



Center-Based and Family Child Care Market Rates in Mississippi



ABOUT NSPARC

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EXECUTIVE SUMMARY

The state developed a methodology to assess the cost of quality under the general framework developed by the Lead Agency in collaboration with SECAC (see Appendix A). In the last few years, the state has engaged in reinventing how child care providers can meet quality expectations without being unduly burdened. This effort involved many early childhood stakeholders across Mississippi.

The state also analyzed tools and methods for evaluating child care quality in all 50 states. This analysis revealed that methods vary across states and that there are questions about reliability and validity regarding measures of quality. This analysis is reported in Appendix B.

The state also engaged stakeholders to gauge the value of quality rating systems as a method to assess the quality of child care. The overall sentiment was that the quality rating system divides providers along arbitrary scales of quality and therefore further stratifies low-income children, especially those in disadvantaged areas. The results of this study are reported in Appendix C.

Guided by the above research, the state created a supporting structure designed to provide customer service for ensuring quality and continuity of care and learning on the 0-8 child care continuum. This was achieved by creating opportunities for licensed, center-based child care providers to be designated as *standard* or *comprehensive*. To be clear, these designations do not represent tiers like a quality rating system. Rather, the *standard* designation ensures a baseline of quality and provides incentives to improve quality through a variety of activities. The *comprehensive* designation describes a child care provider that has not only achieved the standard designation but also provides a continuity of care and learning as the child moves from one learning environment to the next (e.g., from a child care center to a public school).

An online application is available for center-based child care providers to apply to become a standard provider (<https://one.mdhs.ms.gov/#/pip>). The application includes a series

of modules that collect information to verify that the provider is licensed; that all staff are trained according to the federally mandated health and safety training guidelines; and that the provider has adopted a curriculum with activities that align with the state early learning guidelines and standards from the Mississippi Department of Education. The application also includes a self-assessment to help providers identify areas for which they might need technical assistance or coaching. A standard designation is maintained by submitting this online application on an annual basis. Further, the state has developed a toolkit for standard providers that want to become comprehensive (see Appendix D).

A market rate survey (MRS) was conducted to assess the cost of quality to operate as a standard center-based child care provider. The survey specifically included questions about curriculum, a key element of ensuring quality under the standard designation. The data collected from the MRS were used to develop a baseline rate for monthly full-time standard center-based child care at 75 percent of the distribution by age group. Next, models were estimated to assess the cost of quality by age group for the adoption of curriculum and to assess regional variations. The cost for the self-assessment was valued at five hours, which goes toward fulfilling the 12 mandatory hours. The center director also receives a five-hour credit for the self-assessment.

At this time, the rate for comprehensive center-based child care is based on 125 percent of the standard center-based child care market rate. To fully assess the market rate for comprehensive center-based child care, the plan is to conduct a pilot with volunteer providers to learn how such an approach can be implemented without significantly impacting provider operations.

The state plans to complete the pilot in 2019-2020 and have the comprehensive designation fully operational by the beginning of 2021. In this process, the state will validate the market rates necessary to operate as a comprehensive provider.

We believe that this approach is the most appropriate for assessing the market rate for center-based comprehensive child care providers, given that such providers will be specifically designed to level the playing field for access to quality, especially for disadvantaged children in distressed areas. In other words, these providers will require more resources than typical providers in middle-class and affluent areas to overcome the typical barriers associated with concentration and persistence of poverty. The establishment of comprehensive child care will be based on the amount of resources the state can bring to different types of providers. The expectation is that more state resources will be distributed to providers located in economically distressed areas

as opposed to those in more affluent areas. This approach would reduce the burden on the most disadvantaged providers and level the playing field for equal access to quality. The state also examined variation across other states in the Southeast region. The results reveal that the 75th-percentile rates for Mississippi are consistent with those of Mississippi’s neighboring states, such as Alabama and Tennessee.

Market rates for family child care were calculated by applying the market rate for standard center-based child care from the 2016 market rate survey to the original framework of the 2003 family child care rates.

Table 1: Market Rates for Center-Based and Family Child Care

Age Group	Center-Based Child Care				Family Child Care	
	Standard Center		Comprehensive Center		Part Time	Full Time
	Part Time	Full time	Part Time	Full Time		
0-12 Months	\$240.00	\$480.00	\$300.00	\$600.00	\$177.14	\$348.57
13-36 Months	\$246.00	\$480.00	\$307.50	\$600.00	\$180.00	\$348.00
3-5 Years	\$225.76	\$440.00	\$282.20	\$550.00	\$162.08	\$318.42
Summertime (5-13 Years)	\$243.92	\$400.00	\$304.90	\$500.00	\$151.77	\$292.74
Special Needs (All Ages)	\$260.30	\$500.00	\$325.38	\$625.00	\$186.74	\$367.86

MARKET RATE SURVEY

Methodology

To provide adequate subsidy payments for standard center-based child care providers relative to their costs, a market rate survey was conducted to evaluate the current cost of child care across Mississippi. The Mississippi Department of Human Services (MDHS) Division of Early Childhood Care and Development (DECCD) engaged NSPARC, a research center at Mississippi State University, to conduct the survey.

The survey was designed to collect information on current rates charged by center-based child care providers. The survey also gauged the cost of quality by collecting information on curricula

and health, mental health, nutrition, and family support services offered by providers. Providers were asked to supply child care rates according to age group (i.e., infant, toddler, preschool, school age, and special needs) and type of rate (i.e., daily, weekly, monthly, and full time). The survey instrument was drafted and piloted in August 2016. See Appendix E for the survey instrument.

The survey master frame was created using provider lists from MDHS and the Mississippi State Department of Health (MSDH) Office of Licensure. The master frame consisted of 1,462 licensed center-based child care providers in the state. The survey was conducted using a mixed-mode methodology that allowed providers to complete the

survey either online or on the phone. Providers were contacted up to 10 times to encourage participation. Complete surveys were received from

430 center-based child care providers, resulting in a 30-percent response rate. The survey was concluded in October 2016.

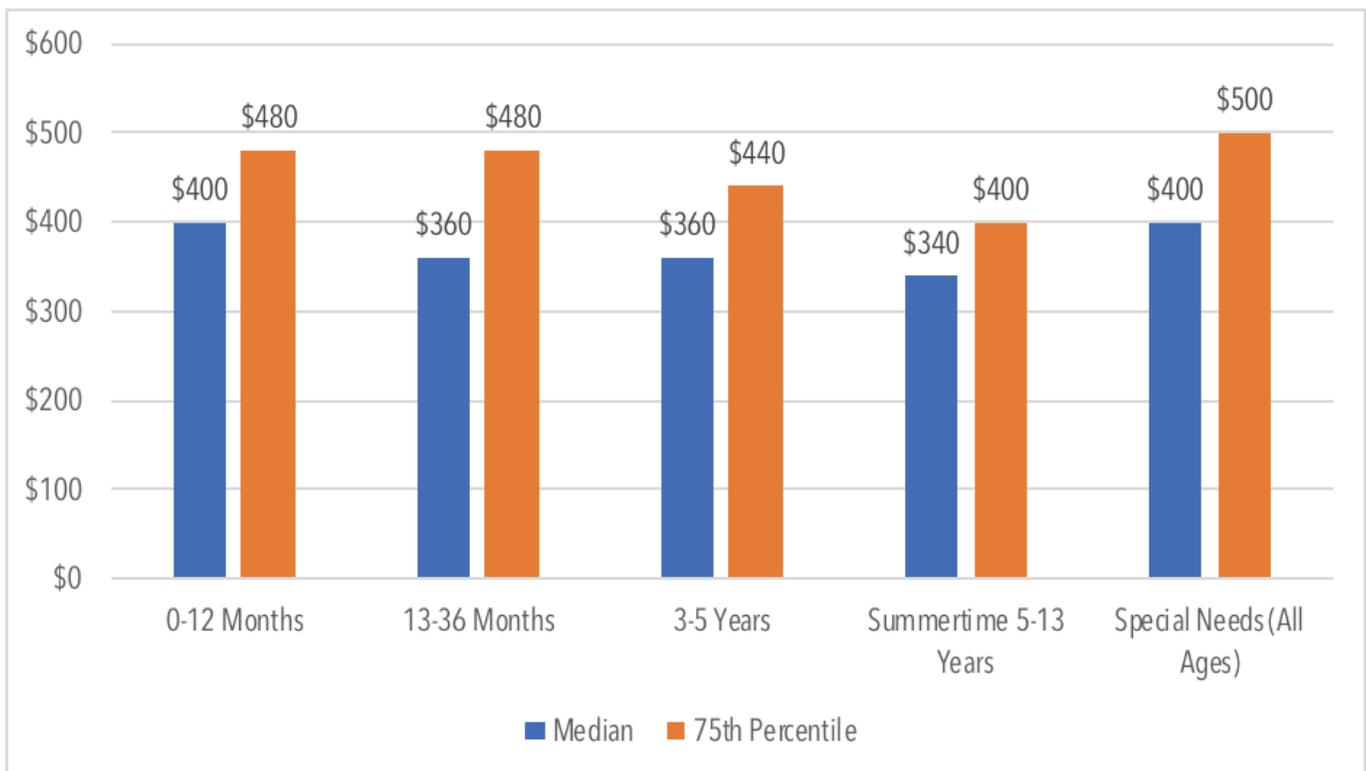
RESULTS

Analysis of the survey data began in November 2016 and was completed in January 2017. The analysis was conducted in four steps. The first step was to estimate market rates for monthly full-time standard center-based child care. The federal Administration for Children and Families Office of Child Care has established the 75th-percentile market rate as a benchmark for determining equal access to child care services for providers receiving child care subsidies. The 75th percentile was used to estimate the monthly market rates for full-time center-based child care for the following

groups: (1) 0-12 months, (2) 13-36 months (3) 3-5 years, (4) summertime 5-13 years, and (5) special-needs (all ages).

Analysis of the survey data show that the median monthly full-time rate for standard center-based child care is \$400 for children 0-12 months, \$360 for 13-36 months, \$360 for 3-5 years, \$340 for summertime 5-13 years, and \$400 for special-needs children (see Figure 1 and Table 2). Overall, the results show that median child care costs tend to decline with the age of the child and are higher for children requiring special-needs assistance.

Figure 1: Median and 75th-Percentile Monthly Full-Time Standard Center-Based Child Care Rates



For children 0-12 months, the monthly full-time standard center-based child care rate at the 75th percentile is \$480. This means that 75 percent of the state's center-based providers charge \$480 or less per month for care of children 0-12 months old. The results also show that the monthly full-time standard center-based child care rate at the 75th percentile is \$480 for 13-36 months, \$440 for 3-5 years, \$320 for summertime 5-13 years, and \$500 for special-needs (see Figure 1 and Table 2).

The second step was to use full-time market rate estimates for standard center-based child care as the base for calculating part-time monthly market rates for standard center-based child care. Follow-

ing agency guidance, the percentage differences between part-time rates and full-time rates currently in effect for center-based child care were calculated for each age group. The group-specific part-time rates ranged between 50 and 60 percent of the respective full-time child care rate. Specifically, the 0-12 months part-time rate is set at 50 percent of the corresponding full-time rate, the 13-36 months part-time rate at 51.25 percent, the 3-5 years part-time rate at 51.31 percent, the summertime 5-13 years part-time rate at 60.98 percent, and the special-needs part-time rate at 52.06 percent. See Table 2 for the monthly part-time rates at the 75th percentile for standard center-based child care.

Table 2: 75th-Percentile Monthly Rates for Standard Center-Based Child Care

Age Group	Part Time	Full Time
0-12 Months	\$240.00	\$480.00
13-36 Months	\$246.00	\$480.00
3-5 Years	\$225.76	\$440.00
Summertime 5-13 Years	\$243.92	\$400.00
Special-Needs (All Ages)	\$260.30	\$500.00

***Part-time rates are set to match percentages currently in effect where the 0-12 months rate is set at 50 percent of the corresponding full-time rate, 13-36 months at 51.25 percent, 3-5 years at 51.31 percent, summertime 5-13 years at 60.98 percent, and special-needs children at 52.06 percent.*

The third step was to use part- and full-time rates for standard center-based child care as the base to calculate part- and full-time rates for family child care. Following agency guidance, the percentage differences between rates currently in effect for center-based child care and family child care were calculated. Specifically, the monthly part- and full-time rates for family child care are set, respectively, to 73.81 and 72.62 percent of

the corresponding monthly center-based child care rates for 0-12 months, 73.17 and 72.50 percent for 13-36 months, 71.79 and 72.37 percent for 3-5 years, 62.22 and 73.18 percent for summertime 5-13 years, and 71.74 and 73.57 percent for special-needs children. See Table 3 for the monthly part- and full-time rates at the 75th percentile for family child care.

Table 3: 75th-Percentile Monthly Rates for Family Child Care

Age Group	Part Time	Full Time
0-12 Months	\$177.14	\$348.57
13-36 Months	\$180.00	\$348.00
3-5 Years	\$162.08	\$318.42
Summertime 5-13 Years	\$151.77	\$292.74
Special-Needs (All Ages)	\$186.74	\$367.86

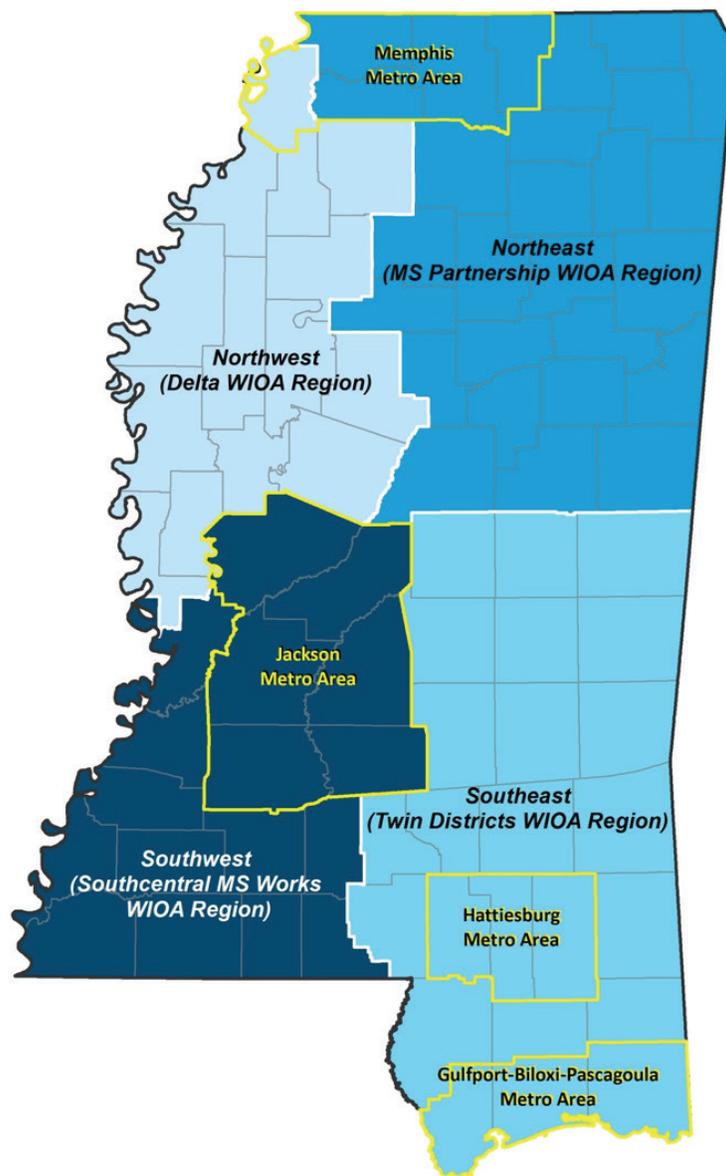
***Rates for family child care are set to match percentages currently in effect where part and full time rates are set, respectively, to 73.81 and 72.62 percent of the corresponding licensed care rate for 0-12 months, 73.17 and 72.50 percent for 13-36 months, 71.79 and 72.37 percent for 3-5 years, 62.22 and 73.18 percent for summertime 5-13 years, and 71.74 and 73.57 percent for special-needs.*

The fourth step in the analysis was to assess the impact of regional variation and the cost of curriculum adoption, as a proxy for quality, on market rates. Specifically, a series of ordinary least squares regression models were estimated to assess if the cost to adopt a curriculum fell within the 75th-percentile market rate. Specifically, we examined variation in cost based on whether the curriculum was a formal curriculum, a teacher-created curriculum, a combination of both, or another type of curriculum. The results revealed that, for all age groups, the adoption of any form of curriculum consistently falls within the 75th-percentile market rate, which therefore accounts for the cost to achieve quality for a

standard center-based child care provider (see Appendix F).

A similar analysis was conducted to assess regional variation in cost. For the purpose of this analysis, we adopted the boundaries delineated by the WIOA local areas. These areas represent variations in social, economic, and demographic conditions and are widely used in other state and federal programs. See Figure 3 for a map of the state's WIOA regions. The results reveal that although there is some variation in the average cost across regions, the 75th-percentile market rate accounts for this variation (see Appendix F).

Figure 3: Mississippi Workforce Investment and Opportunity Act (WIOA) Regions



**APPENDIX A:
MISSISSIPPI FRAMEWORK TO ASSESS THE COST OF QUALITY**

A FAMILY-BASED UNIFIED AND INTEGRATED EARLY CHILDHOOD SYSTEM

December 2016

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I. System Overview

Under the leadership and guidance of the State Early Childhood Advisory Council (SECAC), Mississippi developed a family-based unified and integrated early childhood system that connects and integrates resources and services for both parents/caregivers and their children in three key areas: (1) early care and learning; (2) health, mental health, safety, and nutrition; and (3) family engagement. The system is designed to place parents on a path to self-sufficiency and their children in child care centers that provide high-quality services and learning experiences.

The system is structured to ensure eligible child care providers and early learning programs can provide a healthy, safe, and nurturing environment to children in their early years. Eligible child care providers and early learning programs will be tasked with preparing all young children to be ready for school through various activities, including healthy eating, physical exercise, and improvement of cognitive, early learning, and social-emotional skills. The system is also structured to engage families to promote the welfare, learning, and stability of young children through an integrated network of community-based resources and services. The system operates with common definitions:

- **Health is defined as the physical, mental, emotional, and social well-being of children.**
- **Mental health involves the development of social-emotional and behavioral skills for children to ensure future ability to foster necessary relationships with peers and adults.**
- **Physical health involves helping parents and caregivers to establish the habits needed to encourage children to engage in regular physical activity. Physical activity can promote growth and development while helping children maintain a healthy weight.**
- **Safety involves maintaining environments where children can be free from the exposure of physical, emotional, mental, and social harm or risk.**
- **“Ready to learn” means that when a child takes the kindergarten assessment, the child will score at or above the standard threshold.**

Figure 1 provides an overview of the family-based unified and integrated early childhood system. From an operational standpoint, the system is comprised of five major components: (1) eligibility and redetermination process for receiving vouchers, (2) interagency service and referrals, (3) eligibility and redetermination for child care center status (e.g., standard and comprehensive), (4) continuous center-quality improvement process, and (5) common case management.

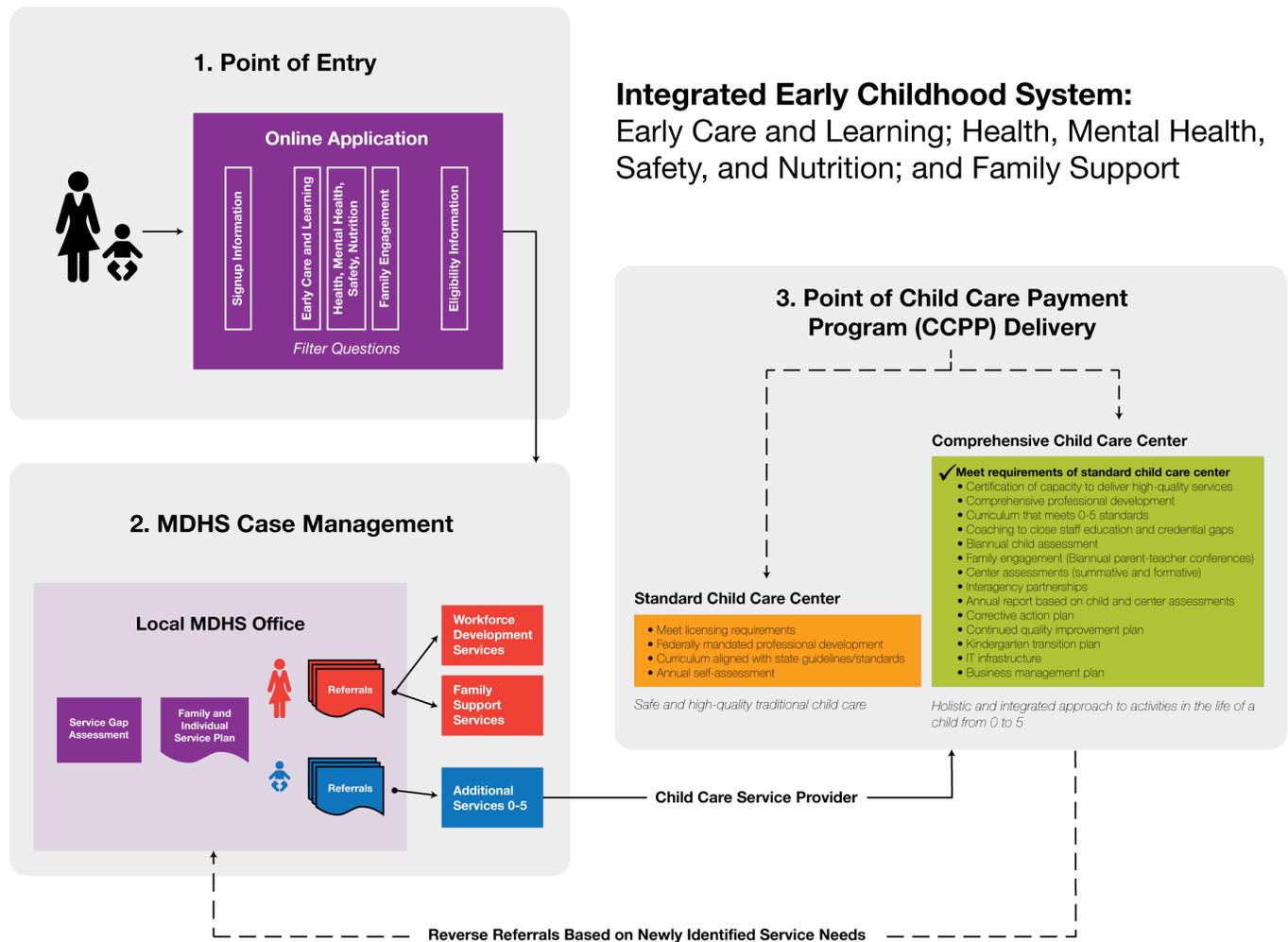
In this system, all activities are linked and integrated from the time an applicant applies for a child care voucher to the time the child is enrolled with a child care provider. Families enter into the system via the eligibility determination process and continue through a service gap assessment and the development of a family and individual service plan. Next, local MDHS case managers will develop a referral plan so that the parents and children can receive appropriate wraparound services. The local MDHS office will be responsible for following up with other service providers (e.g., health, mental health, Medicaid). Finally, the parent/caregiver will be informed of child care providers available within the area. Parents will have the option to enroll their children in one of two types of voucher-eligible centers: (1) standard or (2) comprehensive.

Achieving, maintaining, and promoting quality are at the core of the system. The system takes a holistic approach to the life of a child and fully addresses multiple areas of childhood development. It also offers opportunities to develop physical and structural environments that are safe and conducive to delivering age-appropriate services and learning experiences progressively as a child ages from birth to kindergarten. Child care centers will have opportunities to implement quality-related practices that involve the overall assessment of a child care center environment as well as the performance of the children in every aspect of their development to facilitate the whole-child approach: physical, mental, emotional, social,

and intellectual. The system effectively reduces gaps and duplication of service delivery for parents and their children. Overall system quality is monitored and supported by a data system designed to facilitate interagency program implementation and evaluation for system-wide and center-specific continuous quality improvement.

The operation of the system is driven by common case management. The common case management framework is designed to coordinate activities within and between state agencies that deliver services and programs to children ages 0 to 5. The system will fall under a unified interagency governance structure that outlines the roles and responsibilities of all parties involved in the delivery of family and children services and programs.

Figure 1: Family-Based Unified and Integrated Early Childhood System



Integrated Early Childhood System:
 Early Care and Learning; Health, Mental Health, Safety, and Nutrition; and Family Support

II. System Structure

Eligibility and Redetermination Process for Receiving Vouchers

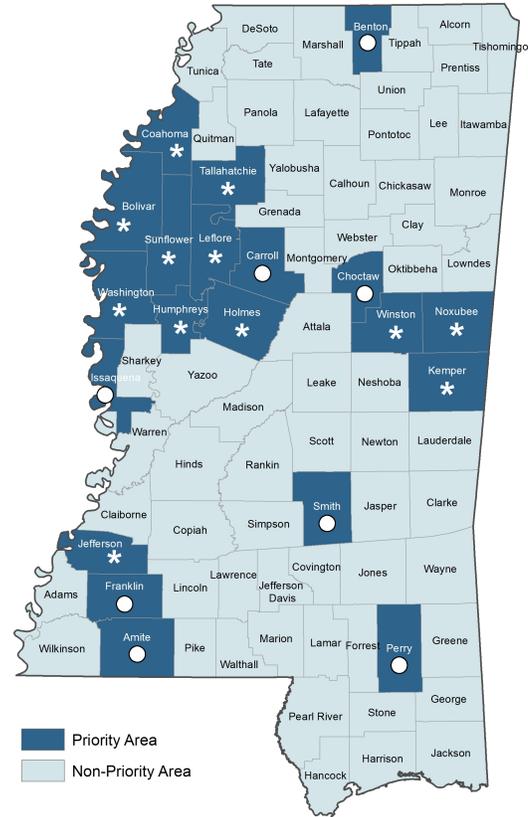
Any parent interested in receiving support under the Child Care Payment Program (CCPP) can do so by submitting an online application. The online application will seek information to determine eligibility as specified by the CCPP Policy Manual.

Vouchers will be prioritized to children who fall into high-priority populations, which include:

- Temporary Assistance for Needy Families (TANF) recipients.

- Transitional Child Care (TCC) recipients.
- Homeless children.
- Children served by the Mississippi Department of Child Protection Services (MDCPS).
- Children served by the Healthy Homes Mississippi (HHM) home-visitation program.
- Special-needs populations.
- Children of very low-income parents.

Figure 2: Child Care Priority Areas

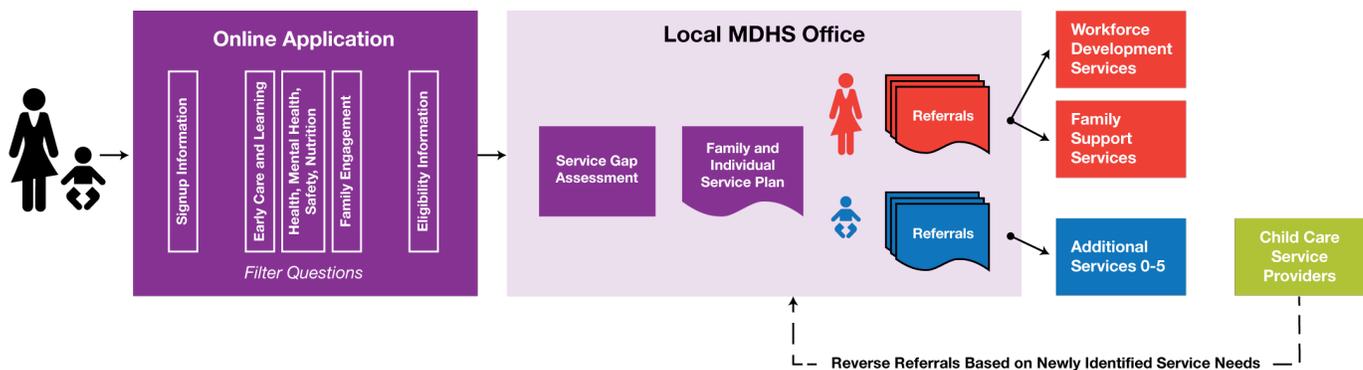


1. **High concentrations of poverty.** A high concentration of poverty is defined as a county where the percentage of children living in poverty is at least one (1) standard deviation above the state mean value for the percentage of children living in poverty. These counties are noted by asterisks in Figure 2.
2. **Limited access to child care providers eligible for the Child Care Payment Program (CCPP).** Limited access is defined as counties that do not contain any CCPP-eligible child care providers. These counties are noted by circles in Figure 2.

Individualized Family Service and Referral Plan

The process to obtain an individualized family service and referral plan is illustrated in Figure 3.

Figure 3: Individualized Family Service and Referral Plan Process



While applying for a voucher through the online process, applicants will be given the opportunity to answer filter questions designed to identify any existing service gaps for them or their children. The filter questions are designed to identify critical

areas of need in three key areas: (1) early care and learning; (2) health, mental health, safety, and nutrition; and (3) family engagement. Applicants can call a toll-free number for technical assistance.

Upon completion of the application, applicants will be directed to a local MDHS office to receive wraparound services based on the information provided in the initial application process. MDHS case managers will develop a family and individual service and referral plan based on a service gap assessment. The service and referral plans for parents might include services to place parent(s) in workforce and educational services geared toward gaining credentials required for middle-skill employment or in family support services such as TANF, SNAP, and transportation vouchers. Plans for children might include services for early screening to ensure health, mental health, and learning needs are met.

Figure 4 provides an example of how the information sought in the initial application process will help develop an individualized service and referral plan by connecting the needs of the applicant to appropriate services. Figure 5 provides a sample individualized family service and referral plan.

An individualized family service and referral plan will be designed to take into account a family's needs and will provide personalized referrals to programs/services on a case-by-case basis. For example, an applicant enters the system, and we learn that she is a 30-year-old woman, heads a one-parent family, is pregnant, and has a four-year-old child. She also suffers from a mild intellectual disability (i.e., ADHD) and has no health insurance. She is presently employed as a custodian in a local supermarket chain. She currently lives in Bolivar County. In this example, she can receive programs and services under three frameworks: (1) Family Support, (2) Early Care & Learning, (3) Health, Mental Health, Safety, & Nutrition.

- **FAMILY SUPPORT:** The applicant is eligible to receive financial assistance, such as TANF, because she has dependent children younger than 18 and because she falls into a low-income threshold.
 - Her low-income status grants her eligibility for additional programs to which she will be referred, such as the Weatherization Assistance Program for energy cost reduction.

- **EARLY CARE & LEARNING:** As a pregnant woman, she is eligible for Early Head Start services.
 - Her pregnancy status and her geographic criteria grant her eligibility for additional programs to which she will be referred, such as the Delta Health Alliance/Save the Children Partnership early childhood education program for expectant mothers.
 - Her four-year-old child is eligible for public prekindergarten.
 - The child will be also referred to Delta's Health Alliance Imagination Library to receive free books before entering kindergarten.

- **HEALTH, MENTAL HEALTH, SAFETY, & NUTRITION:** As a pregnant woman, a mother of a four-year-old, and a low-income earner, she is eligible for nutrition assistance programs, such as SNAP, WIC, and TEFAP.
 - As an expectant mother, she will also be referred to the USDA Healthy Sprouts program to increase her knowledge of child development.
 - She will also be referred to Medicaid and to a managed care program called MississippiCAN.
 - Her child is eligible for insurance coverage through a Medicaid program called CHIP.

Figure 4: Individualized Family Service and Referral Plan Logic Chart

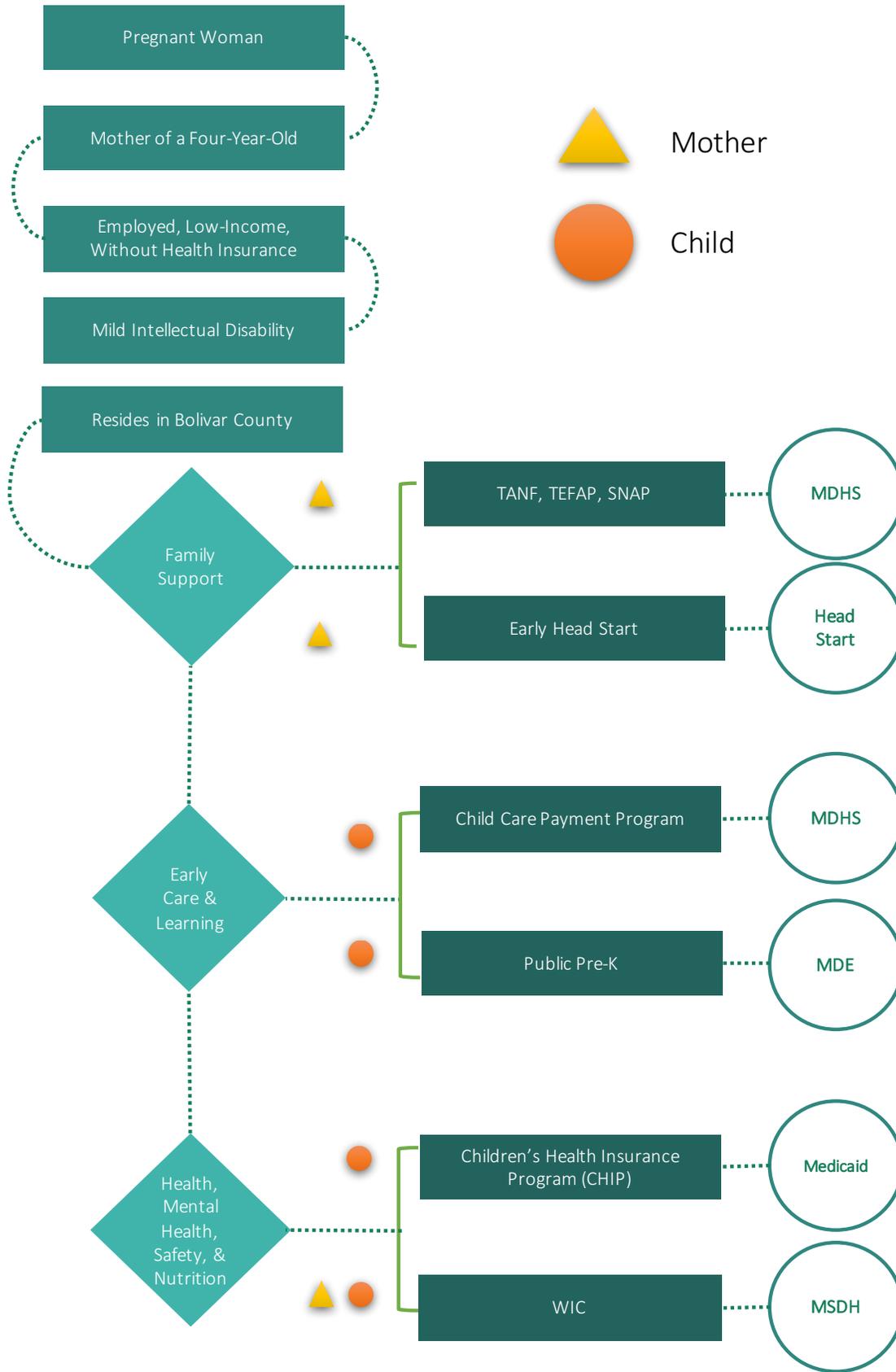


Figure 5: Sample Individualized Family Service and Referral Plan

Family Support

TANF, TEFAP, SNAP (mother only)	MDHS & Local Organizations	Refer
Early Head Start (mother only)	Head Start	Refer
Families First for MS (mother and child)	MDHS & Local Organizations	
Referred on September 17, 2016		
Appointment scheduled for October 17, 2016 Attended Appointment		
Delta Parents as Teachers	Delta Health Alliance	Refer

Early Care & Learning

Child Care Payment Program (child only)	MDHS	Refer
Public Pre-K (child only)	MDE	Refer
Head Start (mother and child)	MBB	Refer

Health, Mental Health, & Nutrition

Perinatal High Risk Management/Infant Support Services (mother only)	MDH & Medicaid	Refer
WIC (mother and child)	MDH & Medicaid	
Referred on September 27, 2016		
Appointment scheduled for October 21, 2016 Did Not Attend Appointment		
Children's Health Insurance Program (child only)	MDH & Medicaid	Refer

Eligibility and Redetermination Process for Child Care Centers

Child Care Payment Plan vouchers can only be redeemed at eligible child care facilities. Two types of voucher-eligible centers will be available to parents: standard and comprehensive (Figure 6 provides a comparison). Voucher amounts will be based on the market value of the quality of services offered by the child care center.

Standard Child Care Centers

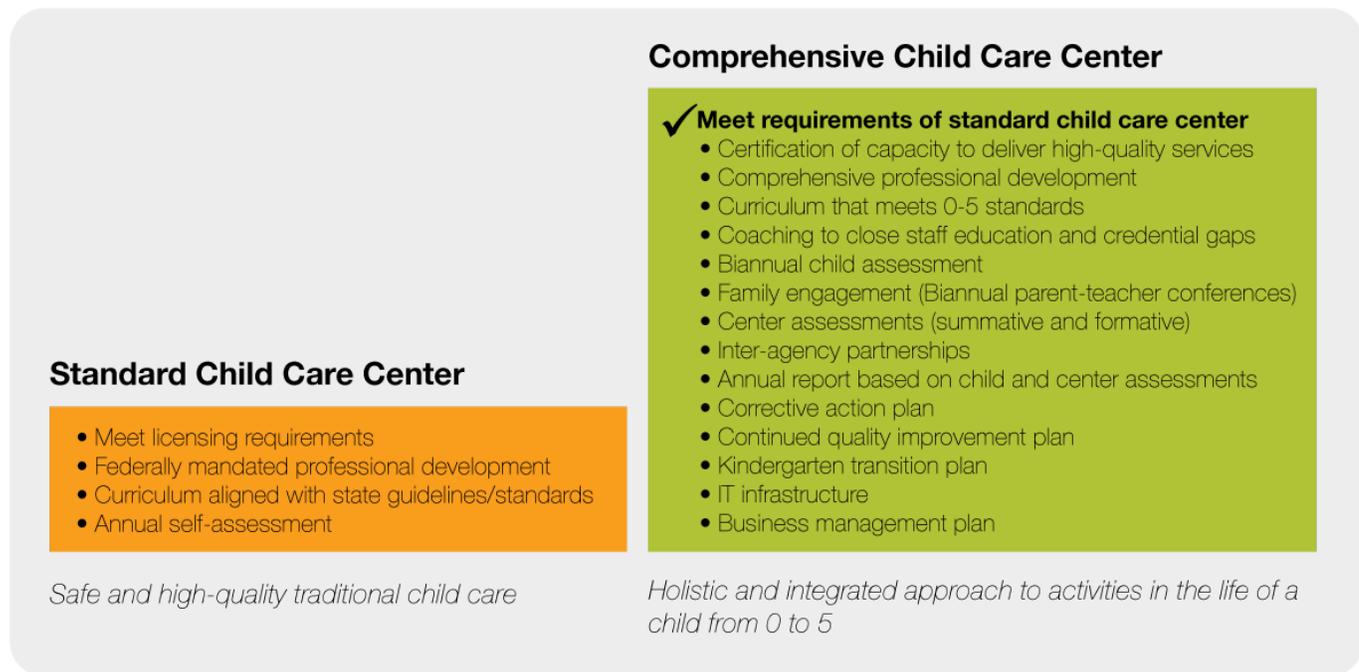
To be classified as a standard center, a child care center must be licensed and meet minimum federal and state standards. Standard centers will operate above licensure expectations in two ways. First, all staff must go through mandatory training as required by the Child Care and Development Block Grant (CCDBG) Act of 2014. Second, all staff must have 15 hours of continuing professional development each year as prescribed by the act. The professional-development areas include health and safety; educational standards and best practices; recognizing signs, symptoms, or behaviors of child abuse and neglect; professional development that addresses social-emotional and behavioral development, mental health, expulsion, and exclusionary discipline practices in child care settings; and developmental and behavioral screenings. The curriculum implemented in these centers must align with the state early learning guidelines for infants and toddlers and the state early learning standards for three- and four-year-olds. These centers must also engage in an annual self-assessment process.

Comprehensive Child Care Centers

To be classified as a comprehensive center, a child care center must first meet the requirements of a standard center. A comprehensive center must also engage in additional activities specifically designed to improve the quality of the learning experience for three- and four-year-old children. Technical assistance to achieve the comprehensive designation will be available. To be designated as comprehensive, a center will be certified that it has the capacity to engage in:

- 1. Additional customized professional development beyond the standard 15 hours.**
- 2. Coaching aimed at closing education and credential gaps that staff might have.**
- 3. Assessing children at least twice a year.**
- 4. Working with an external evaluator to examine how programs and activities are implemented in the center.**
- 5. Family engagement activities that will encourage parents to participate in parenting classes and parent-teacher organizations (PTOs).**
- 6. Working with technical assistance for the implementation of a continuous quality improvement plan, kindergarten transition plan, business management plan, and, when necessary, corrective action plan.**

Figure 6: Comparison of Standard and Comprehensive Child Care Center Types



Child Care Quality Improvement Process

To ensure quality of early learning program and service delivery for children, a center must maintain its eligibility to be designated as either standard or comprehensive following the general recommendations by the SECAC committees (see Appendices A-C). Each year centers will go through an initial eligibility process and subsequent annual redetermination processes. Any center that fails to meet the basic requirements for its designation will be given six months to successfully implement a corrective action plan. The corrective action plan will be developed by an external evaluator in consultation with the child care center director and technical assistance coach. Failing to reach goals outlined in a corrective action plan will result in loss of designation at the end of the current annual eligibility term. Comprehensive centers could be downgraded to standard if the center still meets the minimum requirements for that designation. Any center no longer designated at the standard level will be ineligible to redeem child care vouchers until the center is deemed eligible in the future.

Once eligible, centers must engage in continuous quality improvement based on a scale that assesses the extent to which a center should engage in additional technical assistance for maintaining and improving quality. Standard and comprehensive centers will be scored on type-specific scales that reflect the expectations for each center designation. Each scale will include environmental-quality factors, process-quality factors, and factors related to the center experience of parents and their children. Quality evaluation will also include a parent satisfaction survey seeking input in several areas that best describe the quality of the experience of parents and their children. The survey will be conducted as part of the redetermination process. Comprehensive centers will additionally be scored on the assessment of the children and the results of an external evaluation. The scale will be designed to help identify areas where centers need technical assistance for maintaining and improving quality so that centers can maintain their eligibility to redeem vouchers. Each continuous quality improvement plan will be unique based on a child care center's strengths, needs, and program-specific goals. Scale scores will not be used to rank or grade centers for comparison across centers, unlike the case with the quality rating system, and will only be used to determine appropriate quality-improvement activities and need for technical assistance that will lead to measurable improvement in services and help centers maintain eligibility to redeem vouchers.

The system as a whole will also be assessed for overall quality and to determine the extent to which the system is operating in accordance with the governance structure and program and service quality expectations. The system-wide assessment will include an examination of each component, including the application process, referral process, and technical-assistance activities.

III. System Operation to Support Common Case Management

Figure 7 illustrates the structure designed to support common case management in the family-based unified and integrated early childhood system. In this structure, interagency partners deliver additional services for parents and children ages 0 to 5. Each agency will enter into a MOU with MDHS to specify roles and responsibilities for service delivery and the referral process with their local offices.

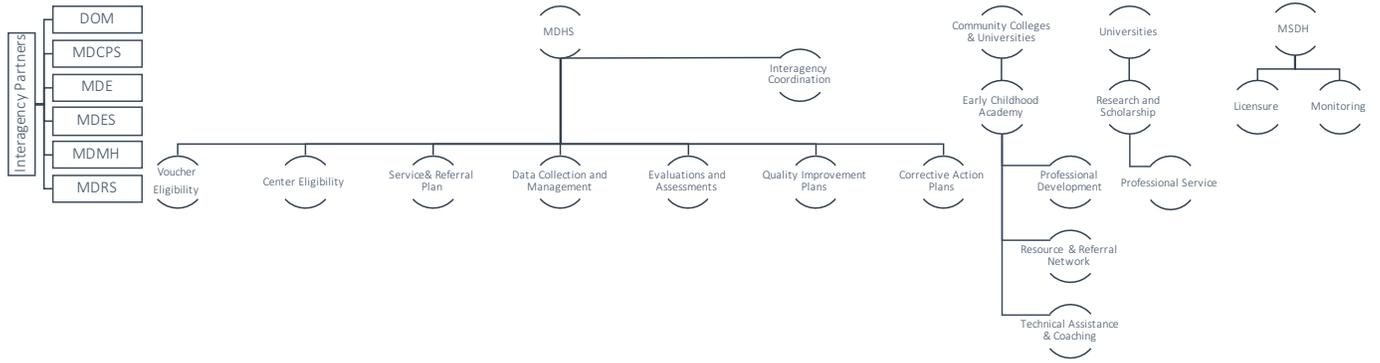
The Division of Early Childhood Care and Development (DECCD) within MDHS will have primary responsibility for the interagency functions and operations of the system. MDHS will also be responsible for determining and redetermining voucher eligibility and for certifying centers (e.g., standard versus comprehensive). MDHS will also manage and operate the online application system, collect and manage administrative data, and develop evaluations, quality improvement plans, and, as necessary, corrective action plans.

The Mississippi Community College Board (MCCB) will be responsible for managing local early childhood academies. These academies will provide technical assistance, coaching, and training and provide management for the resource and referral offices. Mississippi's public universities will play a critical role in providing research to inform service development and delivery through the local early childhood academies. Universities will also provide professional services in specialized areas such as mental health.

The Mississippi State Department of Health (MSDH) will be the agency responsible for licensing childcare centers. MSDH will also be responsible for monitoring licensed centers for compliance with policies and regulations.

Common case management will be governed by an interagency governance policy that will outline roles and responsibilities of all parties in the delivery of services and programs.

Figure 7: Common Case Management





**APPENDIX B:
STATE ASSESSMENT OF TOOLS AND METHODS
TO EVALUATE CHILD CARE QUALITY**

Evaluating and Improving EC Systems: A Nationwide Analysis

Summary: Across the US, states have implemented programs that serve to assess, improve and communicate the level of quality in early care and education settings. Often termed “QRs” or “QRISs,” such ongoing, system-wide evaluation tools have become an almost unanimous feature of developing early childhood systems. This document will catalogue a number of trends in the design and implementation of system-wide evaluation and improvement efforts across the US.

System-wide evaluation and improvement efforts nearly unanimously include these elements:

1. **Standards** for child development and learning that are measurable
2. **Accountability structure** to determine how well programs meet quality standards, validate the assignment of ratings, and verify ongoing compliance with quality standards
3. Program and practitioner **outreach and support**, including technical support and guidance
4. Financial **incentives to help** programs improve learning environments, attain higher ratings, and sustain long-term quality
5. **Parent/consumer education** efforts to spread awareness of the importance of quality in early care and education

Quick Facts

- 41 states have a system-wide evaluation and improvement initiative active in the Early Childhood sector
- Six states are planning or have launched a pilot system-wide evaluation and improvement effort
- The credentials or experience of teaching staff and quality of business practices are the most widely observed components of EC systems
- 26 states include developmental screening as a requirement for demonstrating quality in family- or center-based settings
- The Environmental Rating Scales (ERS) are the most widely used formal measurement tool
- 24 states align their evaluation and improvement program with licensing; alignment with ELG is almost unanimous

Rating Structure

The rating structure used to measure and communicate the level of quality in an education or care setting typically falls in one of three approaches: building blocks, points, or a hybrid of both. There is no best practice to report; different rating structures respond to the individual needs and goals of the state EC system.

Table #: States Similar to MS (n=6)

	Blocks (Levels)	Points	Hybrid
Arkansas	x (3)		
Georgia		x	
Kentucky	x (4)		
Louisiana			x
New Mexico	x (4)		
Utah		x	
Total	3	2	1

Table #: States with Best Child Outcomes (n=15)

	Blocks (Levels)	Points	Hybrid
Colorado			x
Illinois	x (4)		
Iowa			x
Maryland	x (5)		
Massachusetts	x (4)		
Minnesota			x
Nebraska			x
New Hampshire			x
New Jersey			x
North Dakota	x (4)		
Pennsylvania	x (4)		
Vermont		x	
Virginia	x (5)		
Washington			x
Wisconsin		x	
Total	6	2	7

Block System¹

- Building block systems require the early education center to meet all of the standards in one “block” before being able to move to the next block.
- Mississippi’s Quality Stars is a block system: Providers must meet all of the requirements associated with a Star 3 in order to actually earn that star.



Point System²

- Points are earned by meeting guidelines in each component. Scores are summed and the total earned corresponds to a rating.

Family Engagement Score =	<u>4</u>
Teaching Practices Score =	<u>5</u>
Director and Teacher Qualifications Score =	<u>4</u>
Health, Nutrition, and Physical Activity Score =	<u>6</u>
Ratio Score =	<u>4</u>
ERS Average =	<u>4</u>
Accreditation Bonus =	<u>1</u>
Total Points Earned =	<u>28</u>

- Each level in the quality rating structure represents a range of possible total scores.

Total Points	Star Level
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0-14	No Stars
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15-24	One Star
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25-35	Two Stars
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36-45	Three Stars
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- Point-based structures are more flexible in terms of how centers can reach quality ratings. A center may still advance in the rating area offsets weaknesses in others. structure if strength in one

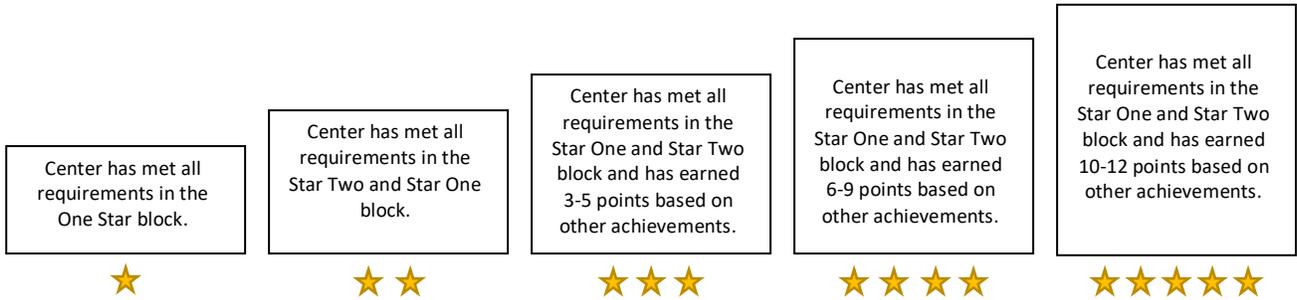
more flexible in terms of how centers center may still advance in the rating area offsets weaknesses in others.

¹ Example based off of Mississippi’s Quality Stars

² Example based off of Georgia’s Quality Rated

Hybrid System³

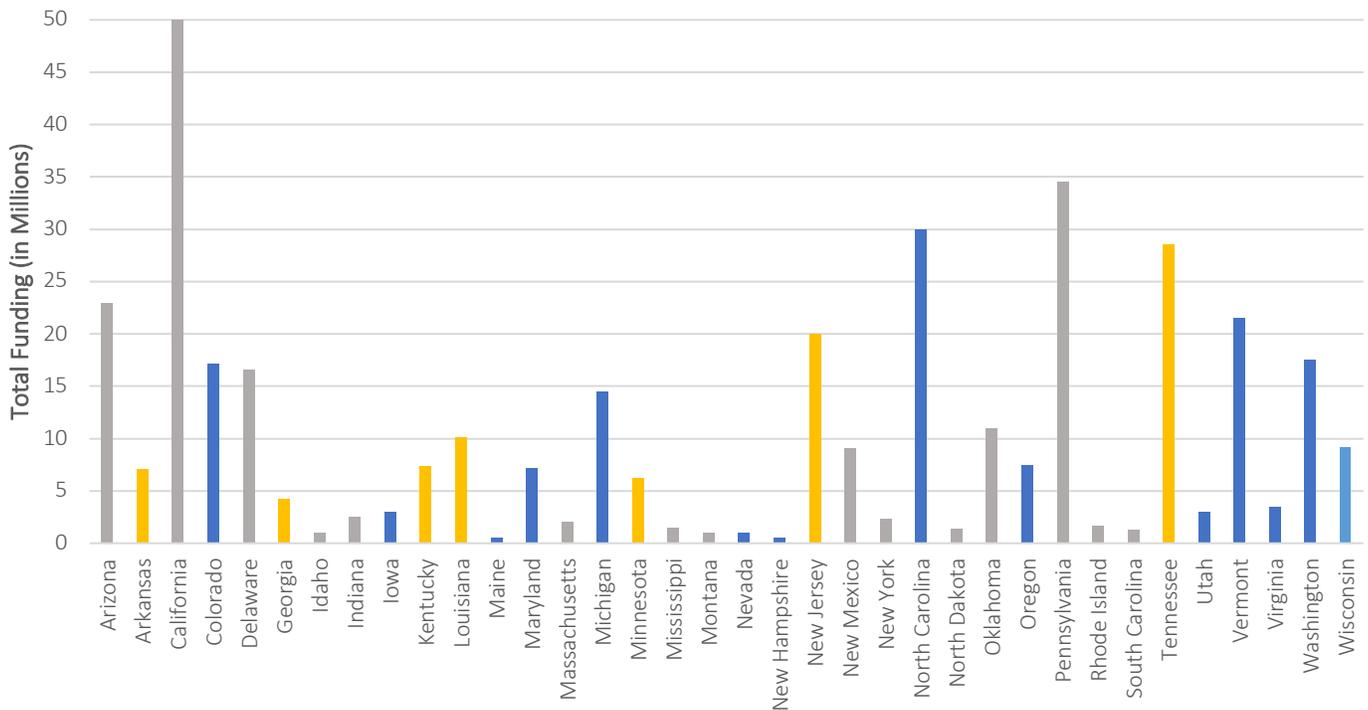
- Hybrid structures combine the building block and point-based structure.
- Hybrid structures usually employ blocks at lower levels and points at higher levels.
- Hybrid structures ensure providers meet a minimum threshold of quality measures before enjoying the flexibility of the points-based structure at higher levels.



Funding

Total funding for statewide evaluation and improvement efforts for early childhood care and education programs varies widely. The range of funding is \$500,000.00 in New Hampshire to \$50 million in California. The average amount of funding allocated is \$11.3 million. The bar chart below shows the amount of funding for these initiatives in states across the US.⁴ States similar to Mississippi are indicated by Yellow. States with best child outcomes are indicated by Blue.

Total Funding: Statewide Evaluation and Improvement Programs



³ Example based off of Louisiana’s Quality Start

⁴ Not all states are represented in Chart #. Total funding is reported for states when the information was publicly available or was reported via personal contact with program administrators.

States also vary widely in how evaluation and improvement initiatives are funded. All states must allocate some funds from their Child Care and Development Fund entitlement toward quality improvements in the EC sector. This mandatory allocation most often ends up supporting the evaluation and improvement efforts in the state. The tables below describe how states are funding their statewide evaluation and improvement effort.

Table #: States Similar to MS (n=6)

	CCDF (Quality Funds)	RTT-ELC	General State Funds	Private or Foundation	CCDF (TANF)	Public Education Funds
Arkansas	x					
Georgia	x	x		x		
Kentucky	x	x				
Louisiana	x					
New Mexico	x	x	x	x		x
Utah	x					

Table #: States with Best Child Outcomes (n=15)

	CCDF (Quality Funds)	RTT-ELC	General State Funds	Private or Foundation	CCDF (TANF)	Public Education Funds
Colorado	x	x	x			
Illinois	x	x		x		x
Iowa	x		x		x	
Maryland	x	x				x
Massachusetts	x	x				x
Minnesota	x	x		x		
Nebraska	x		x	x		
New Hampshire	x					
New Jersey	x	x				
North Dakota	x					x
Pennsylvania	x	x	x			
Vermont	x	x	x			
Virginia	x			x		
Washington	x	x		x		
Wisconsin	x	x			x	

Administration and Management

Rating Structure

The rating structure used to measure and communicate the level of quality in an education or care setting typically falls in one of three approaches: building blocks, points, or a hybrid of both. There is no best practice to report; different rating structures respond to the individual needs and goals of the state EC system.

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Louisiana			x
New Mexico	x (4)		
Utah		x	
Total	3	2	1

Table #: States with Best Child Outcomes (n=15)

	Blocks (Levels)	Points	Hybrid
Colorado			x
Illinois	x (4)		
Iowa			x
Maryland	x (5)		
Massachusetts	x (4)		
Minnesota			x
Nebraska			x
New Hampshire			x
New Jersey			x
North Dakota	x (4)		
Pennsylvania	x (4)		
Vermont		x	
Virginia	x (5)		
Washington			x
Wisconsin		x	
Total	6	2	7

Block System⁵

- Building block systems require the early education center to meet all of the standards in one “block” before being able to move to the next block.

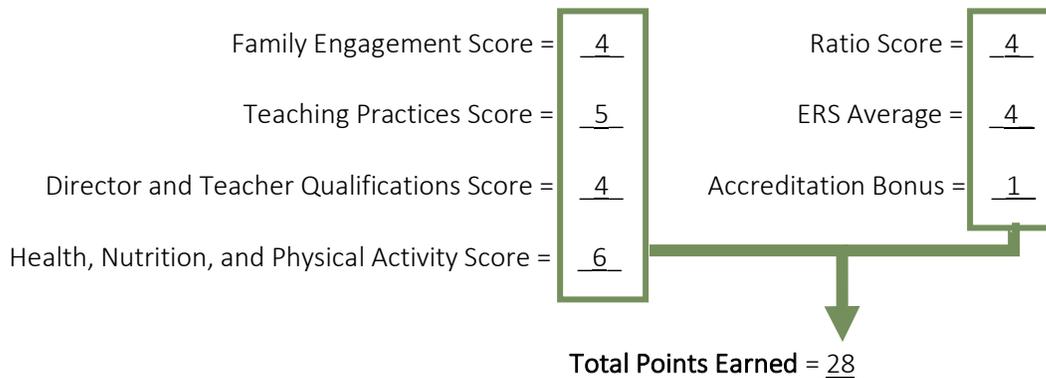
⁵ Example based off of Mississippi’s Quality Stars

- Mississippi's Quality Stars is a block system: Providers must meet all of the requirements associated with a Star 3 in order to actually earn that star.



Point System⁶

- Points are earned by meeting guidelines in each component. Scores are summed and the total earned corresponds to a rating.



- Each level in the quality rating structure represents a range of possible total scores.

Total Points Star Level

0-14	No Stars
15-24	★
25-35	★ ★
36-45	★ ★

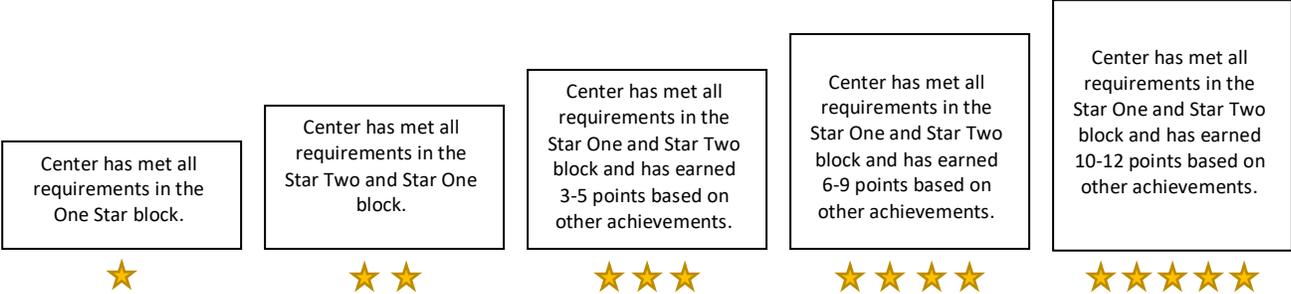
- Point-based structures are more flexible in terms of how centers can reach quality ratings. A center may still advance in the rating structure if strength in one area offsets weaknesses in others.

Hybrid System⁷

⁶ Example based off of Georgia's Quality Rated

⁷ Example based off of Louisiana's Quality Start

- Hybrid structures combine the building block and point-based structure.
- Hybrid structures usually employ blocks at lower levels and points at higher levels.
- Hybrid structures ensure providers meet a minimum threshold of quality measures before enjoying the flexibility of the points-based structure at higher levels.



Organizing Components

Evaluation and improvement programs tend to be organized around a number of components in which childcare providers must meet established criteria of quality for set indicators. The table below indicates which components states are using most often to organize efforts. North Carolina has the fewest components (2); Rhode Island has the most (10). The average number of organizing components across all states is five.

Component	States Utilizing
Teacher Credentials and Professional Development	37
Program Administration	30
Family and/or Community Engagement	29
Learning Environment	26
Curriculum	21
Nutrition, Physical Health and Safety	16
Child Assessment	14
Teacher Practices	12
Center Ratios	9
Accreditation or Regulatory (licensing) History	8
Diversity/Inclusion	6
Program Evaluation	5
Environmental (ERS) Assessment	2
Staff Compensation	2

Variation within Components

States demonstrate a great deal of variability when determining the indicators that correspond to each component around which the evaluation and improvement effort is organized. The table below present three examples of States that have the same organizing component and the various ways the state has chosen to define that component.

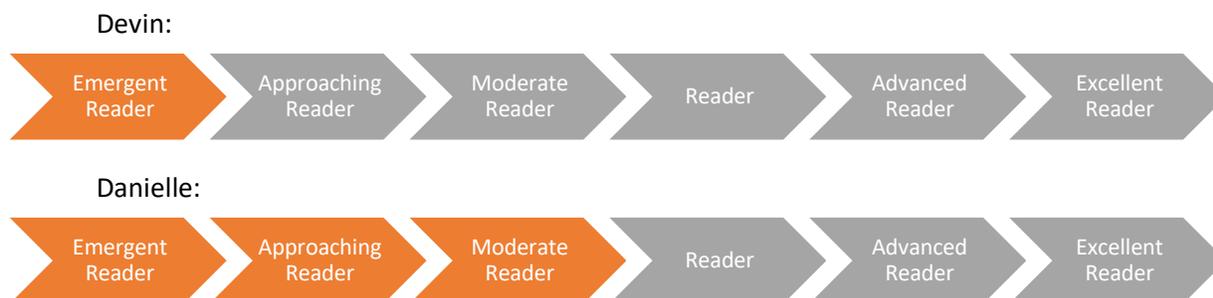
Georgia	Ohio	Utah
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Family and/or Community Engagement	All staff complete Strengthening Families training Family engagement self-assessment and action plan Written inclusion, confidentiality, transition, and family engagement plans Family conferences twice per year Include family feedback into planning	Written transition plans Transition facilitation Parent conference Individualized engagement plans Provision of community resources and services to families Utilize electronic communication Two health/development events per year At least one opportunity per year for parents to join the classroom Policy regarding comprehensive health screening Collaborative goal setting for children Organized parent volunteer group	Monthly calendar of events posted and distributed Written parent handbook Enrollment orientation for new parents Family conferences twice a year Written transition plans Program incorporates family traditions, other languages (if represented in enrollment) into program Volunteer opportunities provided Program utilizes electronic communication Bulletin board displayed Families are involved in the planning of activities and/or menu options Educational workshops for parents
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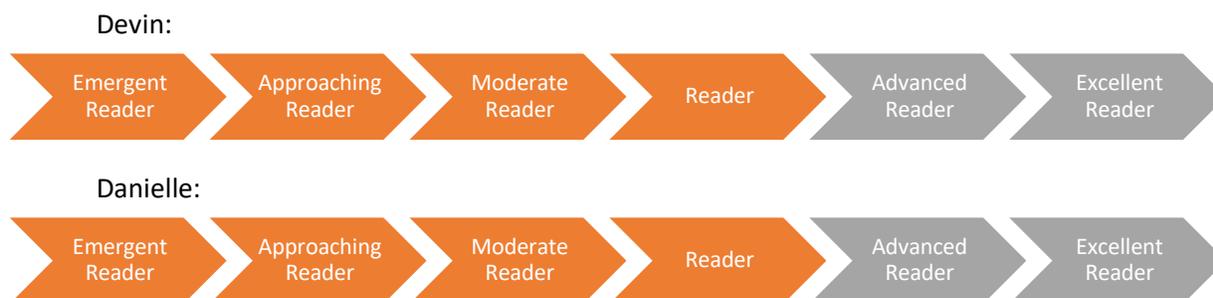
Child Outcomes

No states currently include actual child outcomes in the process of measuring quality of care and education in center- or family-based care. The example below illustrates why children’s scores on developmental screening tools are not adequate for determining quality of care and education provided in center- or family-based care and education settings.

Devin and Danielle attend preschool at two different child care facilities in the same city. Here are their scores on an early literacy assessment when they enrolled in preschool in January 2015:



Devin and Danielle have each been at their center full time, five days a week for the past ten months. Here are their early literacy assessment scores in October 2015:



Observing child outcomes in January would lead one to believe Devin was receiving lesser quality of care and education than Danielle. Observing child outcomes in October would suggest Devin and Danielle are receiving equality quality of care and education when actually Devin has made significant gains in early literacy skills compared to Danielle and is likely receiving a higher-quality early education experience.

Including child outcomes in a system-evaluation program would require a comprehensive analysis of the child in order for child outcomes to be meaningful attributed to the quality of care and education received. What is more, no formal assessment package on the regular consumer market (i.e., Brigance, High Scope, Ages and Stages, STAR, etc.) is designed to measure center- or family-based quality.

Other Considerations: Child Outcomes and Curriculum Planning

Unless otherwise specified, the purpose of developmental screening tools (such as Brigance, High Scope, Ages and Stages, STAR, etc.) is to communicate developmental progress to parents and inform curriculum planning. New Mexico has implemented the only specified purpose of a developmental screening tool into the rating structure for its EC system:

- Star 3 providers must develop a plan for assessing their children (including complete Ages and Stages training)
- Star 4 providers must implement the assessment process and share individual results with parents
- Star 5 providers must implement child outcomes into curriculum planning

Child Assessment (Developmental Screening)

Twenty-six states include administering a developmental screening as a requirement for demonstrating quality in their child care center. Tables 1 and 2 below show the decisions regarding developmental screening in states similar to Mississippi and states which demonstrate best child outcomes in the US.

Table 1: States Similar to MS (n=6)

	Child Assessment Required	No Child Assessment Required	Notes
Arkansas		x	
Georgia	x		Ages and Stages Questionnaire (ASQ)
Kentucky		x	
Louisiana		x	
New Mexico	x		Ages and Stages Questionnaire (ASQ)
Utah	x		Provider's choice; Must be reliable and valid instrument
Total	3	3	

Table 2: States with Best Child Outcomes (n=15)

	Child Assessment Required	No Child Assessment Required	Notes
Colorado	x		Provider's choice; Must be reliable and valid instrument
Illinois	x		Provider's choice from list of approved tools
Iowa		x	
Maryland	x		Provider's choice, but must be aligned with curriculum
Massachusetts	x		Provider's choice from list of approved tools
Minnesota	x		Provider's choice from list of approved tools
Nebraska	x		Provider's choice; Must be reliable and valid instrument
New Hampshire		x	
New Jersey	x		State-funded must use ESI-R; All others, provider's choice from list
North Dakota	x		Provider's choice from list of approved tools
Pennsylvania	x		Ages and Stages Questionnaire (ASQ)
Vermont	x		Provider's choice from list of approved tools
Virginia		x	
Washington	x		Provider's choice; Must be reliable and valid instrument
Wisconsin	x		Provider's choice, must be aligned with curriculum
Total	12	3	

Measurement Tools

Only four states do not use a formal measurement tool (i.e., ITERS, ECERS, ASQ, Brigance, NIH Toolbox, CLASS) to supplement the process of evaluating the quality of education and care provided by the EC system. Tables 3 and 4 below present the choice of measurement tool used by states similar to Mississippi and states which demonstrate best child outcomes in the US.

Table 3: States Similar to MS (n=6)

	PAS/BAS	ERS	ASQ	CLASS	Created Own	Other
Arkansas	x	x				x
Georgia		x	x			x
Kentucky		x				
Louisiana		x				
New Mexico		x	x			
Utah						
Total	1	5	2	0	0	2

Table 4: States with Best Child Outcomes (n=15)

	PAS/BAS	ERS	ASQ	CLASS	Created Own	Other
Colorado		x		x		
Illinois	x	x		x		
Iowa		x				
Maryland	x	x		x		
Massachusetts	x	x		x		x
Minnesota				x		
Nebraska		x		x		
New Hampshire		x				
New Jersey		x		x		
North Dakota		x		x		
Pennsylvania		x				
Vermont		x		x		
Virginia		x		x		
Washington		x		x		
Wisconsin		x				
Total	3	14	0	11	0	1

Alignment with Licensing

Twenty-four states have aligned their system evaluation process with regular facility and home licensing. Alignment between licensing and further evaluation of quality is considered a best practice for early childhood systems. Tables 5 and 6 present findings related to alignment with licensing in states similar to Mississippi and states which demonstrate best child outcomes in the US.

Table 5: States Similar to MS (n=6)

	Aligned with Licensing	Not Aligned with Licensing
Arkansas		x
Georgia		x
Kentucky		x
Louisiana	x	
New Mexico	x	
Utah		x
Total	2	4

Table 6: States with Best Child Outcomes (n=15)

	Aligned with Licensing	Not Aligned with Licensing
Colorado	x	
Illinois	x	
Iowa	x	
Maryland		x
Massachusetts	x	
Minnesota		x
Nebraska	x	
New Hampshire	x	
New Jersey		x
North Dakota	x	
Pennsylvania		x
Vermont	x	
Virginia	x	
Washington	x	
Wisconsin		x
Total	10	5

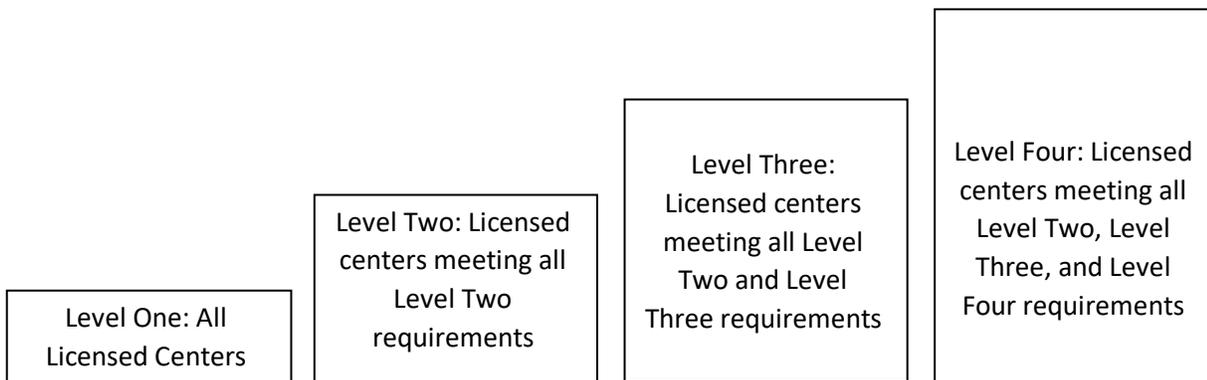
Alignment Example: Illinois

Early care and education providers in Illinois must demonstrate incremental achievement across 14 categories of early learning standards. Licensing is the lowest threshold of each of the 14 categories. Table 7 below illustrates the incremental achievement process using six of the 14 standards categories.

	Learning Environment	Curriculum	Instructional Quality	Child Screening	Inclusive Practices	Family Engagement
Green	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
Bronze	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
Silver	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
Gold	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator
	Indicator	Indicator	Indicator	Indicator	Indicator	Indicator

Alignment Example: Indiana

Indiana has designed a building block approach (similar to MS) to evaluating and communicating the level of quality care and education provided by an establishment. The Indiana approach is aligned with licensing such that licensing represents the first level in the rating structure.



Appendix A: Tables including All States

Table 7: Child Assessment Decisions in all QRIS States (n=40; Florida Excluded)

	Child Assessment Required	No Child Assessment Required	Notes
Arizona	x		Provider's choice, must measure all domains of development
Arkansas		x	
California	x		Desired Results Developmental Profile
Colorado	x		Provider's choice; Must be reliable and valid instrument
Delaware	x		Provider's choice from list of approved tools
Georgia	x		Ages and Stages Questionnaire (ASQ)
Idaho		x	
Illinois	x		Provider's choice from list of approved tools
Indiana		x	
Iowa		x	
Kentucky		x	
Louisiana		x	
Maine	x		Provider's choice; Must be reliable and valid instrument
Maryland	x		Provider's choice, must be aligned with active curriculum
Massachusetts	x		Provider's choice from list of approved tools
Michigan	x		Provider's choice from list of approved tools
Minnesota	x		Provider's choice from list of approved tools
Mississippi	x		Provider's choice; Must be reliable and valid instrument
Montana		x	
Nebraska	x		Provider's choice; Must be reliable and valid instrument
Nevada	x		Provider's choice; Must be reliable and valid instrument
New Hampshire		x	
New Jersey	x		State-funded must use ESI-R; All others, provider's choice from approved list
New Mexico	x		Ages and Stages Questionnaire (ASQ)
New York	x		Provider's choice from list of approved tools
North Carolina		x	
North Dakota	x		Provider's choice from list of approved tools
Ohio	x		EC-CAS
Oklahoma		x	

Oregon	x		Ages and Stages Questionnaire (ASQ)
Pennsylvania	x		Ages and Stages Questionnaire (ASQ)
Rhode Island	x		Provider's choice; Must be reliable and valid instrument
South Carolina		x	
Tennessee		x	
Texas		x	
Utah	x		Provider's choice; Must be reliable and valid instrument
Vermont	x		Provider's choice from list of approved tools
Virginia		x	
Washington	x		Provider's choice; Must be reliable and valid instrument
Wisconsin	x		Provider's choice, must be aligned with active curriculum
Total	26	14	

Table 8: Formal Measurement Tools of All States (n=40; Florida Excluded)

	PAS/BAS	ERS	ASQ	CLASS	Created Own	Other	Notes
Arizona		x		x	x		Levels 1, 2 only ERS; levels 3, 4, and 5 requires all
Arkansas	x	x				x	
California	x	x	x	x	x	x	
Colorado		x		x			
Delaware		x	x	x			
Georgia		x	x				
Idaho	x	x					
Illinois	x	x		x			
Indiana							
Iowa		x					
Kentucky		x					
Louisiana		x					
Maine		x					
Maryland	x	x		x			
Massachusetts	x	x		x		x	
Michigan						x	
Minnesota				x			
Mississippi		x					
Montana	x	x					
Nebraska		x		x			Center picks one of the two
Nevada		x					
New Hampshire		x					
New Jersey		x		x			
New Mexico		x	x				
New York		x		x			ERS levels 3, 4, and 5; CLASS levels 4 and 5
North Carolina		x					
North Dakota		x		x			
Ohio					x		

Oklahoma		x		x			
Oregon		x	x	x		x	
Pennsylvania		x					
Rhode Island		x		x			
South Carolina		x	x		x	x	
Tennessee		x					
Texas							
Utah							
Vermont		x		x			
Virginia		x		x			
Washington		x		x			
Wisconsin	x	x	x	x		x	Provider's choice; ERS required for 5 star
Total	8	34	7	19	4	7	

Table 9: Alignment Practices for All States (n=40; Florida Excluded)

	Aligned with Licensing	Not Aligned with Licensing	Notes
Arizona	x		Licensing satisfies the lowest threshold of each EL standard
Arkansas		x	
California	x		Licensed centers are designated as Level 1 centers
Colorado	x		Licensed centers are designated as Level 1 centers
Delaware		x	
Georgia		x	
Idaho		x	
Illinois	x		Licensing satisfies the lowest threshold of each EL standard
Indiana	x		Licensed centers are designated as Level 1 centers
Iowa	x		Licensed centers are designated as Level 1 centers
Kentucky		x	
Louisiana	x		Licensed centers are designated as 1 Star centers
Maine	x		Licensing satisfies the lowest threshold of each EL standard
Maryland		x	
Massachusetts	x		Licensing satisfies the lowest threshold of each EL standard
Michigan	x		Licensed centers are designated as 1 Star centers
Minnesota		x	
Mississippi	x		Licensed centers are designated as Level 1 centers
Montana		x	
Nebraska	x		Licensed centers are designated as Level 1 centers
Nevada	x		Licensed centers are designated as 1 Star centers
New Hampshire	x		"Licensed Quality" is the first level of the program
New Jersey		x	
New Mexico	x		"Licensed Quality" is the first level of the program
New York	x		Licensed centers are designated as 1 Star centers
North Carolina		x	

North Dakota	x		Licensed centers are designated as Level 1 centers
Ohio		x	
Oklahoma	x		Licensed centers are designated as Level 1 centers
Oregon	x		Licensed centers are designated as Level 1 centers
Pennsylvania		x	
Rhode Island		x	
South Carolina		x	
Tennessee	x		Licensed centers are designated as Level 1 centers
Texas	x		Licensed centers are designated as Level 1 centers
Utah		x	
Vermont	x		Licensing satisfies Level 1 requirements
Virginia	x		Licensed centers are designated as Level 1 centers
Washington	x		Licensed centers are designated as Level 1 centers
Wisconsin		x	
Total	24	16	

	Building Blocks (Levels)	Points	Hybrid
Arizona			x
Arkansas	x (3)		
California			x
Colorado			x
Delaware		x	
Georgia		x	
Idaho	x (6)		
Illinois	x (4)		
Indiana	x (4)		
Iowa			x
Kentucky	x (4)		
Louisiana			x
Maine	x (4)		
Maryland	x (5)		
Massachusetts	x (4)		
Michigan		x	
Minnesota			x
Mississippi	x (5)		
Montana	x		
Nebraska			x
Nevada			x
New Hampshire			x
New Jersey			x
New Mexico	x (4)		
New York		x	
North Carolina		x	

North Dakota	x		
Ohio			x
Oklahoma	x		
Oregon	x		
Pennsylvania	x		
Rhode Island	x		
South Carolina			x
Tennessee		x	
Texas			x
Utah			
Vermont		x	
Virginia	x		
Washington			x
Wisconsin		x	

**APPENDIX C:
STAKEHOLDER ASSESSMENT OF THE VALUE
OF QUALITY RATING SYSTEMS**

A Qualitative Study of a Rural State's Quality Rating and Improvement System

Title: A Qualitative Study of a Rural State's Quality Rating System through the Lens of its
Licensed Childcare Providers

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*The National Strategic Planning and Analysis Research Center (NSPARC) is an interdisciplinary research unit at Mississippi State University (MSU). For more than 15 years, NSPARC has used smart data and analytical techniques to connect academic research to public policy, economic development, and social issues. NSPARC is No. 1 in external research funding at MSU. Dr. Domenico "Mimmo" Parisi is the executive director. For more information, visit www.nsparc.msstate.edu.

ABSTRACT

A Qualitative Study of a Rural State's Quality Rating and Improvement System

This study represents a qualitative statewide research initiative undertaken during the first six months of 2015 to investigate the low participation rates and low ratings earned in one rural, southern state's quality rating system for early childhood care and education. The one-hour, semi-structured group interviews used in this study were held at eight public locations located throughout the state reaching both private and public sectors, for-profit and non-profit care, and those serving middle- and low-income populations in rural and urban areas (n=79). The research analysis merged typological analysis with grounded theory to perform a qualitative analysis of text.

A number of findings emerged from our research. Providers indicated that they participated in the current QRS program because they view the program as a guide to improvement and accountability. Financial gains and market influences were two additional drivers for participation. Providers identified technical assistance and alignment with documentation and licensure requirements as beneficial components to improved business practices. In contrast, providers who did not participate in the QRS program cited irrelevant and unrealistic requirements as well as negative previous experiences with the program.

Our research also suggests that increasing staff requirements, problematic access to training, rigidity of the QRS scoring system, lack of available funding aside from TANF subsidies, and daunting demands from the program impeded providers from advancing within the QRS program. Providers identified the following QRS evaluation criteria as important: credentials, child-staff interactions, staff affective skills, child academic outcomes, curriculum, quality of physical environment, and parent-provider relationships.

Based on this research, the authors conclude that to increase voluntary program participation, quality rating and improvement systems need to build capacity in areas that

A Qualitative Study of a Rural State's Quality Rating and Improvement System

providers have identified as important, such as easily accessible technical support, financial incentives, and ongoing, positive relationships. Program retention efforts must address aspects that appear to deter or discourage providers from continuous improvement, such as unclear expectations, perceived inequity, staffing constraints, and financial barriers. Finally, further research of the QRIS landscape nationwide is needed as multiple states consider restructuring their varied assessment components to more accurately reflect current early childhood policy priorities.

1. Introduction

Quality rating and improvement systems (QRIS)⁸ have become a nearly unanimous feature of early childhood education systems in the United States. The investment in these programs ranges from \$500,000 to nearly \$50 million in a single state (NSPARC, 2016). At the time of publishing, 40 states currently operate or are in planning stages for operating a QRIS (NSPARC, 2016). Quality rating and improvement systems offer states an organized and incremental approach to improving the quality of the learning environment, from curriculum to staff training to social and emotional skills. These programs may be attractive to state leaders and policymakers because they consolidate a monumental and vague task: assessing and improving the quality of early childhood care and education in the state. Considering the importance of children's earliest learning experiences, state leaders and policymakers may approach the task with a sense of urgency and may look to a QRIS as an obvious and welcomed tool to address the need for higher quality in pre-K programs.

In terms of increasing positive child outcomes, previous research indicates mixed findings on the effectiveness of these programs. Children in one study demonstrated better cognitive outcomes (i.e., vocabulary skills, phonological awareness, and mathematics skills) after being enrolled in a high-rated program than children who had been enrolled in low-rated programs (Jeon & Buettner, 2015). Sabol and Pianta (2015) found similar results but also showed that these differences did not hold through the Kindergarten year. A number of studies

⁸ Throughout this report, QRIS and QRS are used interchangeably to refer to the Quality Rating and Improvement System (QRIS) that is currently active in the state in which this research occurred or to QRISs in general. Quotes from providers have not been changed when they have referred to the relevant QRIS or QRISs in general as simply "QRS." For all intents and purposes in this report, "QRIS" and "QRS" are synonymous references to the current QRIS in the region in which this research was conducted or QRIS programs in general.

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(Sabol & Pianta, 2014) have found no relationship between enrollment in centers participating in a QRIS and positive child outcomes.

A few studies have investigated childcare providers' perceptions of these programs. Tarrant and Huerta (2014) report that providers felt QRISs positively impacts some aspects of the learning environment, such as teacher credentials, classroom size and materials, and other features of physical space. These providers report that the QRIS has less of an impact on the quality of teacher-child interactions and instructional practices. In other words, QRISs tend to increase quality in features of the learning environment that are clearly observable and documentable, and sometimes increase the relational aspects of early learning and care. One program evaluation in Massachusetts (UMass Donahue Institute, 2012) included provider voices. Providers in this study were generally positive about the QRIS and appreciated the intents and purposes of the program. Providers in this study also felt that the QRIS tended to focus on easily observable features of the environment and overlooked other important aspects of care, such as whether or not children feel safe and cared for.

Quality Rating and Improvement Systems are a relatively new feature of early childhood systems. It is important to understand how these programs are impacting the early childhood care and education workforce and what providers' expectations are for these programs moving forward.

This Current Project

The current study was undertaken during the first six months of 2015 to investigate provider experiences and expectations related to one rural, southern state's quality rating and improvement system for early childhood care and education. This project emerged from a large, statewide initiative to revise and relaunch the QRIS currently active in the state. This state's

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current QRIS is a five-component tiered system that allows childcare providers to meet a series of benchmarks represented by ratings of one to five stars. Under this program, a higher star rating intends to reflect that a childcare center has higher-quality services. Participation in the state's QRIS is voluntary, and as of June 2015, only 576 of the 1,541 licensed childcare providers across the state, or 37.37 percent, were enrolled (State Department of Human Services, 2015).

Under the current system, licensed providers who opt to enroll in the state's QRIS are given star ratings based on how well the childcare staff and facility score across the five components of the program: administrative policy, professional development, learning environments, parent involvement, and evaluation. One star is equivalent to state licensure requirements; five stars is equivalent to excellence in all five components of the QRIS. As of June 2015, only 3 percent of participating providers have demonstrated five-star excellence across all five domains of the QRIS evaluation (State Department of Human Services, 2015). The overwhelming majority of participating childcare providers in the state (about 79 percent) still rate as one-star or two-star facilities (State Department of Human Services, 2015).

Taken together, these descriptive statistics indicate the QRIS in this particular state is under-utilized. The current study seeks to shed light on providers' current experiences with QRISs and their expectations for these programs.

2. Study Design

A series of focus groups was identified as the most equitable way to hear from as many voices as possible, and a time frame for data collection was established. The focus groups were semi-structured, guided initially by a series of predetermined talking points but also allowed to flow naturally as dictated by provider input at each event. Additionally, a neutral research team

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facilitated an impartial forum environment so that providers could be free to share authentic thoughts and perspectives without concern of repercussion (Kai-Wen Cheng, 2014; Wilson, 1997).

Prior to the first focus group, members of the research team negotiated a key list of questions to ascertain providers' current QRIS experiences as well as perceived needs and wants. This initial list was comprised of ten questions. After the first few focus groups, these questions were refined and reorganized to reflect emerging norms and interests from participants (Charmaz, 2001). The seven resulting questions that were used for the majority of the focus group sessions fell into two distinct categories of current experiences and expectations. In order to understand provider's current experiences in QRIS, participants were asked to respond to the following questions: "Do you currently participate in the state's current QRIS? Why or why not?" "What obstacles or barriers have you encountered that have prevented you from reaching a higher rating or from participating in QRIS?" "What benefits have you seen in your children, staff, or program overall by participating in the current QRIS?" and "How clearly are the expectations for improvement communicated in the current QRIS?" In order to understand providers' expectations for QRIS, participants were asked to respond to the following questions: "What factors of the early education experience are important for childcare centers to be evaluated on?" "What benefits should childcare centers receive by enrolling in a QRIS?" and "How do you think provider input can be best represented in a QRIS revision and relaunch process?"

The questions were designed to be posed in a semi-structured format to encourage dialogue between attendees, probe the exchange of ideas, and allow for the free flow of opinions in a comfortable, relaxed environment. While the number of attendees would determine the

intimacy of the conversations to some extent, this semi-structured interview format could be flexed to accommodate both small and large groupings with either an interview or focus-group approach, respectively (Morgan, 1996).

Site Selection and Geographic Coverage

Eight event locations were positioned throughout multiple regions of the state to remove traveling distance as a barrier to provider participation. The dates for the focus groups were staggered across a six-month period to allow time for multiple recruitment efforts immediately prior to each event. A description of geographic representation and total participation is shown in Table 1.

Table 1. Geographic representation and description of participation (n=79).

Geographic Region	N	Total Number of Children Served by Participants
North West*	--	--
North	12	800
South	5	75
West	6	400
South East	14	6,700
Central	23	1,300
South West	11	500
Central East	6	115
Central West	2	145
TOTAL	79	10,035

*A pilot focus group in this region was completed several months prior to the official launch of the project. This session was not recorded and was not included in the data analysis.

Childcare Provider Recruitment Efforts

Although the focus groups were open to the public, the specific intention was to solicit information from currently licensed childcare providers regarding current, past, or potential participation in the state’s current QRIS. To that end, several different recruitment approaches were undertaken. In January 2015, the research team identified key governmental and nonprofit

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stakeholders with large-scale access to childcare providers across the state. These individuals were contacted electronically with an open-invitation letter to participate in the initiative and were asked to distribute the invitation to their respective networks (see Appendix A). Some stakeholders were given fliers to post publicly within their own organizations to advertise the focus groups. That same month, an electronic announcement campaign utilized Facebook, Twitter, and other social media outlets to announce the tour launch. All scheduled focus groups were listed on several electronic websites several weeks prior to meeting days.

To increase participation, individual phone calls were made directly to area childcare providers during the week prior to each meeting. To accomplish this, an exhaustive call list, which included all of the care and education providers serving children (birth to age 5) within a 30-mile radius, on average, of the meeting location, was generated by the research team. In the days leading up to each event, courtesy calls were made to ensure local providers were aware of the time and location of the meeting. Across the entire duration of the project, approximately 740 phone invitations were extended to childcare centers throughout the state. As a final outreach effort in the days prior to each event, local childcare organizations were engaged via various social media outlets.

Data Collection: Coming to the Table

The research team attended all scheduled events. At the start of each focus group, attendees were asked to introduce themselves by describing the type of center they work for, how many children they currently serve, and whether or not they currently participate or previously participated in the state's QRIS. Research personnel explicitly stated to the attendees that the provision of any names or center-identifying information was optional.

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While individual data were not formally collected during the focus groups, the attendees' introductions provided evidence in aggregate of representation from a number of different provider types (public school, faith-based care, and private provider), participating and non-participating (in the current QRIS program) providers, and providers serving both urban and rural communities. Participants represented a wide range of experience levels, from new provider (less than one year in the industry) to 40 or more years of service, as well as a full range of education and credential levels. A diverse range of subsidy-based income (from no subsidy-based income to 95-100 percent subsidy-based income) was also represented by the attendees. By the conclusion of data collection, only one in-home provider was noted, indicating that representation across the tour was primarily for center-based care.

Each of the focus groups lasted approximately one hour. After the introductions, attendees were informed that the remainder of the meeting would be audio recorded and later transcribed for qualitative analysis. Speakers remained anonymous within the recordings, unless they chose to identify themselves or their early childhood facility.

Across all eight focus groups, a research team member remained actively involved in moderating the conversation, using best-practice skills and techniques to encourage discussion and acknowledge issues raised during the dialogue. In accordance with the semi-structured format, the discussion facilitator moved systematically through the scripted interview questions while allowing respondents to diverge when conversation appeared to be fruitful, eventually guiding participants back to the original question to ensure the full scope of the intended session was achieved. All of the data from the focus groups were captured on two recording devices. At the conclusion of each session, the audio files were immediately transferred to a secure computer at NSPARC. The files were transferred in bulk via a secure connection to the transcription

service provider, who returned text documentation of each focus group to the research team for analysis.

3. Data Analysis: A Qualitative Approach

The research analysis approach for this study merges typological analysis (LeCompte and Preissle, 1993) with the spirit of grounded theory (Glaser and Strauss, 1967) to perform a qualitative analysis of text. Typological analysis relies on a preexisting typology by which data are sorted or aggregated. Sometimes the typology is an existing theory or a concrete set of research questions, such as the questions developed in advance by the research team. Grounded theory relies on the source of data for the formation of a unique theory or set of conclusions. In this approach to analysis, the researcher categorically rejects the testing of existing theory or hypotheses and instead allows data to drive new theory or conclusions.

The purpose of the focus groups was for providers to respond to a set of research questions falling within the realm of typological analysis. However, the intention of the sessions to identify the authentic perceptions and input from providers required retaining the spirit of the grounded theory method throughout the research project in order to underpin the nature of the conclusions and preserve the integrity of providers' voices (Charmaz, 2001). Within the seven-question typology, patterns emerged organically. Data were coded based on the interpretation of the providers' intentions, and every effort has been made to preserve the authenticity of providers' voices. Consistent with grounded theory and in line with the intended scope of this research, this study features the themes and ideas that sampled providers articulated in response to the questions developed by the research team.

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Data Analysis

The first step in the data analysis was to construct the typology. This task was straightforward, as the research questions were prepared by the research team prior to the initiative. Each research question was translated into a corresponding “shorthand” theme, as shown in Table 2.

Table 2: Typological Themes for Research Questions

Theme in Typology	Research Question
Current Participation	Do you currently or previously participate in the state’s current QRIS? Why or why not?
Benefits Received	What benefits have you seen in your children, staff, or program overall by participating in the current QRIS?
Obstacles or Barriers	What obstacles or barriers have you encountered that have prevented you from reaching a higher rating or from participating in QRIS?
Communication	How clearly are the expectations for improvement communicated in the state’s current QRIS?
Important Aspects of EC	What factors of the early education experience are important for childcare centers to be evaluated on?
Benefits Desired	What benefits should childcare centers receive by enrolling in a QRIS?
Provider Representation	How do you think provider input can be best represented in a relaunch or revision of the current QRIS?

Next, the research team reviewed the transcripts for the first three focus groups and developed possible sub-codes for each of the seven themes using the qualitative data software NVivo (QSR International). The research team then discussed overlap and discrepancies in initial identified sub-codes. The next step was to begin solidifying the overlapping information into a codebook. The codebook served as a hub for all of the working definitions of nested codes within the primary hierarchical codes gleaned from the transcripts.

After finalizing the first iteration of the codebook, the research team began coding the data. This step included constant attention to which research question providers were speaking about. At times this step was straightforward. At other times this step required induction by the

research team. Our approach involved multiple readings of each transcript to ensure all of the information was captured completely. This iterative process also improved inter-coder reliability, which helps prevent generation of different codes with similar interpretations.

The process of reading the transcripts, discussing common themes, adjusting the codebook, and coding the transcripts was repeated twice (the second round included transcripts from sessions 4 and 5; the third round included transcripts from sessions 6, 7, and 8). The research team continuously updated and expanded the codebook based on exploration of the data. During the third iteration of the data analysis, the research team added very few new codes, and many of the themes from provider voices were reiterations of themes identified previously, which provided evidence of the completeness of the new, unique framework within which conclusions might be drawn.

The final step of data analysis involved refining the coding scheme. After coding all eight group interviews, each hierarchical and nested code was reviewed individually for its overall clarity, cohesiveness, and uniqueness. The resulting composite of codes was organized into distinct, overarching domains that heavily or sporadically emerged across sessions. Collapsing or expanding codes added to the overall validity of the coding endeavor.

4. Results: What Childcare Providers Say Matters

Based on responses to the initial interview questions and the peer-to-peer conversations that evolved around them, the research team identified multiple themes that succinctly captured providers' past and current experiences with the QRIS in their state and their generally perceived wants and needs related to QRISs in general. The results that follow are in accordance with the original framing of current experiences and expectations as well as a third umbrella of "additional findings," which encapsulates provider perspectives that extended beyond the scope

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of the original research questions. To discriminate effectively between the natures of feedback, “yes” and “no” were coded separately before identifying specific themes within the first research question. A summary of the major findings is shown in Table 3.

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Table 3: Summary of Findings by QRIS Question/Theme

Question/Summary of Theme	Typology Code	Major Findings	
Do you currently or previously participate in the state's current QRIS? Why or why not?	Current Participation -- YES	Program Improvement Financial Benefits	Market Influences Accountability
	Current Participation -- NO	Irrelevance Negative Experience	
What obstacles or barriers have you encountered that have prevented you from reaching a higher rating or from participating in QRIS?	Benefits Received	Lack of Financial Resources Scoring System Inadequate Hand Washing Access to QRIS Resources	"It's too much." Not a Level Playing Field Retaining/Credentialing Staff
What benefits have you seen in your children, staff, or program overall by participating in the current QRIS program?	Obstacles or Barriers	Technical Assistance Center Improvement Better Parent-Provider Relationships	Financial (TANF Subsidy) Improved Business Practices
How clearly are the expectations for improvement communicated in the current QRIS program?	Communication	Expectations Are Unclear General Satisfaction	Misinformation Feedback Harsh/Not Helpful
What factors of the early education experience are important for childcare centers to be evaluated on?	Important Aspects of EC Experience	Staff Quality Child Outcomes Parent-Provider Relationships	Curriculum Physical Environment
What benefits should childcare centers receive by enrolling in a QRIS program?	Benefits Desired	Flexibility Coaching and Mentoring Improved Parental Involvement Alignment with Other EC Entities	Recognition in the Field Kindergarten Readiness Financial
How do you think provider input can be best represented in the QRIS program?	Provider Representation	Providers with Experience Multiple Sector Representation	Geographic Representation
Providers praise other early childhood care and education organizations and acknowledge the role they have played in improving their center.*	Additional Findings	Quality for Kids NOW Ready by 5 Early Education Alliance, LLC	Five-Step Program Resource & Referral Office
Providers experience stress or nervousness on the day of the QRIS assessment.	Additional Findings	Anxiety/Intimidation QRIS Staff Approach	Impact on Children

*Pseudonyms for organizations have been created.

Current Experiences: Reasons I Participate in the Current QRIS

Providers in this study emphasized program improvement, financial benefits, market-based influences, and the provision of accountability as reasons why they currently participate in the state's current QRIS.

Program Improvement. Providers tended to describe the state's current QRIS as a program that offers improvement for their center. A new provider shared, "I just signed up maybe a day ago. But my reasons to sign up, I want to, you know, to improve. To do better." The general sentiment from providers is that enrolling in QRIS means guidance, motivation, or resources to improve the quality of their childcare. Providers specifically mentioned improvement in terms of child outcomes ("I thought it would benefit the children.") and the anticipated benefits of receiving technical assistance from the QRIS staff ("I look forward to them coming to keep my center and trying to get—keep getting ready because I want to keep my score."). Participating providers were also likely to view QRIS staff as experts who would offer them the tools to keep their center and their early childhood program operating efficiently and at a high level of quality ("We knew some things that we could do better, some things that we wanted to do better, but didn't know how to do it."). As one provider expressed, "I wanted to be an innovator. I wanted to increase the quality of my program."

Financial Benefits. Some providers said they participate because of the financial benefit that QRIS participation offers for their center (i.e., higher reimbursement rate from TANF subsidies). As one provider explained, "In order for me to be able to hire the staff that I need to hire, pay all my taxes, and take care of everything the way that I should, I needed the extra money." Providers often framed the financial benefits in this way, emphasizing that the additional income would cover critical expenses and would not be considered a bonus or

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discretionary funds (“I have two deeded people, and if I don’t have those funds, I won’t have those people.”).

Market Influences. Some providers referred to the competitive market to explain why they chose to participate in the state’s current QRIS (“So if it’s a little—it’s a little tougher on the other centers because, you know, you got a little competition behind you.”). Participating providers felt that QRIS adds saleable value to their center. As one provider stated:

My rationale with the [QRIS] program was just in the word quality. Starting out, I knew that I wasn’t exactly where I needed to be and if I wasn’t where I needed to be, then I wasn’t as marketable as other centers in the area. And I wanted to become marketable.

Accountability. Some providers felt the current QRIS would hold their center, including center staff, to a certain degree of accountability. These providers saw the QRIS as a benchmark or measuring rod for them to know exactly what they need to do in order to continue to provide quality services. One provider explained that quality is always the bottom line for childcare providers (“to have a tool to gauge that, that’s what [the QRIS] gave me.”). Another provider explained:

I knew that I couldn’t be as objective as someone else coming in. They’re going to be very objective. They’re going to look at it and they’re going to see it from a way that I wouldn’t see it and then be able to, you know, critique myself.

Current Experiences: Reasons I Do Not Participate in the Current QRIS

Providers in this study who did not participate in the state’s QRIS cited the irrelevance of the program to their provision of high-quality services. Providers also cited previous negative experiences with the program or program staff as reasons why they no longer participate in the QRIS.

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Irrelevance. Many non-participating providers did not see star ratings from QRIS as providing any major advantage to their business. One provider explained: "I feel like I am a quality center. I was a quality center before QRS came along. And my parents have been satisfied with our scope of services that we render. I don't have complaints." Another provider said:

We know what we're doing. You know? And I don't have to have an outside...I don't want to feel like I have to have somebody from the outside come in and say, 'Well, gosh, you all know what you're doing.'

Some non-participants described requirements in the current QRIS program as unrealistic ("I felt some of the things seemed a little unrealistic, good in theory but not good in practicality."). They also tended to perceive the star ratings as unnecessary rather than a deciding factor for attracting new business, with multiple providers sharing thoughts about their families, such as, "They want a good quality daycare or childcare center. But stars would not make that decision for them." Another provider explained:

So when they come and they say, 'You have your license from the Health Department?' and they know you have a certain quality. You don't have 'three-star quality' and they could care less. I mean it's on my door. And I said, 'You know, we're a three-star.' And they're like, 'Is that what the three stars are for?'

As a result, providers in this category were unconvinced that the program would provide any major advantage for their center ("And there's nothing really in it for us. You feel like your center's doing okay or doing well.").

Negative Experiences. Some non-participating providers had once participated in QRIS. Those providers indicated that their previous experiences with the state's current QRIS and/or

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QRIS staff made them feel like the program was not there to help them. One provider admitted, "I opt out then because they come in like, 'You are so dumb.'" Another provider felt the QRIS staff "tore my people down." Another provider spoke of "the damage it did to my staff." The general feelings expressed were that providers felt demoralized and/or punished after the experience rather than edified or improved ("A lot of what we're having a problem with is the punitive nature of the program where you don't fit this check, check, check. We're going to take you off, or you get a one star."). In addition, a few providers spoke generally about the burden of keeping up with the various requirements of the program, such as the director who recounted, "I couldn't meet the criteria and do what I needed to do—take care of my children. I was so consumed with paperwork my teachers started saying, 'You're losing yourself.'"

Current Experiences: Benefits Providers See from Participation

When asked to explain the benefits QRIS has contributed to children, staff, or the childcare program overall, current or past participating providers in this study felt that technical assistance provided a major benefit for their center operation. Providers also cited improved business practices and parent-provider relationships, as well as improvements to the physical environment of their center. Providers also mentioned financial resources as a benefit to current or previous participation in the state's current QRIS.

Technical Assistance. Providers frequently mentioned the technical support and assistance received by participating in the state's current QRIS:

Well, you know, you get your technical assistance that comes in and she's like, 'Well, if you'll do this, this, this, and this.' And I'm like, 'It ain't gonna work, it ain't gonna work, it ain't gonna to work; can't do that, can't do that.' She comes in—she does it! The

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teacher jumps on board. All of a sudden, the room is calm. And I'm like, 'Okay, well, maybe...'

Providers felt that the technical support provided by QRIS coaches and trainers enabled them to improve the childcare facility at multiple levels, such as curriculum ("Now, I like that, because they give you a lot of good ideas to bring back to your center, and I bring them back and give them to my employees.") and teachers ("It gave me higher standards for my teachers. You know? To make sure that there was training that I knew they needed. They just increased, they only increased it 15 hours by a little bit at a time."). Furthermore, providers appreciated the opportunity to learn about program quality improvement, as this positively affected their overall score and confidence ("We started out at, like, a 2.8. And then after the technical assistance, she graded us again. And it was a 3.8."). Providers also tended to indicate that they viewed QRIS as a critical component to the provision of early childhood care and education ("Everybody needs to know what the standards are required, and to help kids get ready for kindergarten readiness. I think it is very beneficial.").

Business Practices. Some providers stated that participation in the QRIS helped them stay aligned with documentation requirements for other purposes like licensure ("...having your documents in place were also something that worked hand in hand when licensure came out."). Accreditation and eligibility for funding were two additional areas where providers found participation in the QRIS useful ("We do participate and we do it because [of] accreditation, of course, speaks volumes when you're seeking funding." and "In grant writing, it does make a difference."). Many of the professional development courses offered to participants were seen as helpful, and in recapping the biggest benefits, one provider summed it up as "mine is totally organization on the part of the QRS. Really made a difference for me."

Parent-Provider Relationships. Providers reported improvement in parent-provider interaction since participating in the QRIS. They felt that the QRIS impacted the parents positively, as they acknowledged providers' services and communication efforts regarding children's learning and well-being. One provider explained:

Parents are very excited about the newsletters going out each month, and activities that's on the newsletter. They are very excited. 'Well, my child is doing this, you know, today, and tomorrow they're doing that.' They're just very excited about that.

Providers described a synergistic, positive effect when they kept families informed through the newsletters, which made parents more cognizant of what was going on in the classroom and the center ("You know, they're getting letters, the teachers are involved with, what the parents, you know, they all know what's going on. And it kind of, it changes."). Moreover, providers felt that participation in the QRIS upgraded their status from being a mere babysitting facility to a facility offering quality schooling for very young children ("Because I think all parents want the best for their children and when they bring a child in here they see that, oh, okay, you know, they're teaching here."). In general, providers observed a positive response from parents by systematically reaching out to and informing them. One provider said:

Not only did I want to be a part of the accreditation, but it also excited the parents to know that we're no longer the babysitter. We're getting our children ready for schooling. For years, people look at childcare as a babysitter, and we're not a babysitter, you know? We're there to teach. And so what QRS has helped is when I let my parents know, and we have our sign, and our letter—it excites them.

Center Improvement. Providers commented positively on center improvements derived through QRIS participation. Providers shared that the "the concept is good" and that it "has made

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us better.” At a center level, providers appreciated the assistance provided by QRIS staff in relation to classroom arrangement (“They did come in, and I was grateful for the way they showed how to set our centers up, you know, more feasible for the kids.”) and equipment:

You’ve got to put some stuff in the center of the room to keep them from running back and forth. A lot of it was visual, you know, visuals that she had them, you know, put the stuff on the walls and stuff like that. And it literally changed my entire room around.

Also, by participating in the QRIS, providers reported they could “understand how to teach- implement the lesson plans in the classroom.” Several spoke about gaining a better sense of how to improvise instructional resources. As one provider said:

With QRS it’s teaching through pictures and, you know, no more worksheets. So, and I’m going to be honest, I didn’t think that it could work—but it does, it does! So I see a lot just teach them with whatever you have in your classroom, you know, the colors, a picture. So it has helped tremendously.

TANF Subsidy. A few providers referred to the higher rate of reimbursement earned through accumulation of rating stars (“if you get a high enough star.”). In these cases, providers correlated the number of children on TANF subsidies with the earned childcare certificate percentage (“You benefit from being on the program because you get a percentage”) and expressed appreciation (“I’m grateful for it.”). Nonetheless, providers stressed that state subsidies may not offer adequate prospects for investing in the QRIS, unless higher ratings are earned:

...because if you only have 10 [children] on there and you get 10 percent, that’s not much as opposed to if I have, you know, 100 children on there, which I had at one time, and I was getting 22 percent. So that makes a huge difference. So it was worth the investment

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for me, but it may not be worth the investment for someone else who doesn't have a large [enrollment of] childcare certificate children.

Current Experiences: Obstacles & Barriers

Providers in this study cite various factors associated with their center staff, inadequate access to QRIS services, the current scoring system, and a fundamentally unequal playing field for small and low-income centers as barriers to participating or achieving a higher score in the state's current QRIS. Providers also mentioned the financial investments needed to move up in the rating system as a barrier to rated improvement, as well as difficulty in satisfying the handwashing component. Some providers in this study expressed a general exasperation ("It's just too much!") with the number of requirements associated with participation and/or improvement.

Staff. Providers mentioned various aspects of quality staffing as a barrier to participating or achieving a higher score in the QRIS ("This past year we opted out because I had a huge turnover in staff."). Providers often felt that reaching a higher star means hiring more qualified staff ("We haven't participated in it because at my center, I don't have a whole lot of employees and staff that have the higher education, the bachelor's degree, the master's degree, things like that. So we're just stuck at three stars."), which can then result in an imbalance in the compensation ratio they are able to maintain ("And we actually—I hired, have hired, people with bachelor's degrees that we couldn't afford."). Others report staff entering employment with a lack of training and other skills ("I'd almost rather close down a classroom and have the same people that I have than hire someone new, because I'd have to get them trained."), with the burden of getting new hires to reach a higher level falling upon the directors. One provider explained:

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The turnover for employees is too great. It's like if I don't have a person with an AA, a person with a CDA, whatever, I'm the one that shoulders the responsibility of making sure my employee comes up to those standards.

Multiple providers described turnover as another huge barrier to cultivating highly skilled and highly credentialed staff (“I’ve got to wait until I can find that right person. And there’s not a lot of them because they’ll go to Head Start or somewhere else because they get paid more money.”).

Inadequate Access to QRIS Services. Many providers cited difficulties with getting the training they needed to advance in QRIS (“They allow all the other people that’s not participating in QRS and to go to the training, and then when we try to get in, they are full.”) and having access to the technical assistance staff (“Unfortunately, I was unable to get them this year. There were so many demands on their time.”). Providers felt that requests for additional class offerings went unheeded:

They’re not very accommodating. And even when you call to ask about the required classes, like a director seminar that’s required, or the Childcare as a Business, or the Early Learning Standards, which is required to get that five, they only offer it one time. And if you miss it, or if you’re pulled for another meeting, or you’re pulled from something else, too bad, so sad. And there you go, you drop down.

Attendees also talked about the difficulties they face in making arrangements to attend scheduled trainings, including staffing (“It’s even hard for me to go because you need to be at your facility because of low staff. So the times and the dates of the trainings are not just readily available for you to take them.”) and travel costs (“You look on the list right now – there’s not anything in [our] county. I mean, you have to travel to go get these classes.”).

Scoring System. At almost every session, some providers identified the current scoring system as a barrier to improvement, though specifics about this barrier varied substantially. Some providers felt that the current scoring was too rigid (“That’s right. If you don’t have every little piece... Like, so many books per child. Right? Okay. Well, book torn, you get points away. That book probably just got torn yesterday.”). Others expressed that the scoring system did not allow for the day-to-day flexibility of their real lives as childcare providers:

Childcare is all about flexibility. One day can be totally different from the next. And I always thought ... I don’t know how to incorporate intent into a guideline because I know that you have to have some kind of guidelines for them to test you or score you, but they should be looking at intent. Like, I am sorry that that child did not stay for the entire two renditions of ‘Row, Row, Row Your Boat,’ but the other eight did. Can you not tell that we are trying to teach them—that the intent is for all of them to do that, even though the two or three are not going to do it when you’re there?

Other providers felt the scoring system does not accurately capture all of the skills and expertise that they believe should matter in a quality center:

I had a lady that’s worked with me for 17 years and she never got no higher than a 1.75. And no baby has ever been hurt. They’ve always been dry and clean. And they love [her]. They see her and children will run through the room for her.

Providers generally acknowledged the need for a measure of accountability (“I agree that there should be some standards and some, you know, guidelines. But I think they’re too rigid.”), but they tended to be unconvinced that the current QRIS has the best available measuring options in place (“I mean, by us being such a poor state, was there something else that they could’ve chosen that would be more compatible?”).

Level Playing Field. This theme emerged early in the tour. The theme continued across multiple locations among providers who feel they are unable to reach a higher star rating because the program is tiered in such a way that some establishments, such as centers serving low-income families (“And they don’t look at that, the kids that we serve and the area that we’re in.”) and small-sized centers (“You’re already in the building and they grade you on the length of your rooms. That’s out of our control. Especially if you, like me, you rent a building. You know?”), are unable to meet all the requirements for the next rating level.

In all of these conversations, providers serving low-income families did not appear to be asking for easier or lower standards. Their comments mostly indicated that they felt the extra effort they devote to quality care, in spite of challenges, gets overlooked by the current QRIS measures (“We love our babies. And so it’s important that we realize that we don’t always have to have the best to have the best center.”). They also saw these systemic challenges as requiring a different evaluation approach:

You’re going to have to have some totally different things when you’re talking about inner city and you have parents who work, single parents that are working. The children are not going to come probably equipped initially. We have to make up for that. We have to comb hair. Sometimes we have to buy clothes. Those things are important to a child’s development. Those are things that have to be addressed from a center’s standpoint...

You’re going to see a difference [in centers serving different income-level communities].

But you come in and you evaluate us all the same.

Similarly, providers in physically small centers described their view of how the current QRIS does not adequately consider differences in center size, putting their centers at a disadvantage:

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But even some environments, you know, they're not all comparable. Just because you have a small space, that doesn't mean that the space is not adequate to get the job done... even if you had all the centers in the world, that doesn't mean that in a smaller space with less centers that you aren't still providing everything that you need to provide for that child to flourish at the next step.

Another provider described the balancing act between expectations and the realities that smaller centers have to manage as an example of the need for QRIS evaluation to account for center capabilities:

I only have 22 children, my rooms are very small, but it meets the guidelines for the number of children that's supposed to be in there. But the problem that we had was, in my area of dramatic play I didn't have 52 things right over there in that area, in the small... I think that there should be some type of consideration for the size of what you're looking at, because there's no way I can get 52 costumes in my dramatic play area.

Another provider explained:

My day care is very small. I got counted off for that, even though I had a writing table and everything that they needed, and all the shelves with the paper and everything accessible to them, they looked for the part that didn't even pertain to the children.

Finances. Many providers reported often feeling thwarted by their lack of funding to make the necessary improvements to reach the higher quality rating demands ("Sometimes it seems like businesses are penalized because they don't have funding to produce the kind of quality program."). One provider explained, "I'm a teacher, a bus driver, everything. You know? And then we just—you know, because we can't afford it. We cannot afford it. You are having

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stipulations for us to do, we cannot afford to do them.” Providers felt that the state’s current QRIS requires a major financial investment (“Now as far as QRS is concerned, I think it’s a good thing, but I also think that, first of all, there’s a lot of things they require we don’t have the money to do.”) that many centers are unable to meet (“I mean, what money? You know? If you have a small center, you don’t have a huge profit margin, you know?”). Many providers expressed financial frustration even as they simultaneously conveyed a desire to be involved to improve their center and to provide the best educational experience for young children (“We want to have more. We cannot afford to have more.”). One provider explained:

98.9 percent of my parents are on the certificate program so I don't have the paying parents. I deal with low-income families. So who's gonna bring the money in to pay these employees? And then when you come in QRS for your evaluation, you need two or three sinks in each classroom. So who's gonna run those pipes and put in some more sinks? You gotta have this, you gotta have that.

Hand Washing. Not a single provider took issue with the actual importance of hand washing (“We do understand the importance of hygiene.”), yet at numerous sessions, many providers felt strongly that the hand-washing requirement was scored too frequently (“I don’t think it needs to be proved the whole time.”) and too rigidly (“It is important for children to wash their hands and know how to wash their hands. But the way they grade us is just impossible.”). Throughout the focus groups, terms such as “unreasonable” and “impossible to score well on” were recorded, with providers at numerous sessions swapping stories of how they intentionally “took a hit” on that part of the evaluation to focus on areas where they believed success was achievable (“And we know we’re going to score poorly on the hand washing, so we just try to up

everything else.”). There was a clear sense of annoyance (“I agree with it. Your hands should be washed. But, my gosh.”).

The hand-washing requirement was repeatedly viewed as an unfair barrier to moving up to the next star level (“But because you spent so much time on hand washing, they subtract the amount of time from another area. And, so, that’s what I really have the great issue with. It shouldn’t cross over into other areas.”). On behalf of the children, providers also felt that ultimately the hand-washing requirement takes too much time away from learning opportunities (“There’s wasted time in there that you can be teaching these children or letting them play through learning.”). The current hand-washing requirement is only one piece of an evaluation measure under the learning environment component of the state’s current QRIS, and providers at many sessions expressed irritation at what they perceived as hand washing overshadowing the overall component (“You’re trying to teach learning. You’re trying to make sure that they’re ready for kindergarten. And you’re so worried about them washing their hands again because they touched something else.”).

Just Too Much. At many of the sessions, providers also described how the number and scope of the guidelines to reach a higher rating can feel overwhelming:

I feel like we have all these rules and regulations and stuff we’ve got to follow. And, then, if you want to get involved with—you already have a book this thick of stuff you’ve got to follow through with the [licensing agency]. And then, you know, your own standards as a center that the owner or director implements. And it’s like, then, if you take on the QRS, then you’re having to go follow another big book of stuff.

Another provider said, “My hands are very full as the director. Keeping up with paperwork with this program and that program and just in general things that goes on in our office as well. It’s

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just, the requirements are high.” At a separate session, one provider was more direct: “Because with the higher you go, the more demand it is. More paperwork—paperwork will get you. It’s paperwork.” The predominant sentiment was exhaustion. Providers want to do well (“We do participate, with a little hesitation. Well, initially when we first decided to participate just looking at some of the things—the obligations were a bit overwhelming.”), but they indicated that they do not have the time or resources to do more.

Current Experiences: QRIS Communication

Providers in this study provided mixed feedback when asked about the quality of communication with the administering agency of the state’s QRIS. Some providers felt the expectations for improvement in the program were unclear and that feedback was not helpful. Others expressed satisfaction with their interactions with the administering entity. Throughout the research process, the research team identified several instances of misinformation or misunderstanding of QRIS policies or intentions.

Unclear Expectations. In almost every focus group, multiple providers indicated that expectations for improvement were often unclear in the state’s current QRIS. Providers voiced confusion and misunderstanding due to a cited lack of coherent instructions (“There’s no policy manual at the moment. So centers don’t really know what the rules of the road are.”). Providers stated that current QRIS guidelines and training leave too much room for subjective interpretation (“... so much subjectivity and individual evaluator-driven decision-making, without any ability to know if that was the rule or just what this person said.”). Providers felt their understanding of guidelines did not match with the evaluator’s rating during assessment (“Well, it’s not real clear and that’s one of the biggest things is that part. You just really don’t know.”).

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Additionally, providers cited evaluator inconsistency. As one provider described, “You do what they say and then an inspector come in and they knock you for it and say, ‘That's not what we wanted.’” Providers volunteered examples, such as technical mistakes that evaluators handled differently (“After the fact I brought it up to them and was like, ‘Well, I’m not sure why you’re counting off for this because this and this and this.’ And she’s like, ‘Oh, okay. Well, they shouldn’t have counted off for this, then.’”). One provider described post-assessment feedback that contradicted the scoring during assessment:

And some of the things that I get back in my report, for one example, about the height of my changing station. Well then I got, didn’t get any points. But then when I go and take the same tape measure and ruler and whatever, I’m getting what it should be. And then you tell me it’s not.

Moreover, providers described geographic discrepancies “among the coordinators, how they train, the feedback that they give, if any, and also, the follow-up.” Overall, providers highlighted disconnects between the guidelines they perceive to be in place, the assessment process, and the particular individual scoring the results. One provider explained:

Once you go and do the training then you have to take your own perception. You take your own perception and you say, ‘Okay, this is what I perceive this to mean, or this is what I think they should do.’ And when you have people that come out to your facility and they do their evaluation, then it’s truly based on what they think or how they perceive those skills are stated.

The course of action regarding the procedures and moving up the stars ladder was also described as hazy because “there isn’t any guidance about what’s supposed to happen, so [that] people know.” Providers were unsure how to question the type of evaluation, the documentation

provided, or the next steps they should take to improve the quality of their early childhood facility. As one provider related:

How long do you have before you get the rating? What is the rating going to cover? How is the rating going to be communicated to you? When are you going to be able to do your corrections? How long do you have to do that? If you have a disagreement, what kind of a process is there in place to challenge a score in a certain area? None of that is written down anywhere.

Satisfactory Communication. Even though many providers talked about unclear expectations, not all conversation around this topic was negative. At almost every session there were also providers who reported general satisfaction with how expectations were communicated. One provider explained:

I think it's very clear, you know. They give you the checklist. You have to have everything in this to be a one, and everything in this checklist to be a two. So, I think it's very clear and precise. You just have to read it.

Providers who expressed satisfaction were content with the services and assistance received (“... the interaction, and technique that you need to do with the children, all of that was done very well.”). These providers viewed communications as timely:

I've always talked to them over the phone and they have been most helpful. They have been polite. And, if I did not reach anyone, I was able to leave my name and number and I was called back usually within that same day.

Problematic Feedback. Providers who discussed the topic of feedback were generally dissatisfied (“And we definitely need follow-up, because we pretty much are scoring the same

thing year after year on the same part.”). Much of these conversations, which occurred at more than half of the focus groups, centered on the lack of feedback. One provider explained:

And when we did go through the entire process a couple years ago and got our evaluation, you know, they gave you the report but there was no explanation of the report. So I'm sitting there trying to figure okay what does all of this mean?

Some of the criticism was directed at the timing of feedback (“They cannot say nothing to you during the whole time they are evaluating you. They don't give you any feedback. I didn't get any feedback that day.”) or what was perceived as a long delay (“For the last two I've had, it was months and months before I heard anything from them at all.”). Another provider explained:

They're not very clear at all. In fact, after you get your sheet back explaining why your scores are what they are, I mean the top of your head is blown off because, you know, you say, 'I got three?' And as I'm reading this, it looks like I shouldn't have gotten anything.

Several providers indicated that they found the feedback harsh and discouraging rather than empowering. One provider summed up the feedback situation with the following: “So you didn't get the help piece, you just get the evaluation.”

Misinformation. As the focus groups unfolded across the state, one interesting aspect to our inquiry of communication was the erroneous information that participating providers sometimes shared with one another. While the presence of misinformation itself is not a surprise in any large organizational structure, examining the nature of its content can be informative. In the case of this state's QRIS, providers showed confusion about its powers of authority (“And we just frightened. We frightened that they going to close our doors, if we don't do what they say to.”), free access to benefits (“I have a question, 'cause I'm hearing something that I didn't know

exist. Why is some centers having technical assistance from QRS and some centers don't?", and funding avenues ("Well, we got an email that says about this \$10,000 thing."). On some occasions, one provider corrected another ("The QRS program has no ability to take funds from you, to close down your doors."), or the session facilitator stepped in to correct an error ("That's part of the stipulation for the grant, which is separate from the QRIS."). In other instances, it was not until the data were analyzed that the misperception was caught by one of the researchers, such as when a provider confused the names of agencies providing technical assistance or support.

Expectations: Important Factors to Evaluate

Providers in this study felt that the quality of center staff, child outcomes, the sort of curricula employed by the center, the appropriateness of the physical environment, and the quality of parent-provider relationships are all important aspects of the early care and education experience for a QRIS to evaluate.

Staff Quality. Staff quality was raised as a key component of early childhood care at every focus group across the state. As one provider explained, "The point I'm trying to say is, it might look perfect on the outside. When you walk in—oh, that's a perfect center. But how is the teacher working with that child in that center?"

Opinions varied among attendees as to what constituted staff quality, but three primary aspects appeared to surface: (1) training or type of credentials ("... an environment where people are trained ... not just, you know, educational training, but also have training in the field that they're in. That they have life experience."); (2) the type and amount of interactions that occur between staff members and children ("That's a must, because without the interaction, there is no classroom."); and (3) affective skills for fostering positive relationships with the children

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("Everybody thinks everybody ought to go to college. Well, you know, some people aren't meant for college. But there are people who are meant to nurture children.").

Child Outcomes. At almost every meeting, providers enunciated the importance of looking at child outcomes to evaluate how well a childcare facility does its job. Academic skills were mentioned frequently ("You've got to teach them the reading. You've got to teach them to write."), as were behavioral skills ("... they can even hold themselves accountable when they're three and four to know that, I'm supposed to act a certain way. And at this time I should do this. And at this time I should do this.") and functional skills ("They have to know how to hold that fork and spoon when they're eating."). Finally, providers mentioned the overall well-being of the child, which was expressed in terms of safety, trust, and a notion of belonging. One provider explained her role to "make them feel loved; that somebody cares about them, security, that they can trust us." Another explained:

What do you have after your children have come through this program? Do you have children who are successful in school, very successful in life, who have emotional maturity, who physically developed and do what they need to do in life?

The Curriculum. Almost universally, sessions included provider conversation on the importance of the educational curriculum. While varied opinions existed across providers and sessions regarding what the curriculum might look like and how it might be accomplished, both the "what" and the "how" were viewed as critical aspects that should receive more focus. Providers talked about the need to provide education to all age levels through developmentally appropriate practice ("knowing that there are developmental stages, and developmental activities, and how they build, and they scaffold up."). Providers also described curriculum content ("You know, lots of talking. Lots of language opportunities. Lots of language experience activities.")

and expressed the need for alignment (“There is no one particular thing that we have to do together as far as teaching. Just like in the public schools, like you said, they have one basic curriculum. We don’t have that.”).

The Physical Environment. When the physical environment came up as an evaluation factor, providers tended to describe what mattered in two different directions. At times, conversation revolved around the importance of room arrangement, appropriate equipment, and adequate supplies for all children. This aspect of the physical environment created some tension from an equity perspective, suggesting that at least some providers believe that item quality is more important than item quantity. At other times, discussion of the physical environment was about the health and safety of the child, no matter the equipment or materials. Nutrition, cleanliness of the children, and overall playground safety and space were examples given from this perspective (“The most important thing to me is the safety. Nurturing—safety and nurturing. That’s the most important thing to me.”).

The Parent-Provider Relationship. Although less emphasized than other factors, the importance of the parent-provider relationship was also raised by some participants at multiple sessions. Providers tended to speak more generally about what this entailed, from offering “lots of parent involvement activities” to getting to a point when “that parent trusts what I say.” Several providers described a personal connection beyond the business relationship. One provider explained, “Talking to the parents, making it more—and I even tell parents, when we come, when they come into our center, we want you to feel like you’re at home.”

Expectations: Benefits of Participation

When asked to explain what benefits they would like to receive from participating in a QRIS, providers in this study cited flexibility throughout the process, coaching and mentoring,

and alignment of requirements with other entities, such as the licensing agency. Providers in this study also felt that their participation should result in a financial benefit or reward to offset the costs associated with improvement. Many providers felt that adherence to the QRIS should result in kindergarten readiness in their children and improved parent-provider relationships. Providers in this study also felt that higher ratings in QRIS should bring recognition in the early childhood care and education community.

Flexibility. At every session, a desire for flexibility in training and classroom visits received more attention from providers than any other benefit topic raised. Flexibility, as the providers described it, was not about raising or lowering expectations for different centers but rather about being more accommodating to the different ways and means for attending training or demonstrating quality during assessment visits. On the topic of training, participants felt it should be more accessible, offering ideas such as scheduling the most critical sessions multiple times within a year, having Saturday classes, and planning more training dates in rural locations. Given the staffing difficulties of sending individuals to training during childcare hours, providers suggested flexibility in training delivery. One provider said:

Maybe if they could come to you, or if there was a different delivery method. Maybe a webinar, or you could print it out, or where they could do it on their own, some kind of... something... a different delivery.

When talking about classroom visits for assessment purposes, providers repeatedly expressed that the timing and length of the assessment visit often fail to provide a full picture of their center. One provider stated, "It's not adequate. A one-day evaluation of somebody coming in." At times, provider comments relayed a feeling of unfairness ("So, how are you going to count me off for something that we didn't do while you were here, but we may do that in the

afternoon?"). Providers' solutions for achieving the flexibility they desired included the possibility of multiple visits ("But more than one day. You're not really going to get in one day's time the quality of my program.") or a longer single stay:

I think, in order for them to really get a true account or score for what you're doing at your center, they should stay there as long as the kids are in the classroom. As long as the teacher is there. Because I don't think it's a whole accurate account of everything.

Coaching and Mentoring. The second most commonly requested participation benefit was more coaching and mentoring ("To have somebody come in and work with you for a week, telling you what you're doing wrong, saying that, you know, this is a different way and another. That would really bring us up. I would like that."). One provider explained:

Come in and set us up—I mean, even if you don't give us new stuff, set us up with what we have. Set us up, and show us. You know, because we want to do right. We want to do what we're supposed to do.

Providers expressed a desire to have an ongoing coaching relationship with those who would ultimately be returning to assess their centers:

Maybe they can come and, you know, kind of interact with the teachers so they can get comfortable with them. You know, that's calming. Not tell them what they don't do. But just come in, and get comfortable with them. Have conversations, feedback from them to them.

The possibility of some kind of peer-to-peer mentoring was also suggested:

It would be interesting if there was some way for centers that have climbed up [in star ratings] to be included in a peer technical assistance exchange for centers that are just coming in. I think that could really be helpful.

Alignment. At more than half of the focus groups, providers expressed a strong desire for tighter alignment between agencies, across centers, and with kindergarten expectations. One provider's comment, "We all need to be on the same page," was echoed across all of these conversations. Some expressed confusion about the differing expectations between state agencies:

Okay, it's basically like, you are planning to open up a daycare center. You know, you've got all these rules you've got to follow. So basically, it's the same thing with QRS. You have all these rules you have to follow. But if you don't do this, you get five for, you know, through your childcare license person. But if you don't do this, you get, what? No points for it with QRS? So, to me, it's basically... It's kind of like an all-in-one thing to me... It's... You've got extra paperwork over here. Then you've got extra paperwork over there. But it's totally different. You know.

Others were concerned about instructional alignment with schools ("to determine school readiness with kids transferring from childcare into either Pre-K or Kindergarten") and with other centers ("It does need to be streamlined so that children that are moving from one center to another, you know, there's some kind of continuity. And so I think centers need to have guidelines about that information.").

Financial Benefits. At many of the focus groups, providers asked for compensation for QRIS participation beyond what is tied to the TANF subsidy program. The reasons were many, but all stemmed from the view of cost as a barrier to quality. Some providers referenced families they serve that qualify but sit on a waiting list ("Several of our parents have already applied for it. They're just on a waiting list for it. Their grandparents are paying their tuition every week because they can afford it. My parents can't afford it."). Providers also expressed that they did

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not want to raise prices on parents who can't afford it ("I don't charge an extra pay because they can't afford it. But if you get on the QRS program and you have to buy all this equipment, you're going to charge extra, aren't you?"). Concern was also raised about which aspects of quality to pay for at the expense of others.

In a separate financial benefits direction, multiple providers also spoke on behalf of their staff, suggesting that the QRIS could raise employee quality through formal education assistance:

We have wonderful, wonderful, wonderful childcare workers who don't have anything but a GED. Now let me tell you something—you offer some type of program to them to further their education, or if they think they'll make 25 cents more an hour, they'll be there.

Kindergarten Readiness. At half of the sessions, providers were quick to identify kindergarten readiness as a benefit that the children should receive for their centers' participation in QRIS ("Kids ready to enter kindergarten, developmentally ready for kindergarten."). Several asked for training on the educational aspects of quality care ("I think more education needs to be involved in it than just cleaning.") and on how to differentiate instruction to help all children be ready ("And there's nothing in QRS about, you know, differentiating your instruction. And I think it should be.").

Recognition in the Field. At some sessions, providers talked about the recognition that a star rating might bring them: "It would make me feel good to know that I'm a five star, you know, get to that five star." However, this sentiment was typically qualified by others with the idea that it might only matter in certain situations ("If you had some clientele that have the resources to pay, they will look at the star rating."). Overall, this general desire for recognition

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(“And so, that’s a reward to see, but also to be able to measure, to have somebody to come in and say that, you know, this is where you stand, nationally.”) was mentioned at half of focus groups on the tour but was not a strong focus overall.

Improved Parent Involvement. Another benefit that was requested at about half of the sessions was assistance with getting parents involved (“But I know my parents, they don’t like to get involved that much. I have to beg them.”). These providers recognized the importance of partnering (“Our parents are very important, and they need to know. They need to understand as well.”) and felt that additional support in the form of resources or strategies would make QRISs a benefit for parents as well.

Expectations: Best Representation Method

When asked how they would like to be represented in the policy-making process, providers in this study desired actual providers who represented multiple regions of the state and came from multiple care and education sectors, including public pre-K providers, center- and home-based providers, and faith-based providers.

Actual Providers. Direct representation by practicing providers was the most popular suggestion across the focus groups. Issues of credibility in proposing solutions were noted (“They need to select from a select group, because often times they’re not real providers. I mean, I’m just being frank.”), and the need for practical experience to inform decision-making was raised across multiple sessions. One provider explained:

It's easy to make decisions when you sit behind a desk with a pencil and a pen. But unless you go out into the field and actually know what happens and what goes on out there, then you won't be able to make a good call.

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When conversation involved proposing solutions for QRIS, direct representation was expressed as an important prerequisite (“Bringing us to the table, like you’re doing now.”).

Geographic Representation. Providers suggested representation according to geographic location: “Because what’s particular for this particular group or area, it may not be applicable for the inner-city school. You have to have more input and it really needs to be more diversity.” Both county and region were variously emphasized, and the possible benefit of geographic representation providing opportunities for vested parties to visit multiple regions of the state was also expressed.

Multiple Sectors. Along with a call for direct representation from actual providers, participants also saw value in having multiple viewpoints represented:

Input from all of the entities that is going to be participating, such as the private sector, the nonprofit, the for-profit, faith-based, all of those that need to be around the table when the decision is made, need to be involved in the decision-making process.

Additional Findings

As stated earlier in this report, the focus group study design employed a typological approach, meaning that data analysis was primarily organized around a seven-theme typology based on the seven research questions developed by the research team. However, at the end of the qualitative coding process, we identified a number of coded data that did not fit squarely as a response to any of the seven questions but nonetheless arose organically as providers talked between themselves. Based on the grounded theory approach, the research team opted to delineate the two additional themes that appeared frequently enough to warrant attention in this report: (1) praise for other early childhood organizations and (2) stress during assessment visits.

Praise for Other Early Childhood Organizations.⁹ When providers reported general satisfaction with participation in the state's current QRIS, those comments were quite often discussed in the context of interactions and assistance from entities in addition to the administering agency. The predominate mentions related to services from not-for-profit organizations currently active in the state. These entities contributed to improve early childhood facilities in areas such as equipment, room arrangement, staff interactions, and incentives. Some spoke of the outside help as a critical factor in persevering with quality improvement:

I started trying to participate in the program on my own. And after the first year, I just dropped it. I didn't want to have anything else to do with it at all. But then we were sponsored through Kimberly and the Five-Step Program.

Others shared experiences in which other organizations provided free materials ("And had it not been for the funding that they provided, I never—I can only speak for myself and some more friends that I'm close to—we couldn't have done it.") and staff development ("I have some staff that were, have some weaknesses and strengths. They were able to focus on the weakness and we would help bring them up to a different level without coming in with the pen, standing and watching."). One provider explained:

So if you're interested in the quality of your program, they [Quality for Kids NOW] train each teacher individually for an extended period of time. And they stay in your centers for an extended period of time. And it was—to me, I like that program much better because it wasn't just giving you a list of stipulations. They were training the teachers, helping the director out so that they did not have to do all of the hands-on.

⁹ Names of individuals and organizations in this section have been modified to ensure anonymity.

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Providers felt this improvement assisted them with passing the QRIS assessment. Some providers described other organizations as critical to fulfilling their obligations to the QRIS program:

They [Ready by 5] put everything in there that was supposed to go in there, and they set it up the way that it was supposed to be set up, and they came in probably once a week. And they [QRIS] came the very next day of the next week and we passed with flying colors.

In general, providers voiced high praise toward services provided from external organizations, as these organizations helped providers accomplish the QRIS requirements.

Stress during Assessment Visits. At almost every session, when conversation turned to the accountability aspect of QRIS, providers spoke about the stress experienced on assessment day (“And the first time it was—it scared us all to death.”) and stress-related feelings in following years (“We already know how to do most everything the child needs us to teach them. We have a curriculum. And for them to keep coming, it makes you very nervous—you know, sick.”). In more than one session, providers shared stories of staff who quit because of the stress associated with assessment day: “What they’re saying, what makes the turnover so many, is that once they go through the process, and they hear someone is coming in to monitor them, you know, they get fearful. And next thing you know, they gone.” Another provider explained:

For somebody to be walking behind you every step you make, it’s like breathing down your neck. They breathe down your neck. You're being wrote up and you're not even, you don't even know what you're being written up for, until the evaluation is done and the papers come back.

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Providers blamed some of the stress on the lack of personal interaction between center staff and the assessor (“And that was really the most offensive to me because the presence that you have—somebody with a pen who’s not engaged.”). One provider described a sense of fear that this dynamic generates as the visit goes on: “They didn’t say anything. They had notebook and pencils. They don’t do no talking. You can’t ask them no questions. They’re just watching you. They’re just sitting down, watching. And you—who won’t be scared of that?”

Another frequently mentioned stress factor was the impact the assessment process had on children in the classroom (“When they come, the children get all hysterical.”). As another provider explained, “Wherever you go, they go, you know. They follow the children, and they’re... They just make you feel uncomfortable. You know? As well as your staff, and the children.” Providers at many sessions believed the current assessment process impacts the way children behave. One provider explained:

We have never had just one person come in and do an ITERS and ECERS. It's always been two or three or four people in a classroom that's already full of kids. And the kids go crazy when there's new people in the room.

This shift in behavior causes additional stress for staff (“And so—and the teachers are intimidated because the kids are actin' like kids because—so anyway it's a bad experience.”). One provider explained: “I found it very difficult, when they come in, to be relaxed and have the children relaxed, when they’re sitting there and they’re not talking.” Overall, providers expressed that the approach of QRIS assessment personnel causes them stress and anxiety, as opposed to seeing an assessment visit as an accountability opportunity that offers strengths-based recognition of a center’s improvement.

5. Discussion and Conclusion

The purpose of this study was to improve understanding of providers' experiences and expectations in regard to a QRIS in a rural, southern state. This goal was accomplished by soliciting licensed childcare provider input on current experiences and perceptions of QRIS participation, both in terms of its current version and of what the program might become. The strong response to this endeavor, evidenced by the consistent turnout across all of the focus groups statewide, demonstrates the importance of these questions in the eyes of childcare providers.

With the opportunity to have their voices heard, providers talked at length about their decisions to participate in the state's current QRIS, the benefits they receive, and the obstacles to quality improvement that they face. That providers view a rating system as something that matters was clearly demonstrated by the attendance of those with an active stake in the program, past participants who have opted out of the QRIS, and new providers expressing a desire to learn more about getting involved. While it is important to acknowledge that the information in this report contains only one viewpoint—that of licensed childcare providers—this report nonetheless contributes critical information to the current conversation regarding quality rating and improvement systems in the United States.

Based on the results of this study, it appears that a provider's primary decision to participate currently hinges on whether the provider believes the QRIS provides program improvement or is irrelevant to maintaining a viable center. While some do see the financial subsidy program as beneficial, many providers in this study suggested the program has limited scope that reduces its attractiveness as an option. According to these sessions, the promise of

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additional stars as a means of attracting more business does not appear to impact decision-making on whether to remain in the QRIS, even if this potential benefit is initially enticing.

The participation benefit that providers most emphatically described was technical assistance, from staff-training sessions to phone support to on-the-ground advice during visits. Such assistance allowed providers to acquire the scaffolds they needed for center improvement. Even the other specific benefits that attendees identified, such as improved parent relationships and better business practices, were often tied back to provider comments about technical assistance or the help providers received from other outside organizations. At the same time, inadequate access to these desired services was one of the top obstacles reported by providers. The appearance of an additional finding during the study—praise for other outside organizations—can arguably be interpreted as a willingness on the part of participating providers to take advantage of training, mentoring, and assistance wherever it can be obtained for the sake of center improvement.

Providers who came to the focus groups were in general agreement that a rating system should hold centers accountable for staff quality, student outcomes, curricula, the physical environment, and relationships with parents. Yet the current scoring system was seen as a significant barrier to demonstrating good-faith efforts to achieve in these areas. Participants' ongoing conversations cast the structure of the QRIS evaluation process as one that favors material resources over efforts and the letter of the law over its intent, disadvantaging many centers invested in showing high-quality care.

Providers asked for clearly stated, consistent expectations that provide flexibility for childcare centers to demonstrate their own areas of competence and excellence in addition to goals for continued improvement. Providers asked for genuine, positive working relationships

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with those who will hold them accountable for improvements. Such relationships could potentially alleviate much of the reported stress that generated its own category within the results. Providers also wondered whether the QRIS might help with the continual challenge of fostering and maintaining high-quality staff through alternative training delivery formats and assistance with formal education. Finally, providers asked to be directly represented in the decision-making process if and when stakeholders consider ways to revise or improve the current QRIS.

6. Acknowledgements

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Appendix A: Sample Open Call Letter to Providers

Good morning (Director or Person of Contact),

I am writing in regards to soliciting feedback on the state's effort to improve the quality rating and improvement system (QRS/QRIS) in our state. QRS/QRIS programs have become a standard part of early childhood care and education systems across the U.S. These programs work best when participation among providers is strong and when the programs help guide centers on ways to continually improve their environments, curriculum, and workforce. As you may know, enrollment in the current QRS program in Mississippi is low, and few enrolled child care centers are able to reach beyond the 1-star rating (the current system offers up to 5 stars).

The Governor's early child advisory Council, SECAC, is sponsoring an open-access listening tour to better understand what is going on with QRS/QRIS in Mississippi. These listening sessions are open to the public and access is unlimited. We are traveling to eight cities around the State before July 2015—Tupelo, Biloxi, Jackson, Oxford, Hattiesburg, McComb, Meridian, and Greenville—and are open to including more locations upon request. I am reaching out to early childhood care and education organization in Mississippi to promote this listening tour so we garner as much participation as possible so we better understand the issues and ways to improve the state's QRS program.

The information gathered during this tour will be summarized and presented directly to the broader 24 member SECAC as well as the Governor. The information will also be provided to the University of North Carolina at Chapel Hill who are conducting the outside evaluation of the existing QRS. No individual responses will be identified – only the summary will be given to the Council, the Governor, and the UNC evaluators. We anticipate that the information will be a pivotal part of the State's strategic planning in the coming year, particularly in our efforts to increase awareness of and participation in the QRS/QRIS program.

We want outcome of this tour to reflect the child care community's view of how we might increase participation in the QRS/QRIS program in Mississippi. We ask that you help promote this tour among the centers your organization serves. The official announcement flier with the dates and times of the listening sessions is attached. The young children in this State and the professionals who nurture and teach them deserve a program that works for them.

Please feel free to contact me with any questions you might have. Thank you for your time and I look forward to being in touch.

Danny Spreitler, SECAC Member and QRS Committee Co-Chair
Executive Director
The Gilmore Foundation

**APPENDIX D:
OVERVIEW OF TOOLKIT FOR COMPREHENSIVE
CHILD CARE CENTERS**

APPLICATION FOR COMPREHENSIVE CHILD CARE CENTER

This is the application site to become a comprehensive child care center. Centers who have already achieved the designation STANDARD may choose to apply for COMPREHENSIVE.

All centers who are participating in the Mississippi Child Care Payment Program (CCPP) or those who would like to participate may apply.

Overview

The process for becoming a comprehensive child care center may begin once the standard center application has been approved and the owner or director indicates an interest in moving to this next step. Moving from one designation to the next will involve the center directing its own evaluation and preparation of evidence for becoming a comprehensive center.



Professional development, in the form of trainings and workshops, as well as coaching, guides this process. Once a center director feels ready to make the application for comprehensive status he or she may begin the process.

Toolkit and Electronic Portfolio

The digital *Toolkit* consists of materials that aid a center director in assessing where his/her center is on each goal area that is required for comprehensive status, and in planning and developing the needed measures or processes to achieve that goal area.

For each goal area required for comprehensive status, there is a toolkit chapter. Each chapter has a consistent format and presents information on:

- overview
- area outcome for the electronic portfolio
- key issues/considerations for goal planning
- resources
- frequently asked questions
- a planning guide which leads the director through preparing the material that will be uploaded into the electronic portfolio.

Each goal area in the toolkit begins with an overview of best practices or essential components related to that goal area. The overviews are derived from current research and other leading voices in the early childhood care and education field. You should read each overview and follow up with your own

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research to learn more about the each topic area. The planning guide provides the direction for goal attainment by leading the applicant in compiling the support materials to be uploaded into the electronic portfolio. Each planning guide asks a series of planning, designing, and evaluating questions. These questions allow the center director to work through the goal area and then upload materials into the electronic portfolio that address the goal. The submitted materials serve as evidence-driven data that allow MDHS to determine that services are being offered at the comprehensive level.

The following goal areas are required as part of the electronic portfolio:

1. Continuous quality improvement
2. Professional development
3. Curriculum and standards
4. Child assessment
5. Kindergarten transition plan
6. Family engagement practices
7. Community partnerships
8. Business practices
9. Information technology infrastructure
10. Program evaluation

Additionally, an executive summary which describes your capacity to deliver high-quality services. Additionally it should indicate how coaching helped close staff education/credential gaps, and how continuous quality is employed at your approach.

How to Use the Toolkit

The process of obtaining comprehensive status for a center is evidence driven with the goal of continuous quality improvement so that high quality is evident. It basically requires a director to “tell the story” of how the center offers quality care and learning for young children. By providing information and resources, it allows to develop your narrative to support your application. Because of this approach, no two center applications will be the same. Each application for comprehensive status will provide evidence and explanations for the ten required areas, followed by an executive summary that makes the "case" for the center receiving comprehensive status.

Some of these goal areas require that you have specific plans or processes in place, while others will be more developmental and progressive. For example, everyone would be expected to have a curriculum in place and functioning while technology infrastructure might be more changing. You may have some procedures in place, but be in the process of adding other software or equipment over the next year.

The *Toolkit* consists of information and resources to guide you through each of the goal areas. You may begin by reading the information and making your notes on where you are on each area. Once you are ready to begin the electronic portfolio, you will answer specific questions on each area using planning guides. These questions focus on where you are, what you have done, and how you monitor your actions for meeting your goals and maintaining continuous quality improvement. These planning guides will also be part of the electronic portfolio to guide you in your submission of information. Some of these questions will require short paragraphs, and you may upload materials to support each area.

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Coaching and Technical Assistance

Coaching and technical assistance are available through the Early Childhood Academies. These specialists will be able to help you with questions you have about each area. Additionally, short courses on these topics will be available throughout the year.

Beginning the Application

Once you are ready to begin submitting your evidence into the electronic portfolio, you may log onto the application site and begin your application. You will be allowed to save it as your work and return to over time. As with the standard application, you will verify your application information and submit the entire portfolio as your final step. ***Your application will not be reviewed until you submit it.***

The application has the following sections:

Section 1: Licensed Provider Information

Section 2: Electronic Portfolio

Section 3: Verification and Submission

There is no specific time line for you to submit your electronic portfolio to begin your review for comprehensive status. However, if you do not submit the application within one year of initial beginning the process, it will be discarded.

Once you have submitted the application, you will be contacted to schedule an onsite visit. After the site visit, you will be notified of the outcome of your application for comprehensive status.

Video Overview

A video overview of the application to achieve comprehensive status can be viewed here:



Toolkit

To review the *Toolkit*, click here: (links to table of contents, click on each chapter.)

Application

To begin the application, click here: (link)

APPLICATION OPENS

Section 1 – Licensed Provider Information

Section 1 opens the same as on the standard application – Licensed Provider Information. Add the question below:

When was this center granted standard status? date/month drop down click

Section 2 – Electronic Portfolio

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Each of the following goal areas with accompanying planning guide is shown. Click on any one to begin your submission. For each goal area, upload the information that is requested for each section. You may save at any time.

At the end of each part, you will be allowed to upload any additional materials that you would like to share. This is an optional section.

You will submit the complete document at the end of the application.

Here are the sections of the electronic portfolio:

1. Continuous quality improvement
2. Professional development
3. Curriculum and standards
4. Child assessment
5. Kindergarten transition plan
6. Family engagement practices
7. Community partnerships
8. Business practices
9. Information technology infrastructure
10. Program evaluation
11. Executive summary

(DEVELOPER: As they click on a chapter the portfolio opens up with these guides from the goals areas, and they answer/upload the relevant parts. It should be set up to do a section at a time, with ability to save.)

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Goal 1. Continuous Quality Improvement

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Continuous Quality Improvement	Electronic Portfolio
<p>1. <i>Perform a needs assessment</i></p> <ul style="list-style-type: none"> • Reflect on your internal capacity and your overall program level and list the processes in place that you already use. • Develop your goals. (Please limit to maximum 3 goals). What do you need to design or obtain to improve quality in your center? Your goal is the desired state you hope to achieve. 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> • Prioritize your goals by level of importance. • Identify strengths in achieving your goals. • Identify challenges in achieving your goals. • Set projected timeframes for goal completion. • Identify staff responsible to assist with center goals. It could be a team of staff members or an individual. • List resources that will help you progress toward your goals. (Resources may range from professional development opportunities to materials and partnerships with external organizations.) 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p> <p>e.</p> <p>f.</p>
<p>3. <i>Designing your strategy to meet your goals</i></p> <ul style="list-style-type: none"> • Describe your plan of action. • List each action step required to successfully achieve your objectives. • List the sources of evidence that you will use to support the need of your objectives. Evidence could include reports, surveys, assessments, observations, budgets, etc. • Identify how the strategies and process you will use will improve quality in your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> • Reflect on your strategies and how they lead to goal attainment. • Discuss any persisting challenges or barriers in your goal attainment. 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>

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<ul style="list-style-type: none"> List your proposed revisions and update your strategies. 	c.
5. Optional section	⇒ (add as needed)
<ul style="list-style-type: none"> Use this section to upload any samples, pictures, data, or other relevant supporting evidence not already described or attached. 	

Goal 2. Professional Development

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Professional Development	Electronic Portfolio
1. Assessing where your center is presently	⇒ 1. Current Status
<ul style="list-style-type: none"> Show whether all of your staff members are fully trained in mandatory PD. List your staff’s strengths and how are they related to their training. 	a. b.
2. Planning what you will have to design or need	⇒ 2. Plan your Approach
<ul style="list-style-type: none"> Assess the areas on which your staff will need to be trained. 	a.
3. Designing your strategy to meet this goal	⇒ 3. Design your Strategy
<ul style="list-style-type: none"> Describe how you will use PD opportunities to increase quality care in your center. 	a.
4. Evaluating your approach	⇒ 4. Evaluating
<ul style="list-style-type: none"> How does your strategy lead to goal attainment? What are your future plans? 	a. b.
5. Optional section	⇒ (add as needed)
<ul style="list-style-type: none"> Use this section to upload any samples, pictures, data, or other relevant supporting evidence not already described or attached. 	

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Goal 3: Curriculum

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Curriculum	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> • List the curricula by age groups that you already use. • Describe how well the curricula works by age group. 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> • What additional materials will you need to establish activities and themes as part of your curricula? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> • Attach sample lesson plans by age group and developmental domain (link to early learning guidelines for infants and toddlers, and standards for 3s and 4s). • Describe how you will use this process to enhance quality care in your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> • How does your curriculum lead to goal attainment about the “what-why-how” things should be learned in your center? • What are your future plans about the curriculum? 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> • Use this section to upload any samples, pictures, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 4: Child Assessment

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Child Assessment	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> • List the processes in place that you already use. • What do you need to design or obtain to meet this goal? 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> • How will you obtain the materials or implement the process you will need to obtain this goal? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> • Describe your plan • List the measures/instruments/ or process you will use • Provide the instruments/measures you will use, including the ones you design (upload samples across age groups) • Describe how you will use this process to increase quality in your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> • How does your strategy lead to goal attainment? • What are some additional future plans? 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> • Use this section to upload any samples, plans, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 5: Kindergarten Transition Planning

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Kindergarten Transition Planning	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> • Describe your current status in terms of setting individualized kindergarten goals for your students. • List the persons responsible to provide oversight in the kindergarten transition process. • Identify gaps and discuss anticipated goals that will enable you to design a kindergarten transition package. • What do you need to design or obtain to meet this goal? 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> • What kind of materials and resources will you use to create an individualized kindergarten transition package? • What process will you implement to satisfy your goals, e.g. providing training to staff, aligning curriculum to kindergarten requirements, fostering relationships with children, families and community, etc.? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p> <p>b.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> • Provide samples of your activities-assessments-events that help in creating a kindergarten transition package. • Create developmental profiles unique to your children’s needs. Provide samples. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> • How does your strategy lead to goal attainment? • What are some additional plans for a more effective kindergarten transition package? 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> • Use this section to upload any samples, plans, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 6: Family Engagement

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Family Engagement	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> Describe the family engagement practices currently implemented in your center, e.g. parent-teacher conferences, parent handbook, newsletter, etc. Identify gaps in family engagement practices not currently implemented in your center, e.g. do you have a family engagement policy or position statement, or do you conduct a parent satisfaction evaluation? What do you need to design or obtain to address gaps? 	<p>⇒ 1. <i>Current Status</i></p> <p>c.</p> <p>d.</p> <p>e.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> Describe the steps necessary to implement family engagement practices not currently implemented in your center. What process will you implement to satisfy your goals, e.g. hold parent meetings, draft position statement, have staff attend professional development hours related to family engagement, conduct parent surveys? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>g.</p> <p>h.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> Consider the resources your center will need in order to implement the family engagement practice, e.g. family engagement policy or position statement, trainings, parent satisfaction instrument, etc. Describe how you will use documents and processes to enhance family engagement practices in your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>e.</p> <p>f.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> How does your strategy lead to goal attainment? What are some additional future business plans? 	<p>⇒ 4. <i>Evaluating</i></p> <p>d.</p> <p>e.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> Use this section to upload any samples, plans, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 7: Community Engagement

Planning Guide

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Community Engagement	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> • List the processes in place that you already use to engage the community in your area. • What do you need to increase outreach in your community? 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> • Think about partners and their role. Identify key people in your center and in your community that can assist with your outreach efforts. • Describe your plan to engage stakeholders and expand your impact in your community. 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p> <p>b.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> • List the measures or processes you will use to achieve your goals. • Describe how you will use these measures or processes to enhance quality in your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> • How does your strategy lead to goal attainment? • What are your future plans for outreach? How will you continue building partnerships in your community? 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> • Use this section to upload any samples, plans, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 8: Business Management Practices

Planning Guide

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Business Management Practices	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> • List the business functions you currently perform, e.g. budgeting, business plan, data storage, marketing activities, etc. • Describe how your business functions adhere to laws and regulations. • Identify gaps and discuss anticipated goals that will improve your business functions. • What do you need to design or obtain to meet this goal? 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> • What kind of materials will you use to improve your business functions, e.g. manuals, software for business plan, templates for budgeting? • What process will you implement to satisfy your goals, e.g. applying for grants to increase revenue, or increase social media presence? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p> <p>b.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> • Provide samples of your business plan. These samples may include your center’s mission, structure, services, financial viability, projections, etc. • Describe how you will use documents and processes to enhance business practices and increase quality in your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> • How does your strategy lead to goal attainment? • What are some additional future business plans? 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> • Use this section to upload any samples, plans, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 9: Information Technology (IT)

Planning Guide

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Information Technology (IT)	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> For each area, where would you place your center on each tier? 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> For each area, what technology will you need to move each one to the next tier? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> Describe your plan for increasing technology use over time in your center. Describe how this process will enhance quality care in your center 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p>
<p>4. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> How does your strategy lead to goal attainment? 	<p>⇒ 4. <i>Evaluating</i></p> <p>a.</p>
<p>5. <i>Optional section</i></p> <ul style="list-style-type: none"> Use this section to upload any samples, pictures, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

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Goal 10: Program Evaluation

PLANNING GUIDE

Directions: For each area below, answer the questions about your center and this area. You will enter this information into the Electronic Portfolio.

Program Evaluation	Electronic Portfolio
<p>1. <i>Assessing where your center is presently</i></p> <ul style="list-style-type: none"> List the processes in place that you already use for your program evaluation. What is the problem statement or challenge that your program aims to address? 	<p>⇒ 1. <i>Current Status</i></p> <p>a.</p> <p>b.</p>
<p>2. <i>Planning what you will have to design or need</i></p> <ul style="list-style-type: none"> What is the purpose of your program evaluation? What are the perceived short-term and long-term effects of your evaluation? What are the anticipated changes (impact)? What questions will you ask? What is your target group? What will your questions be? 	<p>⇒ 2. <i>Plan your Approach</i></p> <p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>
<p>3. <i>Designing your strategy to meet this goal</i></p> <ul style="list-style-type: none"> Describe your plan. List the measures/instruments/or process you will use. Provide the instruments/measures you will use, including the ones you design. Describe how you will use this process to increase program effectiveness of your center. 	<p>⇒ 3. <i>Design your Strategy</i></p> <p>a.</p> <p>b.</p> <p>c.</p>
<p>4. <i>Implementing your approach</i></p> <ul style="list-style-type: none"> How will the data collected look like? What are your action steps when reporting your data? 	<p>⇒ 4. <i>Data Collection/Reporting</i></p> <p>a.</p> <p>b.</p>
<p>5. <i>Evaluating your approach</i></p> <ul style="list-style-type: none"> How does your strategy lead to goal attainment? What are your future plans? 	<p>⇒ 5. <i>Evaluating</i></p> <p>a.</p> <p>b.</p>
<p>6. <i>Optional section</i></p> <ul style="list-style-type: none"> Use this section to upload any samples, pictures, data, or other relevant supporting evidence not already described or attached. 	<p>⇒ (add as needed)</p>

11. Executive Summary

The purpose of the executive summary is to briefly summarize the evidence you have submitted on each of the goal areas. This section should certify your center's capacity to gain a comprehensive center designation. There is no set format for this section other than to submit it as a narrative summary. However, you should specifically address the following:

Provide a brief summary of the goal areas and your accomplishments and plans.

How professional development has allowed you to reach your goals.

How your center employs continuous quality improvement to assure high quality services in early care and learning.

Your assessment of whether your center should be comprehensive and your reasons to support it.

You may upload your executive summary as a PDF document or enter the narrative.

Click here to enter your summary: (Text box opens to allow for uploaded a PDF or entering information)

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Section 3 - Verification and Submission

Please verify that the information in this application is correct. Once you have submitted this application, it will be pending until you are notified of the final outcome. You should be contacted by the Department of Human Services within 30 days to schedule a site visit which is the next step in the review process.

Please list names and titles of all of the employees who participated in this application:

I certify to the best of my knowledge and belief that all of the information on this form is correct. I also understand that failure to report completely and accurately may result in my center being removed as an approved provider in the Child Care Payment Program v. (Please check in box)



Initial to sign

Previous

Cancel

SUB

Mississippi Child Care Market Rate Survey

Section 1. Age Groups Served

T1: In this section, I would like to ask you some questions about the age groups your center serves.

1) How does your center define full-time enrollment? Please base your answer on the minimum hours per day required to be considered full-time.

2) Which age group is your center licensed to serve?

Age Group	Yes	No
Infant (<18 months)		
Toddler (18-36 months)		
Preschool (3-5 Years)		
School Age (5-13 Years)		
Special Needs		

3) How many children does your center currently have enrolled from each age group? Each child should only be counted in one of the following groups. Please enter '0' if none are currently enrolled.

Age Group	Number Enrolled
Infant (<18 months)	
Toddler (18-36 months)	
Preschool (3-5 Years)	
School Age (5-13 Years)	
Special Needs	

4) How many children are enrolled at your center in the following categories?

Infant (<18 months)	
Hours Served	Number Enrolled
6 or more hours per day	
5 hours per day	
4 hours per day	
3 hours per day	
2 hours per day	
1 hour per day	
Less than 1 hour per day	
Toddler (18-36 months)	
Hours Served	Number Enrolled

**APPENDIX E:
MARKET RATE SURVEY INSTRUMENT**

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Mississippi Child Care Market Rate Survey

Section 1. Age Groups Served

T1: In this section, I would like to ask you some questions about the age groups your center serves.

1) **How does your center define full-time enrollment? Please base your answer on the minimum hours per day required to be considered full-time.**

2) **Which age group is your center licensed to serve?**

Age Group	Yes	No
Infant (<18 months)		
Toddler (18-36 months)		
Preschool (3-5 Years)		
School Age (5-13 Years)		
Special Needs		

3) **How many children does your center currently have enrolled from each age group? Each child should only be counted in one of the following groups. Please enter '0' if none are currently enrolled.**

Age Group	Number Enrolled
Infant (<18 months)	
Toddler (18-36 months)	
Preschool (3-5 Years)	
School Age (5-13 Years)	
Special Needs	

4) **How many children are enrolled at your center in the following categories?**

	Infant (<18 months)
Hours Served	Number Enrolled
6 or more hours per day	
5 hours per day	
4 hours per day	
3 hours per day	
2 hours per day	
1 hour per day	
Less than 1 hour per day	

	Toddler (18-36 months)
Hours Served	Number Enrolled

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6 or more hours per day

5 hours per day

4 hours per day

3 hours per day

2 hours per day

1 hour per day

Less than 1 hour per day

Preschool (3-5 Years)

Hours Served

Number Enrolled

6 or more hours per day

5 hours per day

4 hours per day

3 hours per day

2 hours per day

1 hour per day

Less than 1 hour per day

School Age (5-13 Years)

Hours Served

Number Enrolled

6 or more hours per day

5 hours per day

4 hours per day

3 hours per day

2 hours per day

1 hour per day

Less than 1 hour per day

Special Needs

Hours Served

Number Enrolled

6 or more hours per day

5 hours per day

4 hours per day

3 hours per day

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2 hours per day

1 hour per day

Less than 1 hour per day

Section 2. Rates and Fees

T2: In this section, I would like to ask you some questions about the rates and fees your center charges for your services.

5) What tuition options do you offer for the Infant Age Group?

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Infant (≤18 months)										

6) Please enter the tuition charged for the Infant Age Group.

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Infant (≤18 months)										

7) What tuition options do you offer for the Toddler Age Group?

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Toddler (18-36 months)										

8) Please enter the tuition charged for the Toddler Age Group.

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Toddler (18-36 months)										

9) What tuition options do you offer for the Preschool Age Group?

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Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Preschool										

10) Please enter the tuition charged for the Preschool Age Group.

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Preschool										

11) What tuition options do you offer for School Age children during the school year?

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
School Age										

12) Please enter the tuition charged for School Age children during the school year.

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
School Age										

13) What tuition options do you offer for School Age children during the summer months?

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
School Age										

14) Please enter the tuition charged for School Age children during the summer months.

Age Group	Full-time				Part-time			
	Hourly	Daily	Weekly	Monthly	Hourly	Daily	Weekly	Monthly
School Age								

15) What tuition options do you offer for children with Special Needs?

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Special Needs										

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16) Please enter the tuition charged for children with Special Needs.

Age Group	Full-time					Part-time				
	Hourly	Daily	Weekly	Monthly	Annual	Hourly	Daily	Weekly	Monthly	Annual
Special Needs										

17) In addition to the standard tuition rates entered in the previous section, does your center charge families the fees for the following items? If yes, please indicate the dollar amount.

	Fee Charged		
	Yes	No	Amount (\$)
Annual Registration Fee			
Application Fee			
Materials Fee			
Field Trip Fee			
Activity Fee			
Transportation Fee			
Other Fee (please specify):			

Section 3. Early Learning and Development Services

T3: This section focuses on the Early Learning and Development Services provided by your center.

Section 3A: Infant Age Group (<18 months)

18) Please Indicate the types of Early Learning and Development services your center provides for children in the Infant Age Group (check all that apply)

- a) Free play
- b) Motor activities
- c) Art activities
- d) Other (please specify):

19) Which of the following best describes the curriculum used by your center for children in the Infant Age Group?

- a) We use a formal published curriculum (if 'a' then answer Q19 and Q20)
- b) We use a teacher created curriculum (if 'b' then skip Q19)
- c) We use a formal published curriculum and teacher created curriculum together (if 'c' then answer Q19 and Q20)
- d) We do not use a curriculum (if 'd' then skip Q19)
- e) Other (please specify):

20) To the best of your ability, please list the name(s) of the formal published curriculum that is used at your facility for Infant Age Groups:

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21) How is student learning assessed for Infant Age Groups? (check all that apply)

- a) Pre-post Tests
- b) Observation by center staff
- c) Standardized assessments
- d) Other (please specify):

Section 3B: Toddler Age Group (18 months to 3 years)

22) Please Indicate the types of Early Learning and Development services your center provides for children in the Toddler Age Group (check all that apply):

- a) Free play
- b) Motor skill development
- c) Language and literacy
- d) Math skills
- e) Science and reasoning
- f) Social studies
- g) Fine arts
- h) Field trips
- i) Other (please specify):

23) Which of the following best describes the curriculum used by your center for children in the Toddler Age Group?

- a) We use a formal published curriculum (if 'a' then answer Q23 and Q24)
- b) We use a teacher created curriculum (if 'b' then skip Q23)
- c) We use a formal published curriculum and teacher created curriculum together (if 'c' then answer Q23 and Q24)
- d) We do not use a curriculum (if 'd' then skip Q23)
- e) Other (please specify):

24) To the best of your ability, please list the name(s) of the formal published curriculum that is used at your facility for the Toddler Age Group:

25) How is student learning assessed Toddler Age Groups? (check all that apply)

- a) Pre-post Tests
- b) Observation by center staff
- c) Standardized assessments
- d) Other (please specify):

Section 3C: Preschool Age Group (3-5 Years)

26) Please Indicate the types of Early Learning and Development services your center provides for children in the Preschool Age Group (check all that apply):

- a) Language and literacy
- b) Math skills
- c) Science and reasoning
- d) Social studies
- e) Fine arts
- f) Field trips
- g) Other (please specify):

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- 27) Which of the following best describes the curriculum used by your center for children in the Preschool Age Group?**
- a) We use a formal published curriculum (if 'a' then answer Q27 and Q28)
 - b) We use a teacher created curriculum (if 'b' then skip Q27)
 - c) We use a formal published curriculum and teacher created curriculum together (if 'c' then answer Q27 and Q28)
 - d) We do not use a curriculum (if 'd' then skip Q27)
 - e) Other (please specify):
- 28) To the best of your ability, please list the name(s) of the formal published curriculum that is used at your facility for the Preschool Age Group:**
- 29) How is student learning assessed for the Preschool Age Group? (check all that apply)**
- a) Pre-post Tests
 - b) Observation by center staff
 - c) Standardized assessments
 - d) Other (please specify):

Section 3D: School Age Children (5-13 years)

- 30) Please Indicate the types of Early Learning and Development services your center provides for School Age Children (check all that apply)**
- a) Language and literacy
 - b) Math skills
 - c) Science and reasoning
 - d) Social studies
 - e) Fine arts
 - f) Field trips
 - g) Other (please specify):
- 31) Which of the following best describes the curriculum used by your center for School Age Children?**
- a) We use a formal published curriculum (if 'a' then answer Q31 and Q32)
 - b) We use a teacher created curriculum (if 'b' then skip Q31)
 - c) We use a formal published curriculum and teacher created curriculum together (if 'c' then answer Q31 and Q32)
 - d) We do not use a curriculum (if 'd' then skip Q31)
 - e) Other (please specify):
- 32) To the best of your ability, please list the name(s) of the formal published curriculum that is used at your facility for the Preschool Age Group:**
- 33) How is student learning assessed for School Age Children? (check all that apply)**
- a) Pre-post Tests
 - b) Observation by center staff
 - c) Standardized assessments
 - d) Other (please specify):

Section 4: Health, Mental Health, and Nutrition Services

T4: This section focuses on the Health, Mental Health, and Nutrition Services provided by your center.

- 34) Please Indicate the types of Health services your center provides for the following age groups.**

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Infant (<18 months)

Service	Yes	No
Hearing testing and Screening		
Vision Testing & Screening		
Dental Health Program		
Physical Activity		
Other (please specify):		

Toddler (18-36 months)

Service	Yes	No
Hearing testing and Screening		
Vision Testing & Screening		
Dental Health Program		
Physical Activity		
Other (please specify):		

Preschool (3-5 Years)

Service	Yes	No
Hearing testing and Screening		
Vision Testing & Screening		
Dental Health Program		
Physical Activity		
Other (please specify):		

School Age (5-13 Years)

Service	Yes	No
Hearing testing and Screening		
Vision Testing & Screening		
Dental Health Program		
Physical Activity		
Other (please specify):		

Special Needs

Service	Yes	No
Hearing testing and Screening		

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Vision Testing & Screening

Dental Health Program

Physical Activity

Other (please specify):

35) Please Indicate the types of Mental Health services your center provides for the following age groups.

Infant (<18 months)

Service	Yes	No
Social skill building		
Problem solving activities		
Socio-emotional screening		
Early intervention services		
Other (please specify):		

Toddler (18-36 months)

Service	Yes	No
Social skill building		
Problem solving activities		
Socio-emotional screening		
Early intervention services		
Other (please specify):		

Preschool (3-5 Years)

Service	Yes	No
Social skill building		
Problem solving activities		
Socio-emotional screening		
Early intervention services		
Other (please specify):		

School Age (5-13 Years)

Service	Yes	No
Social skill building		
Problem solving activities		

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Socio-emotional screening

Early intervention services

Other (please specify):

Special Needs

Service

Yes

No

Social skill building

Problem solving activities

Socio-emotional screening

Early intervention services

Other (please specify):

36) Please Indicate the types of Nutrition services your center provides for the following age groups.

Infant (<18 months)

Service

Yes

No

Healthy Snacks/Meals

Nutrition Education

Other (please specify):

Toddler (18-36 months)

Service

Yes

No

Healthy Snacks/Meals

Nutrition Education

Other (please specify):

Preschool (3-5 Years)

Service

Yes

No

Healthy Snacks/Meals

Nutrition Education

Other (please specify):

School Age (5-13 Years)

Service

Yes

No

Healthy Snacks/Meals

Nutrition Education

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Other (please specify):

Service	Special Needs	
	Yes	No
Healthy Snacks/Meals		
Nutrition Education		
Other (please specify):		

Section 5: Family Support Services

T5: This section focuses on the Family Support Services provided by your center.

37) Please Indicate the types of Family Support services your center provides for the following age groups.

Service	Infant (<18 months)	
	Yes	No
On-site parent-teacher conferences		
Home visits to families		
Progress reports and updates		
Other (please specify):		

Service	Toddler (18-36 months)	
	Yes	No
On-site parent-teacher conferences		
Home visits to families		
Progress reports and updates		
Other (please specify):		

Service	Preschool (3-5 Years)	
	Yes	No
On-site parent-teacher conferences		
Home visits to families		
Progress reports and updates		
Other (please specify):		

Service	School Age (5-13 Years)	
	Yes	No
On-site parent-teacher conferences		

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Home visits to families

Progress reports and updates

Other (please specify):

Special Needs

Service

Yes

No

On-site parent-teacher conferences

Home visits to families

Progress reports and updates

Other (please specify):

38) Does your center inform parents of additional health and human services they may qualify for?

- a) Yes
- b) No

Section 6: Special Education

T6: This section focuses on the Family Support Services provided by your center.

39) Please Indicate the types of educational services your center provides for children with Special Needs (check all that apply):

- a) English as Second Language (ESL)/English Language Learner (ELL)
- b) Physical Disabilities
- c) Mental/Emotional Disabilities
- d) Behavioral disorders
- e) Learning disabilities
- f) Language/Speech
- g) Other Special Education Services (please specify):

**APPENDIX F:
ANALYSIS OF THE IMPACT OF COST OF QUALITY
AND REGIONAL VARIATION ON MARKET RATES**

Table D1: OLS Regression of the Cost of Quality and Regional Variation on Market Rates for Infants

Parameter	Estimate	Standard Error	P-value
Intercept	319.209	211.821	0.133
Type of Curriculum (No Curriculum as Reference)			
Formal	-33.096	224.293	0.883
Teacher Created	219.985	179.253	0.221
Combination of Formal and Teacher Created	45.706	173.164	0.792
Other	46.314	271.039	0.864
Region (Delta as Reference)			
Northeast	14.950	219.268	0.946
Southeast	266.299	218.827	0.225
Southwest	75.070	215.912	0.728

Table D2: OLS Regression of the Cost of Quality and Regional Variation on Market Rates for Toddlers

Parameter	Estimate	Standard Error	P-value
Intercept	262.442	229.905	0.254
Type of Curriculum (No Curriculum as Reference)			
Formal	7.181	249.246	0.977
Teacher Created	-33.543	226.618	0.882
Combination of Formal and Teacher Created	144.905	210.997	0.493
Other	136.969	302.534	0.651
Region (Delta as Reference)			
Northeast	95.390	210.870	0.651
Southeast	324.660	213.303	0.129
Southwest	123.327	208.917	0.555

Table D3: OLS Regression of the Cost of Quality and Regional Variation on Market Rates for Preschoolers

Parameter	Estimate	Standard Error	P-value
Intercept	359.590	53.797	<.0001
Type of Curriculum (No Curriculum as Reference)			
Formal	34.969	52.699	0.507
Teacher Created	31.902	51.432	0.536
Combination of Formal and Teacher Created	70.481	46.524	0.131
Other	128.603	63.985	0.045
Region (Delta as Reference)			
Northeast	-23.303	45.989	0.613
Southeast	6.066	46.190	0.896
Southwest	-16.441	45.969	0.721

Table D4: OLS Regression of the Cost of Quality and Regional Variation on Market Rates for School Age Children

Parameter	Estimate	Standard Error	P-value
Intercept	284.501	31.806	<.0001
Type of Curriculum (No Curriculum as Reference)			
Formal	-65.765	47.961	0.172
Teacher Created	-2.226	26.568	0.933
Combination of Formal and Teacher Created	51.907	29.306	0.078
Other	7.699	39.009	0.844
Region (Delta as Reference)			
Northeast	-14.045	35.919	0.696
Southeast	15.396	36.849	0.677
Southwest	28.751	36.481	0.432

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