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# Child-Care Quality Rating and Improvement Systems in Five Pioneer States

Implementation Issues and Lessons Learned

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Prepared for the Annie E. Casey Foundation, the Spencer Foundation,  
and United Way America



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## Summary

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### Introduction

The generally low quality of child care in the United States, documented in a number of studies (e.g., Karoly et al., 2008), has led to calls for improvement. One approach that has been gaining momentum involves the development and implementation of quality rating systems (QRSs): multicomponent assessments designed to make child-care quality transparent and easily understood. Participating providers are assessed on each of the system components and receive a summary rating that they are encouraged to display and that may be made public in other ways as well. In theory, these simple ratings (often 0 to 5 stars or a rating of 1 to 4), enable parents, funders, and other stakeholders to make more informed choices about which providers to use and support, and they encourage providers to improve the quality of care that their program provides. Quality rating and *improvement* systems (QRISs) include feedback, technical assistance, and other supports to motivate and support quality improvements.

A systems perspective provides a useful framework for examining QRISs. Systems analyses posit a set of fundamental activities that, if carefully linked and aligned, will promote system goals. These activities include (1) setting goals, expectations, and standards for the system, (2) establishing incentives for participation and consequences for meeting (or failing to meet) expectations and standards, (3) monitoring the performance of key system entities (in the case of QRISs, program quality levels), and (4) evaluating how well expectations are being met, encouraging improved performance through quality-improvement (QI) support, and distributing performance incentives and other rewards.

### Study Questions

In this report, we summarize the QRISs of five states that were early adopters of such systems. We then present results from in-depth interviews with key stakeholders in each of these states; the interviews focused on identifying major implementation issues and lessons learned.

The work attempts to answer four questions:

1. What is the theory of action underlying these systems?
2. What do these pioneer QRISs look like? Which aspects of quality are included as components in these QRISs?
3. How were they developed?
4. What challenges have system designers faced? What lessons may be learned from these early systems?

## Methods

The five states included in the study were selected from among the 14 states that had a statewide QRIS in place as of January 2007. The states we chose were QRIS pioneers—they had longer experience designing and implementing a QRIS—and they represented a range of different approaches to QRIS design. We selected states that reflected diversity in terms of geography and population size because we thought that the presence or absence of large rural areas and wide dispersion of programs might significantly affect QRIS implementation. For example, if programs were widely dispersed and there were few programs in an area, parents might be less likely to use ratings as a program selection criterion.

Using these criteria, we selected Oklahoma, Colorado, North Carolina, Pennsylvania, and Ohio for study. We conducted a total of 20 in-depth telephone interviews from February 2007 to May 2007 with four key stakeholders in each state, using a semi-structured interview guide developed for the project. Interviewees included employees at state departments that oversaw or regulated early childhood programs, child care, or education; QRIS administrators; child-care providers; and representatives of key organizations involved in child care, such as local child-care resource and referral agencies, advisory group representatives, funders, and child-care advocates. Interview notes were transcribed, and coded. We then reviewed the interviews, identifying overarching themes and extracting key lessons learned.

Once our draft of the state QRISs was completed, we sent each interviewee our write-up of his or her state's QRIS for review. We then revised and updated our descriptions based on their feedback, incorporating changes that had been made to the systems after the interviews were conducted. In July 2008, one interviewee in each state was asked to review the entire manuscript. These reviews resulted in additional revisions, so that the information on each QRIS presented in this report is current as of July 2008.

## Findings

QRISs generally adhere to a model similar to the one we developed and display in Chapter One. Key to the model are ratings of participating provider quality. The theory underlying the model posits that as parents learn about ratings, they will use them in making child care choices, selecting the highest-quality care they can afford. As the ratings are used, more programs will volunteer for ratings so as not to be excluded from parents' ratings-based choices. In the longer term, parents will have more higher-quality choices and more children will receive high-quality care. Ultimately, the logic model posits that this will result in better cognitive and emotional outcomes for children, including improved school readiness.

Across the five systems, there was considerable consensus concerning the key components of quality that belong in a QRIS. Each system includes measures of (1) staff training and education and (2) classroom or learning environment (although the latter is only measured at higher levels of quality in some states). States differ on whether they include parent-involvement assessments, child-staff ratios, or national accreditation status. Those states that include accreditation relied primarily but not exclusively on accreditation by the National Association for the Education of Young Children (NAEYC).

Cost issues strongly affected the choice of components and the use of particular component measures in most states. In a number of these pioneer states, environmental rating scales

(ERSs) are a particular subject of debate because of their high cost. An ERS evaluation requires an in-person visit by a trained observer, who evaluates such factors as the physical environment, health and safety procedures, and the quality of staff-child interactions. The ways in which the various quality components are summed and weighted to produce a rating differ across states. States also differ in the level of autonomy afforded providers in earning a rating. In point systems, in which summary ratings are based on total points across components, providers may focus their improvement efforts on those components they believe they can most easily improve (or those that are most important to them); in block systems, where providers must improve in all areas, improvement efforts are more prescribed.

The five states tended to follow similar processes in developing and implementing their QRISs. Each state set goals, assessed feasibility, and designed and implemented its system. In implementing a system, assessments must be conducted, ratings determined, and QI efforts begun. States devised a variety of ways to accomplish these tasks and used different combinations of staff to carry them out. The lack of piloting in most of these states and the relatively fast implementation of their QRISs led to early reassessments and numerous revisions, for example, in the role of accreditation and the number of rating levels.

Most interviewees reported increases in provider and parent interest in QRISs over time. They noted that more providers are volunteering to be rated, and more parents are asking resource and referral agencies about program ratings. Most interviewees believed that their QRIS had been helpful in raising awareness of quality standards for child care. They attributed success to political support, adequate financing of provider incentives, provider buy-in, public-awareness campaigns, and QI support for providers.

These states faced numerous challenges in implementing QRISs. First, a number of states struggled with standard-setting. Some states initially set standards low, because average quality of care was poor and designers worried that overly high standards would discourage provider participation. As programs improved over time, administrators increased standards, which programs resented. Second, states made different decisions concerning minimum standards that programs must meet to receive a rating. Three states require programs to be licensed before they can be rated. The other two states require some level of QRIS participation from all providers by assigning the lowest level of rating to licensed providers; to raise their rating, providers must agree to undergo a full QRIS rating. Several interviewees told us that this latter practice was confusing to parents because it was not clear whether a program received the lowest rating because it was licensed and chose not to participate in the QRIS or because it was part of the QRIS and had earned a low rating. At the same time, this practice brings licensing and the QRIS together and may encourage more providers to be rated so that they can attain a rating higher than the lowest one. States also faced challenges in making QI increments between ratings comparable. In one state, this issue led to significant changes in rating levels.

States also had to decide which components to include. Decisions about which components to include or omit are critical because they send a message to providers, parents, and policymakers about what is important in child care. Several programs struggled in particular about a parent-involvement component. Measures of this concept are not well developed, and the inclusion of additional components generally has nontrivial cost implications. At the same time, unmeasured components are likely to be ignored in favor of the measured ones.

The states we studied have invested substantial resources in their QRISs and have developed a range of financial incentives for system participation and quality improvement, including, for example, professional development support for staff in centers that attained a specified

rating and reimbursements for subsidy-eligible children that increased with provider rating. But funding remains an issue in most states. In some states, low reimbursement rates for children receiving child-care subsidies make it impossible for programs serving these children to attain the highest quality levels because these levels require low child-staff ratios and relatively well-educated providers, two very costly aspects of quality.

Providers are often understandably wary of the rating process and tend to view these ratings as they do licensing: something to “pass.” QRIS designers would like programs to replace this view with a culture of continuous quality improvement, but are unsure about how to effect this cultural change.

## Recommendations

Based on our interviews and interpretation, we came up with the following recommendations for developing and refining QRISs.

### Precursors to a Successful QRIS

**1. Obtain adequate funding in advance and decide how it will be spent.** QRISs require money to be effective. It is important to develop realistic cost estimates and to design the QRIS so that sufficient funds are available for key activities and are used in the most effective way.

**2. Garner maximum political support for a QRIS.** Such support does not require legislation, but lack of support from government, funding agencies, and other organizations that influence the child-care sector can be a major barrier to the ramping up of a QRIS in a timely manner and its continuing fiscal health. The need for broader public support, particularly from parents, is also important, as discussed below.

### System Development Process

**1. Conduct pilot work if possible and make revisions to the system before it is adopted statewide.** If at all possible, significant time and effort should be devoted to an iterative revision process in response to a system pilot. Without a pilot phase, states were forced to make many changes after implementation was underway, which led to confusion and resentment. If pilot work is not possible, recognize that revisions are likely and both prepare participants and design the system to accommodate changes to the extent possible.

**2. Limit changes to the system after it is implemented.** Setting up a system of continuous quality improvement with clear incentives for improvement and a substantial number of rungs to climb may be the best way to encourage continuous quality improvement without imposing new requirements. Constant changes, including raising the bar to prevent provider complacency, create confusion for parents and may undermine their trust in the system. A strategy should be put in place as well to avoid the “provider fatigue” that may result from frequent changes.

### What Should QRISs Include?

**1. Minimize use of self-reported data as part of the QRS.** Such data may bias ratings because providers have strong incentives to be rated well in these increasingly high-stakes systems where there may be significant consequences attached to ratings. However, such data can be helpful as part of QI efforts.

**2. Licensing should ideally be integrated into the system.** To the extent possible, rating systems should be integrated. One way to do this is to assign all licensed providers a star rating of “1” unless they volunteer for a rating and are rated higher.

**3. Use ERSs flexibly by incorporating both self-assessments and independent assessments at different levels of the QRS.** ERSs have substantial value. At least some of this value may be captured by using ERSs in more creative—and economical—ways.

**4. Do not include accreditation as a mandatory system component.** Accreditation based on the former NAEYC system imposed high costs (although limited scholarship dollars were available through NAEYC) and sometimes caused delays in completing ratings due to involvement of another entity. The new NAEYC system may obviate these problems but that is not yet clear. Using accreditation as an alternative pathway to higher ratings may be feasible but requires that decisions be made about equivalence.

**5. The rating system should have multiple levels.** Including many rungs makes progress more attainable at the lower quality levels, thereby facilitating provider engagement. It also allows for improvement at the higher end, preventing providers from shifting to a “maintenance” mode in which they no longer strive to improve.

### Quality Improvement

**1. Create a robust QI process.** Without resources and support, few programs will be able to change. To effect change, a QRIS needs to provide some mix of staff development, financial incentives, and QI support.

**2. Separate raters and QI support personnel.** The rating and coaching tasks should be conducted by different individuals so as to avoid creating conflicts of interest that may bias the assessment process.

**3. Public-awareness campaigns are important but should start after the system is in place; these campaigns need to be ongoing.** Parents only need information about child-care quality for a relatively brief window of time while their children are young. To be useful, public-awareness campaigns need to be big enough to reach many parents and available on an ongoing basis. Such campaigns should be initiated once the system is fully developed, so that the system can deliver on its promises.

### Evaluate the Effectiveness of the QRIS

**1. Support research on systems and system components.** Research that identifies best practices in QRISs is needed so that these practices can be shared. States would benefit from empirical work on key measurement issues, including how best to assess important components and how to combine ratings across components to provide reliable and valid ratings. Research on optimal QI practices and ways to reach parents is also needed. Establishing a QRIS Consortium is one way to accomplish this research.