engaging in responsive care actions, including singing to children (see Figure 11), an activity that has been associated with relational closeness and social bonding (Fancourt & Perkins, 2018; Pearce, Launay, & Dunbar, 2015). However, there was also a fair amount of variability in these responses. Of note, this variability confirms our trust in caregivers' self-reports, as participants did not select the most socially desirable indicator of 'all the time' each month.

Several FFN caregivers also qualitatively shared stories that demonstrate their high level of attunement to the emotions of the children in their care. One FFN caregiver asked the following:

"But well, either way, we do it to make our time with the children more enjoyable, to keep them occupied, and to engage them in productive activities. It's like showing them that we care about them, right?"

Participants shared conducting activities ranging from educational activities such as reading sessions in the library, to play-based activities such as LEGOs, to essential care such as cooking for, feeding, and bathing the children. FFN caregivers in focus groups also talked about playing outside and going to the park. Many references were made to technology and not wanting children to sit in front of a screen. Specific skills like fine and gross motor skills or sensory work were planned in addition to wellness activities such as breathing exercises. Participants frequently referenced TPP money when discussing their care activities, with one FFN caregiver sharing that they,

"Have used the money to buy materials, to go out with the children…not only do we benefit, but the children benefit as well."

It is also important to note that many FFN caregivers attested to using the DCTs to buy educational materials for the children in their care. One FFN caregiver summarized the range of materials she was able to purchase with the cash, writing in a survey response,

"I've been able to buy toys, carpets, I've been able to buy colors, little things for activities, snacks. It has been a great support."

Several participants shared that DCTs enabled them to buy materials that are necessary to provide the high-quality care that all children deserve. The following quote from one FFN caregiver demonstrates how she used the DCTs to invest in her professional development to improve the quality of her services and, accordingly, felt more equipped to engage in trauma responsive interactions with the children in her care:

"With this same income, I took another class where I learned how to [identify] language from the little kids when they have struggles to communicate. So I felt a lot of support, less stressed definitely."

Beyond purchasing materials and participating in trainings, some FFN caregivers also shared that the DCTs enabled them to spend more quality time with children. A few FFN caregivers shared that the DCTs enabled them to spend more hours taking care of children since they were not worried about seeking out other sources of income; one FFN caregiver stated,

"Well, I feel less financially pressured and have more time available with the children."

Another FFN caregiver mentioned that,

"Because of the money received, I can have more time available for childcare, and if a family has financial problems I can help. With my pay I can wait."

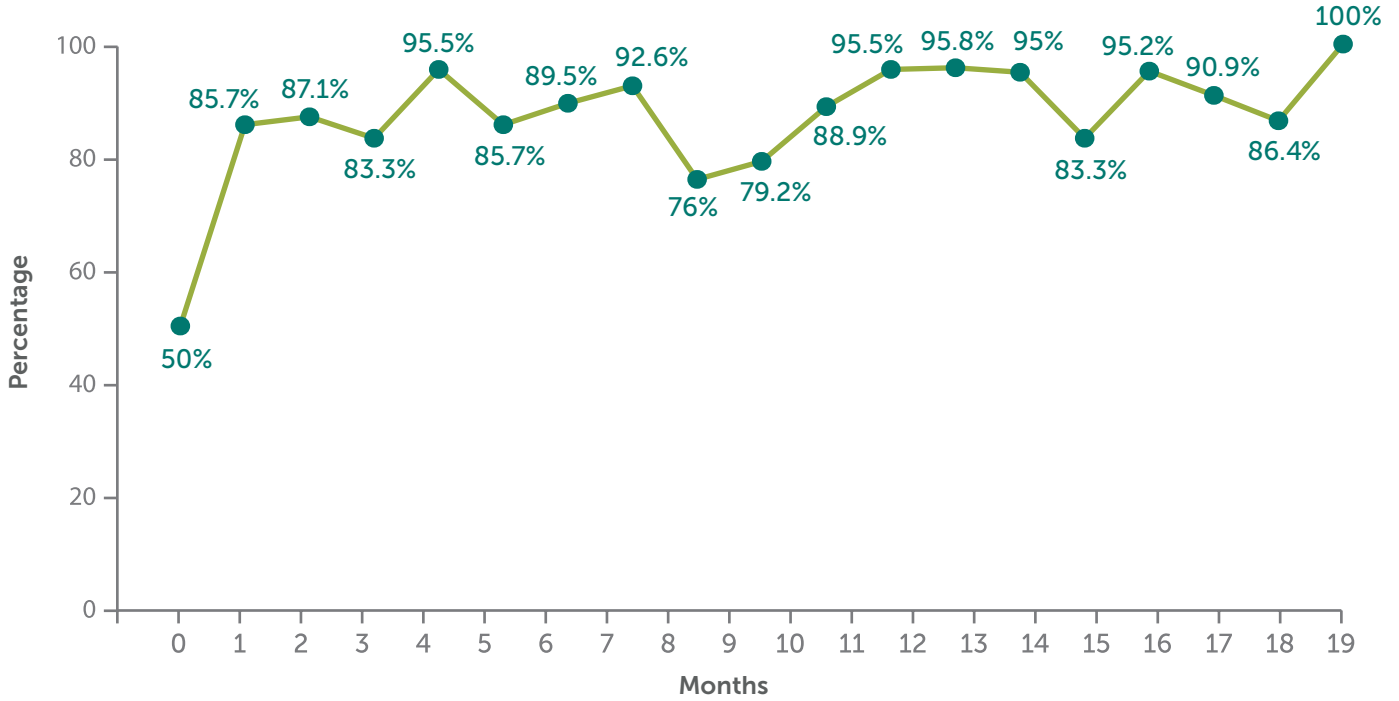
Many FFN caregivers spoke to the emotional impact of the cash and how it allowed them to be more present with children. As one participant remarked,

"It made a big difference in me for the care of the children, it kept me calmer, more relaxed, and that is reflected in the care of the children."

Another FFN caregiver underscored this point, sharing that,

"I do my job with more enthusiasm knowing that someone cares for me financially."

Figure 11. Percentage of Participants' Singing across 18-months of TPP



Finally, a participant summarized the impact of the cash by saying,

> *"I feel less stressed and more 100 percent with the children."*

In summary, TPP DCTs enabled some FFN caregivers to purchase more learning materials, access professional development opportunities, and to be more calm when caring for children.

Family Benefits

1. Increased stability of parental/caregiver employment & improve parent/caregiver well-being

Given the challenges that the SCEC team encountered regarding parent/caregiver response rates (refer to the recruitment section for a detailed explanation of these methodological challenges), we were not able to conduct longitudinal analyses of their survey responses. However, we are able to report on descriptive data that provides a picture of the parents/caregivers whose children received care from FFN caregivers enrolled in TPP.

Of the 20 parent/caregiver respondents, 94% identified as Hispanic/Latino(a) and female. The majority of respondents (71.4%) indicated that paying for basic needs was hard, with healthcare, housing, and food as the top rated material hardships. Twenty percent of parents/caregivers noted child care as a material hardship. Parents/caregivers also reported income volatility, with less than half (42.9%) sharing that their income stayed the same from month to month. While nearly three quarters (71.4%) of participants reported being employed, 40% felt that their work schedules were only "somewhat predictable" or "not predictable." The vast majority (91.1%) of parents/caregivers reported that their housing situation was stable or very stable, and 70% of respondents indicated that their weekly income from all sources was over $500.

Existing literature supports the link between reliable access to child care and parent/caregiver well-being. In a 2023 study conducted by the Harris Poll of over 2,000 parents in the United States, 55% said that piecing together enough child care coverage is a significant source of stress, and 88% of respondents said that consistent, high-quality child care would improve their mental health. Another interesting study using child care cut-off rules to determine causality in Germany found that access to child care strongly increases the life satisfaction of mothers (Schmitz, 2020). With learnings from Colorado, we plan to capture parent/caregiver experiences over time in future TPP implementations to gather evidence for this link within TPP.

1. Improve child well-being

While we added several items from the Positive Behavior Scale to the parent/caregiver survey, we did not have enough responses to analyze these data. However, it is important to note that many of the targets and outcomes described in earlier sections of this report, particularly around quality indicators, are likely related to child well-being. In the field, there has been increasing attention to understanding how early childhood educator well-being is related to child well-being and related outcomes. Researchers at UNC Greensboro found that children in classrooms of teachers who can pay for their basic expenses exhibited more positive emotional expressions and behaviors than children in classrooms of teachers who cannot pay for their basic expenses (King et al., 2015).

Policy & Public Systems

1. Policy changes that impact FFN caregiver payment systems

As a policy demonstration project, the ultimate hope of TPP is to serve as a reference for policymakers and public investments regarding what happens when FFN caregivers are financially supported. By sharing key findings and lessons learned with key stakeholders in Colorado and at the national level over the past year and a half, TPP has meaningfully contributed to the home-based child care policy landscape.

Most recently, in March, the US Department of Health and Human Services enacted the 2024 Child Care and Development Fund (CCDF) Final Rule, which included many of the core strategies of TPP as summarized in Home Grown's submitted comments on the rule. Specific elements of the federal legislation include that states must pay providers prospectively for child care services, pay providers based on enrollment rather than attendance, use grants and contracts to create payment predictability for providers, and use narrow cost analysis when determining payment rates. Each of these requirements is in line with TPP's predictable, reliable, ongoing, and sufficient direct cash strategies. Of particular note, TPP's tested methods of delivering cash in a way that FFN caregivers found to be accessible and easy may prove useful to states as they work to be in compliance with the CCDF Final Rule.

Within the local Colorado context, policymakers and advocates have utilized TPP learnings to inform several

important policy discussions to improve the financial well-being of FFN caregivers. One local leader in this space, Miguel In Suk Lovato from the Donnell-Kay Foundation, shared that,

> *"TPP has helped us tell the story of how financial supports ultimately are having an impact on FFN providers' ability to do their work, provide care, in a much better way, a much less stressful way and is recognizing that FFN providers – unlike other child care providers in licensed settings – lack access to subsidies and some of the financial supports that we see in the licensed care space."*

Specifically, in an interview with the SCEC team, Mr. Lovato referenced three areas of ongoing policy advocacy in Colorado that build on the work of TPP and relate to the findings of this evaluation study: 1) Colorado House Bill 24-1312: State Income Tax Credit for Careworkers, 2) access to the federal Child and Adult Care Food Program (CACFP), and 3) access to the Colorado Child Care Assistance Program (CCCAP).

First, in Colorado's most recent legislative session, policymakers enacted House Bill 24-1312, a State Income Tax Credit for Careworkers, in which FFN caregivers, regardless of documentation status, will be eligible to receive $1,200 annually. TPP served as a model for the trust-building that CBOs will need to continue to do to ensure that FFN caregivers are aware of this opportunity and supported as they file their taxes.

Second, child care advocates in Colorado are using TPP data – around FFN caregivers using their DCTs to provide nutritious food for the children in their care – to continue advocating for increased access to the federal CACFP. This program provides reimbursement for healthy meals and snacks served to children and adults in care settings across Colorado. Currently, to receive reimbursements, FFN caregivers have to become "qualified exempt" and then apply for CACFP specifically. TPP findings have reiterated that food, for themselves and the children in their care, is a top priority for FFN caregivers. As such, there is work happening in Colorado, and other states, to make accessing CACFP funds more direct and less burdensome.

Lastly, Colorado advocates are investigating FFN caregivers' low uptake of the state's federally-funded child care subsidy program, the CCCAP. Colorado currently has a process in which FFN caregivers do not have to become licensed, but rather can become "qualified, license-exempt providers" to access CCCAP funds. Despite this alternative to licensure, very few FFN caregivers access these federal dollars. As such, stakeholders in Colorado are digging into this issue of low take-up of resources to see what the best policy solutions may be. TPP provides evidence that ease and trust are paramount when creating policies to ensure that FFN caregivers are actually receiving the financial resources for which they are eligible.

In addition to interviewing Mr. Lovato, the SCEC team also directly asked a subset of TPP participants what policy changes and improvements they want for providers and caregivers. Multiple FFN caregivers underscored the importance of amnesty for FFN caregivers who are undocumented, with one voicing,

> *"I would like that providers like us, that [there] would be amnesty... so providers who don't have status... can be legalized. That would be wonderful, because we have in our hands the future of the entire country, so I believe we deserve it."*

In this participant's view, a pathway to citizenship is an important way of recognizing and valuing the work that HBCC providers do to provide essential services for children and families and of contributing to HBCC provider economic stability and growth through federal-level immigration policy change.

2. Increase FFN caregiver participation in public systems

Many CBOs were involved in helping eligible individuals and families apply for public benefits. As such, it was posited that by improving FFN caregiver and CBO relationships, FFN caregivers would also engage more with their CBOs, ultimately increasing FFN caregivers' use of public or employment benefits. However, it should also be noted that by the end of TPP, many FFNs still did not have access to or were not eligible for certain benefits that licensed providers have access to, as discussed in greater detail in the TPP Policy Scan.

In analyses looking at participant responses over the course of TPP, we calculated the percentage of survey respondents who ever reported having benefits and those who reported not having benefits. While 65% of respondents reported never receiving public benefits, 10% reported having benefits since before TPP, 17.5% reported newly receiving benefits during TPP, and 7% reported losing benefits over the 18 months of TPP. We

do not know if these lost benefits were a direct result of the DCTs or other financial changes in the lives of these participants.

Of participants who report receiving benefits, the vast majority referred to benefits related to health or medical services. This is notable, as HBCC providers are far more likely to not have medical insurance, compared to center-based providers and K-12 educators (Gotfredson, 2023; Rudich et al., 2021).

When asked specifically about child care subsidies (e.g., CCCAP and CACFP), there were slight decreases in participants indicating that they did not know what these programs were. However, there were not noticeable increases in engagement with these benefits. Similarly, it is not evident yet in the data that TPP increased FFN caregivers' use of benefits more generally, though 20% of FFN caregivers in their exit survey felt that being connected to their CBO would allow them to enroll in public benefits that are available to them. Therefore, the actual engagement with benefits may be a more distal outcome or require additional intervention.

To better understand engagement with public systems, the SCEC team asked a subset of TPP participants what would encourage them to use benefits. One FFN caregiver shared that she was initially in disbelief about the DCTs because *"who's gonna give you $500 a month?"* The fact that the support from TPP came through on a monthly basis made her feel less skeptical about financial supports for FFN caregivers, as she shared,

> *"After this experience... I would definitely be able to reach out for public benefits."*

Another FFN caregiver shared that TPP helped mitigate the fear that she and other immigrants experience around getting a driver's license,

> *"Right now I have a license. That's something that before, I was afraid of doing... I believe I grew in so many ways. Like another colleague of mine said, you're so empowered."*

Although the DCTs through TPP are not financial assistance provided by the government, these FFN caregivers' experiences speak to instances of the initiative meeting its intended outcome of increasing FFN caregivers' trust and participation in public systems with regard to benefits as well as routine tasks. It is clear from our conversations with Mr. Lovato and FFN caregivers that barriers related to immigration status are especially critical for policy advocates in Colorado and across the country to consider in their ongoing work to ensure that all HBCC providers, regardless of licensing, receive the financial support they need.

Limitations and Caveats

The following limitations and caveats are relevant to the interpretation of our findings and the strength of the conclusions we can draw from them. First, as noted in the Methodology: Research & Participants section, not all TPP participants opted to also participate in the evaluation; therefore, what we present here represents the experiences of those TPP participants who consented to participate in the evaluation (e.g., 54%) and may or may not be consistent with the experiences of those who did not opt in to the evaluation. It is possible that these two groups (i.e., TPP participants who opted into the evaluation and those who did not) are different on meaningful dimensions such as their demographic characteristics and/or their experiences of TPP, but we cannot assess these differences with our current data. We note in the following section important learnings from TPP in Colorado that we have already and will continue to apply to future sites to increase participation in the evaluation.

Second, due to the nature of the rapid-cycle monthly surveying approach, a somewhat different set of TPP evaluation participants completed the evaluation survey each month. This varying participant base likely contributed to the noise seen in the quantitative data reported above. Again, learnings described below will be implemented in future sites to ensure a higher and less variable amount of participation from month to month.

Third, though the RAPID comparison sample was matched on key dimensions to the extent possible, this sample was still quite different from the TPP sample, particularly in that it consisted of 30% FFN caregivers compared to 97% of the TPP sample. These differences do reduce the utility of the sample as a pseudo-control group for this particular TPP implementation. However, as provider types vary from TPP site to TPP site, this comparison to RAPID survey respondents will continue to provide important context when methodological limitations are appropriately acknowledged.

Fourth, the divergence between terminology used to describe FFN caregivers in research contexts and how these caregivers self-identify added additional complexity

and challenge to interpretation of our results. TPP participants did not always self-identify as FFN caregivers though this identification may have been appropriate from the perspective of the field's definitions. We have attempted to balance readability and interpretability of our findings with honoring participants' self-identifications and acknowledge that this terminology is a nuanced issue within the field of ECE.

Conclusions

Lessons Learned for Future TPP Implementations

The first pilot of TPP provided countless opportunities for learning and improvement for future iterations of TPP implementation. As we worked to plan the roll out of TPP in Philadelphia and New York City in Spring of 2024, we relied upon many critical takeaways from implementation in Colorado.

Our first observation was that **provider consultants** are an essential part of the evaluation process. Our provider consultants continuously gave the SCEC team an inside perspective on what was working and what was not working for evaluation participants. For example, we learned that participants preferred a different Spanish translation for certain items to increase clarity and that we needed to add more examples to the preamble of survey modules. We also received invaluable feedback on how to recruit for the evaluation and encourage continued participation. We recommend that all future TPP evaluations, and all evaluations with HBCC providers more broadly, include provider consultants.

Over the past 18 months, we have reflected on how to **increase participation** in the evaluation, both initial consent and ongoing survey completion. During the initial application and enrollment periods, it is critical that CBO staff have trusting relationships with participants and that the "why" surrounding learning and evaluation is clearly communicated to participants. To facilitate the communication around the evaluation in future sites, we created additional recruitment materials in both Spanish and English: an introductory video, an FAQ document, additional training materials for CBO staff, kick-off events for evaluation enrollment, and a new texting platform. Through these channels, the SCEC team seeks to convey the following sentiments to participants: TPP is a first-of-its-kind direct cash transfer initiative; we have a lot to learn; we hope to expand support for HBCC providers; policymakers look to data when making decisions; and we want to amplify HBCC providers' lived experiences.

In a similar vein, low response rates with the **parent/caregiver surveys** presented an ongoing challenge throughout the 18 months of TPP implementation in Colorado. Between September 2022 and December 2023, we received 20 parent/caregiver surveys (15 baseline, 5 follow-up). We continuously workshopped different recruitment strategies, including sending mail fliers (English and Spanish) to FFN caregivers' homes to inform parents/caregivers of the opportunity, increasing the compensation rate for survey completion from $5 to $20, and employing provider advisors and peer navigators to help spread the word. Ultimately, we heard from FFN caregivers that their parents/caregivers were not accustomed to completing surveys and would likely be more engaged with qualitative data collection formats. As such, when looking ahead to TPP in Philadelphia and NYC, we are working with provider advisors to plan for parent/caregiver focus groups to collect qualitative data.

Lastly, our experiences troubleshooting **survey and payment technology systems** through this pilot will serve us moving forward. For example, early in the evaluation process we learned that a mobile phone provider was blocking text messages from Qualtrics for several participants. In response, we shifted all participant text messages to Google Voice. For Philadelphia and NYC, we are using a new text messaging platform that works directly with Qualtrics. We also learned that some participants struggled with how to redeem their electronic gift cards. To ensure proper and accessible compensation, we worked closely with our third-party contractor to revise the instructions and increase language accessibility for Spanish-speaking participants.

Key Takeaways

TPP was born in response to the economic hardships of HBCC providers highlighted by the RAPID national survey, with the goal to bolster this critical but underpaid workforce and engender policy shifts around stable, increased compensation. The first implementation of TPP in Colorado was a success in many respects. As one TPP participant poignantly summarized, *"many people will think that $500 is very little, but it really was such a huge help."* Quantitative data revealed that while TPP may have had some impact on FFN caregivers' financial well-being, the experiences of FFN caregivers are complex

and not always consistent. It is important to note that while the impact of DCTs on participants' lives cannot be understated, it is unreasonable to expect them to solve for all deep-rooted structural and financial inequities that FFN caregivers face.

The SCEC team is eager to continue to refine, learn, and improve how we both collect data and also listen to FFN caregiver participants about our evaluation processes, and we are encouraged by these key takeaways from our mixed-methods evaluation of TPP in Colorado:

Key Learnings

1. **TPP participants in the evaluation found the process of enrolling in the program easy and accessible, and they reported receiving their payments reliably and on time.** These findings provide proof of concept for this mechanism of cash distribution that may have relevance as states consider implementation strategies for the new Child Care and Development Fund (CCDF) rule that requires timely and reliable methods for paying HBCC providers.
2. **Qualitative reports from focus groups and open-ended survey responses indicated that many evaluation participants experienced more stability in their income month to month due to the DCTs provided through TPP and used the extra money to pay for necessities.** These qualitative findings bolstered the subtle patterns found in quantitative data on financial indicators, which were less conclusive due to high variance in survey data from month to month. Overall, these findings point to the potential for time-limited DCTs to reduce providers' experiences of income volatility and material hardship.
3. **Many FFN caregivers in the evaluation qualitatively reported that the DCTs allowed them to purchase educational and material resources for the children in their care, while also allowing them to be more present in their caretaking and engage in more training.** As one focus group participant shared, *"[TPP] helped me to want to keep updating myself as a provider, to keep informing myself and to keep taking courses to give the best of myself."* Each of these findings points to the fact that children may benefit from HBCC providers' enrollment in TPP, since FFN caregivers use the funds to invest in increasing the quality of their services. This sentiment is captured in the following quote from a focus group participant: *"I believe that the work of a provider is not only taking care of children, we are raising them. And these children are going to grow. And much depends on our care, on our stability, both emotionally and economically as well as mentally."*
4. **According to multiple FFN caregivers who participated in focus groups, the DCTs made them feel a greater sense of financial stability, lower levels of stress, and that their work as a child care provider was valued.** One FFN caregiver noted how TPP affected her care in this regard: *"[TPP] made a big difference in me for the care of the children, it kept me calmer, more relaxed, and that is reflected in the care of the children."*
5. **Some evaluation participants reported that receiving the DCTs made them feel more confident that they could stay in the early care and education field, indicating that support like that provided by TPP could be a stabilizing force within ECE.** As one FFN caregiver stated, *"When I started receiving the TPP, not only did I stay, as my colleagues say, but it also helped me to pay for the most essential expenses."*
6. **Evaluation participants reported increased comfort with CBOs, which is a critical first step in bolstering this workforce's access to public benefits.** However, rates of benefit utilization for evaluation participants remained low throughout TPP, indicating that these relationships alone are not sufficient to increase FFN caregiver use of public benefits. There are likely other barriers outside those addressed by TPP that limit FFN caregivers' use of benefits. TPP implementation partners will continue to use these findings to support the important advocacy work happening in Colorado to eliminate barriers preventing FFN caregivers – many of whom are immigrants – from receiving public benefits.

Methodology: Data and Analysis

Mixed-Methods Data Sources

This evaluation involved both primary quantitative data and secondary quantitative and qualitative data. Each of these data sources is described below.

Primary Data

All primary survey data was collected via a web-based survey platform (Qualtrics) that was accessible via smartphone, tablet, or computer. Survey items were both multiple choice and open-ended, addressing most constructs from the TPP Theory of Impact. When appropriate, the SCEC team utilized RAPID survey items to enable comparison with the RAPID national sample comparison. In addition, the SCEC team co-created original survey questions with input from Home Grown and HBCC providers. For example, we wanted to understand the impact that DCTs had on FFN caregivers' ability to stay in the field of child care. Since this was a construct specific to TPP, and not shared with RAPID, we worked with our provider consultants and partners to create three original survey items surrounding this construct. In accordance with the principles of RAPID, we grounded survey items in the concept of empirical pragmatism, or the balance between rigor and practicality (Liu, Fisher, & Lombardi, 2023; Kaushik & Walsh, 2019). In practice, operationalizing this approach meant using subsets of measures to avoid survey fatigue and tailoring items in response to participant feedback. We also paid special attention to the preamble that accompanied survey items, often adding additional clarity or examples, when we heard from provider consultants that this information was necessary for comprehension.

FFN Caregiver Surveys

Providers completed four types of surveys:

1. Initial/first time survey: the longest survey we fielded (about 15 minutes), including retrospective questions about the month prior to TPP beginning, as well as questions that only need to be asked once (e.g., demographics)
2. Monthly pulse surveys: brief (5-10 minute) set of items to collect information related to constructs that were expected to change in shorter time intervals
3. Quarterly surveys: a longer survey (10-15 minutes) to collect information related to constructs that were expected to change over a longer time scale than monthly intervals
4. Exit surveys: similar to a monthly pulse survey, with the addition of an exit module, containing items that asked participants to reflect on the entirety of their experience in TPP

The FFN caregiver survey content was aligned to the strategies, targets, and outcomes outlined in the TPP Theory of Impact. Specifically, the different surveys comprised modules on the following topics: demographics; the experience of receiving DCTs; financial well-being (e.g., income changes, stability, material hardship); psychological well-being (e.g., depressive and anxiety symptoms, stress, and loneliness); engagement with CBOs and connectedness to benefits, community, and resources; and child care attributes (e.g., children served, schedule, care actions).

As previously described, we used a combination of original and shortened validated measures. For example, consistent with the RAPID survey (Liu, Fisher, Lombardi, 2023), we included the following validated measures in the emotional distress module of the survey: depressive symptoms assessed via the Patient Health Questionnaire 2-item scale (Kroenke et al., 2003), anxiety symptoms assessed via the Generalized Anxiety Disorder 2-item scale (Kroenke et al., 2007), stress symptoms assessed via a one-item scale (Elo et al., 2003), and loneliness assessed through one item from the NIH Toolbox (Gershon et al., 2013). In addition, every survey had 1-4 open-ended response items that we qualitatively coded and analyzed.

Parent/Caregiver Surveys

Parents/caregivers were given the opportunity to participate in a quarterly survey, which was consistently between 5-10 minutes in length. Survey items consisted of a subset of closed and open-ended items from the FFN caregiver surveys. In the first parent/caregiver survey, we also asked participants brief demographic questions.

In follow-up parent/caregiver surveys, several modules were identical to the FFN caregiver survey, including material hardships, income changes, stability of housing and employment, predictability of work schedule, psychological well-being, and income. After identifying gaps in the TPP Theory of Impact in August 2023, the SCEC team added additional items to the parent/caregiver survey regarding continuity of care, the impact of child care on parental employment, and child well-being (using items from the Positive Behavior Scale (Quint, Bos, & Polit, 1997)).

CBO Staff Surveys

CBO staff completed a survey after the initial enrollment period (i.e., enrollment survey) and when TPP ended in Colorado in April 2024 (i.e., exit survey).

1. Enrollment survey: The enrollment survey contained 1) questions specific to the experiences of the staff member who recruited and enrolled FFN caregivers into TPP, and 2) general questions about the organization. The survey included a question that asked the staff member if they felt well-suited to answer the general organization questions. If they did, they were taken to the final section of the survey. If they did not, they provided a suggested contact with whom the SCEC team could follow up about collecting that information.
2. Exit survey: Questions in this survey sought to understand how TPP participants utilized community resources and services, including those from the CBO.

Secondary Data

Payment platform (AidKit) Administrative Data

Impact Charitable, the implementation lead in Colorado, utilized AidKit, a technology platform, to enroll participants in TPP and deliver the bi-monthly DCTs. Stanford University and AidKit had a Data Use Agreement that enabled AidKit to share administrative program data with the SCEC team. This data includes application metrics (e.g., when the application was completed), whether or not the DCT was administered, and when the DCT was administered. The study consent form outlined the data that would be requested from AidKit so that participants were aware and could provide their consent for these data to be accessed by the SCEC team. We analyzed these data (e.g., descriptive statistics) to assess several strategies from the TPP Theory of Impact.

FFN Caregiver Focus Group/Interview Transcripts

The SCEC team also obtained de-identified focus group and interview data on a subset of TPP participants from Impact Charitable. Participants in these focus groups and interviews were all TPP participants (N=100) but may or may not have been involved in the evaluation study (N=54). Impact Charitable collected qualitative data at two time points: May 2023 (N=19) and April 2024 (N=5).

Prior to collecting this qualitative data, the SCEC team conducted a training session with Impact Charitable around best practices for focus group and interview facilitation. Participants received a consent form that asked for their consent to participate, to have the sessions audio-recorded, and to have the de-identified transcript data shared with the SCEC team. The majority of these focus groups and interviews were conducted in Spanish. Demographic data on the interview and focus group participants was not collected by Impact Charitable.

Interviewers covered questions pertaining to both TPP participants' experiences with TPP and also insights that could inform the process of developing exit strategies and future program improvements. These questions included but were not limited to the following topics: entrance into the field of child care provision; characteristics and quality of the care that they provide to children; financial, mental health, and well-being impacts of participating in the TPP program; and suggestions for long-term support once the program ends.

RAPID National Data

As previously described, for the past several years, the SCEC's RAPID project team has collected data from early childhood providers via a monthly Qualtrics survey. This convenience sample includes providers of all types (e.g., center-based, home-based, Head Start, etc.), but for the purposes of comparisons to the TPP sample of FFN caregivers, we identified a subset of participants who were HBCC providers and who reported having a household income 200% below the Federal Poverty Line (FPL). While the RAPID sample is not matched to the TPP sample exactly, this national comparison has led to rich advisory board conversations that have improved the overall evaluation process as well as the opportunity to further explore TPP impacts, as detailed in the findings below.

Analysis Methods

Quantitative

In accordance with the principles of formative rapid-cycle evaluation, the SCEC team engaged in an accelerated process of data analysis. Each quarter, data was immediately cleaned and analyzed within 1 week of the most recent data collected. From there, we utilized descriptive statistics to summarize participants' experiences (e.g., bar charts for single time-point items and line/ribbon charts for trend analyses) and compared findings to the national RAPID sample. The SCEC team presented these data to both national and Colorado-specific advisory boards of content area experts and participants. Participant feedback led to tangible improvements in the survey content and experience. We used feedback from advisory meetings to not only improve our ongoing data collection efforts but also to inform our analyses for this 18-month report. For

example, we responded to requests for data to be presented in more intuitive ways by recoding certain variables as continuous or combining relevant survey items into one data visualization.

In the current report, we share descriptive data (e.g., percentages of participants who respond in certain ways to survey items), as well as trend data, visualizing changes monthly and quarterly over the past year and a half. Due to the small sample size and sampling strategy, we have determined that pre-post analyses are not appropriate and have opted to instead use national sample comparisons when available. We used both income and provider-type data to subset the RAPID provider sample and create a sample as similar to the TPP sample as possible; however, this is not a true matched sample. Nonetheless, comparing the changes of the TPP sample and RAPID national sample from June 2022 (equivalent to TPP pre-) through April 2024 (equivalent to TPP post-), with the RAPID national sample serving as an imperfect but helpful control group, allows for more confidence that effects in the TPP group are likely due to TPP rather than other confounding variables over time.

Qualitative

The SCEC team used deductive thematic analysis (Bingham & Witkowsky, 2022) to interpret the available qualitative data using Dedoose as the primary coding software (Dedoose, 2021). Two members of the team developed a codebook based on the TPP Theory of Impact targets and outcomes. We refined the codebook during early stages of the coding process to incorporate further examples and clarity. The team members leading the coding used the monthly survey open-ended responses to gain familiarity with participant concepts and the codebook, prior to analyzing and coding focus group/interview transcripts. Through the process of dual coding open-ended responses, the coders gained clarity on the codes through practice and discussion. To prepare for coding the transcripts, the coders conducted three rounds of inter-rater reliability tests with a new set of excerpts each round to determine consistency in the application of codes to excerpts in the transcripts. We collaboratively adjusted the codebook in between these rounds to improve the specificity of the definitions of codes and add necessary missing codes. In order to increase the trustworthiness and actionable takeaways from the data, we engaged in a detailed memoing process at each stage of analysis (Birks et al., 2022).

The SCEC team's final Cohen's pooled kappa result was 0.87, which several methodological sources consider "near perfect agreement" between coders (De Vries et al. 2008; Cicchetti 1994; Fleiss 1971). After reaching this metric of consistency across coders, we each coded several transcripts using the latest and final version of the codebook.

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