Virginia Star Quality Initiative Family Child Care Home Provider Demonstration Pilot Evaluation Report

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Executive Summary

The Virginia Star Quality Initiative (VSQI) family child care home demonstration project was a pilot quality rating and improvement program designed to provide intensive professional development services to family child care home providers. The pilot project took place between October 1, 2010, and June 30, 2011, and was funded by federal American Recovery and Reinvestment Act monies awarded to the Virginia Department of Social Services. The Virginia Early Childhood Foundation (VECF) piloted the family child care home provider program as an extension of the classroom-based VSQI, currently in its fifth year of a pilot phase. Through a competitive process, VECF selected six geographically and culturally diverse regions encompassing 35 Virginia localities to participate, with a recruitment target of 75 licensed family child care providers. Regions included nine localities in the Southwest (coordinated by Smart Beginnings Appalachia), Arlington/Alexandria, six localities in Central Virginia (coordinated by Smart Beginnings Central Virginia), Fairfax, seven localities in the Greater Richmond area (coordinated by the Richmond Resource and Referral Agency, ChildSavers) and five localities in South Hampton Roads (coordinated by Smart Beginnings South Hampton Roads and The Planning Council).

Local coordinators recruited providers and administered rating and mentoring procedures for their regions, while VECF provided training, technical assistance, data coordination, and project oversight. Researchers at Virginia Tech were selected to (1) assist VECF in evaluating the four draft home-based Star Quality Standards; (2) conduct a process evaluation of the demonstration program; and (3) develop a short-term continuing evaluation plan for the home-based pilot. The findings reported in the evaluation report address the first two of these three evaluation charges.

Results of the Standards evaluation indicated that three of the four draft home-based Standards—Standard 1 (*Education, Qualifications and Training)*; Standard 2 (*Environment and Interactions);* and Standard 3 (*Structure)*—received support from the research literature and were endorsed as important quality indicators by a panel of national quality rating and

improvement experts and by a large majority of Virginia stakeholders, including pilot local coordinators, raters, mentors, and family child care providers. Little research evidence was found to guide decision making regarding Standard 4 (*Program Management)*, and local stakeholders expressed mixed views on the validity of this Standard to measure family child care home quality. National expert and pilot coordinators agreed that—if given sufficient educational opportunities, mentoring, and other instrumental support—family child care providers were likely to achieve high Star Ratings, although obtaining a bachelor's degree in the field might represent a significant hurdle.

National experts and local coordinators recommended changes regarding how to calculate Star Ratings, many of which were incorporated into VECF's Star Rating calculations for the demonstration project. Baseline ratings, conducted by trained raters in family child care homes prior to mentoring, indicated that pilot providers fared well with Standard 3 (*Structure,* or age-weighted group size and adult-to-child ratios), achieving an average Star Rating of 4.6 out of a possible 5 Stars. Average rankings for the other Standards were considerably lower: Standard 1 (*Education, Qualifications and Training*), 1.7; Standard 2 (*Environment and Interactions*), 2.05; and Standard 4 (*Program Management*), 1.14. Across all providers, Star Ratings for all Standards except *Program Management* spanned the entire range, from 1 to 5 Stars. Overall baseline Star Ratings averaged 2.31, ranging from 1 through 4 Stars.

Subscale scores on the standardized tool used to measure Standard 2 indicated considerable variation. Pilot providers as a group averaged mid- to high-middle scores on environmental subscales—*Parents and Providers* (4.95, on a 7-point scale*), Interactions* (4.9), and *Listening and Talking* (4.2), with each of these subscales ranging across the scale (from 2 –7 for *Parents and Providers*; 1 – 7 for the other subscales). The remaining four environmental subscale averages were lower, ranging from *Program Structure* (3.5), *Space and Furnishings* (3.08), *Activities* (2.7), to *Personal Care Routines* (2.5). The baseline ratings underscore the need for efforts to help family child care providers improve the quality of their care, and point to areas that require more targeted training and mentoring for providers. The range found among subscales on the tool used to measure Standard 2, and across the first three Standard

Star Ratings, suggest that these draft Standards appear to be reasonable for family child care providers if accompanied by sufficient and affordable opportunities for professional development and education. The limited range for *Program Management*, coupled with the lack of strong empirical evidence relating it to child care quality and stakeholder ambivalence about this Standard, suggests that this Standard may need to be modified or eliminated.

Process evaluation: Findings indicate that on balance, the pilot was well conducted despite the considerable challenges that were encountered, many of which appeared related to the project's short timeline. Raters and mentors received extensive preparation, spending eight or five full days, respectively, training with experts and VECF staff. Target recruitment levels were achieved. Twelve raters observed and provided detailed feedback to 75 family child care providers. Twenty mentors developed Quality Improvement Plans (QIPs) with 74 providers and delivered an average of 26 hours of personalized mentoring services to each. Providers and their mentors collectively developed between seven and 36 (with an average of 18) goals per provider, collectively addressing quality improvement activities across the four Star Quality draft Standards.

The pilot goal of having providers meet at least half of their goals by the end of the demonstration project was largely achieved: reports by mentors or local coordinators showed that all but six providers met this benchmark, and 90 percent exceeded it. Completed goals ranged in complexity. Examples include meeting regularly with a mentor, making environmental improvements, practicing communication feedback loops with children, developing an employee handbook, and enrolling in Child Development Associate or college early childhood education programs to start in Fall 2012. Mentors reported working primarily one on one with providers at their homes, though in at least two pilot regions, mentors also hosted group training sessions for pilot providers and facilitated local provider networking.

Satisfaction with the pilot appeared to be high among all stakeholder groups. Seventy-five percent of family child care providers across all pilot regions completed a telephone interview toward the end of the pilot project. These providers reported being "very satisfied" with their mentor relationship (96%), the process of developing QIPs (90%), and the pilot

overall (78%). Ninety-four percent would likely recommend the program to other child care providers, and 74 percent reported it "very likely" that they would continue with the VSQI. Ninety-two percent of all raters would like to continue, as would 81 percent of surveyed mentors.

At the same time, aspects of training and procedures need modification to maximize the likelihood of future smooth administration, quality control, and sustainability. Challenges experienced during the pilot are instructive for the future administration of the family child care home VSQI. Key recommendations based on challenges related to recruitment, training, rating, mentoring, and data management are summarized here:

- *Institute a formal provider orientation phase as the first step into the Star Quality system and avoid recruitment drives around holidays or other related state initiatives.* Recruiting providers was challenging for at least half of the pilot regions, and four lost at least two providers during the course of the pilot, necessitating additional recruitment in three regions (12 providers withdrew overall). Recruitment around the winter holidays and the short duration of the pilot appeared to play a large role in enrollment difficulties, but other factors also operated, most notably providers' perceiving the initiative as complex or confusing, the low density of eligible providers in more rural areas, concurrent changes in state licensing standards, and cultural or language barriers (approximately one-quarter of the pilot sample spoke a primary language other than English). The concept of the "three-week window," in which a rater, unannounced, would observe a family child care home during a specified range of dates, was confusing or distressing to some providers, an obstacle that resulted in some initial scheduling difficulties. Instituting a longer, more standardized orientation to the VSQI that includes broader dissemination of information to providers and parents; offering translators for non-English speaking providers; and possibly adding a self-assessment or initial mentoring component prior to conducting publishable ratings should help offset many of these challenges and reduce turnover.

- *Schedule and manage inter-rater reliability "buddy checks" at the administrator rather than the rater level and troubleshoot potential difficulties in scheduling unannounced rater visits ahead of time.* Thirty-three percent of the original rater pool was unable to conduct ratings for unexpected personal reasons or because some raters never achieved reliability on rating tools. These complications, coupled with there being one or no original certified rater in some regions, resulted in a few protocol irregularities in order to meet demonstration deadlines. Two sets of raters did not conduct inter-rater reliability checks, and eight rater visits were scheduled between one hour and one day in advance due to a variety of reasons, including apartment building visitor regulations, rater travel schedules, prior missed visits, and a provider's home being quarantined. While these irregularities were infrequent and appeared motivated by the compressed pilot time frame, strict oversight of these procedures is critical to the integrity of the rating system, particularly once Star Ratings are published.

- *Modify the Summary Report to reflect positive aspects of providers' child care practices as well as areas that need improvement, and provide support for providers when they receive their Reports.* The main hurdle of the demonstration project lay in providers' negative reactions to the Summary Report. Although later in the pilot many providers reported it was helpful (52% of surveyed providers found the Summary Reports to be "very useful" by May or June), across all localities mentors reported expending considerable time, resources, and effort to allay provider concerns, soothe distressed feelings, and prevent participants from quitting the pilot in the wake of receiving their Reports. It is a testimony to the skill of the pilot mentors, who began working with providers after they had received their Reports, as well as local coordinators and VECF pilot staff that no provider formally withdrew due to the Report. However, these concerns about the Summary Report can be reduced, if not eliminated, by reformulating the Report to include positive comments and encouragement and by better preparing providers about what to expect.

- *Provide mentors and local coordinators with more training and guidance regarding how to develop QIPs and more specific guidance on how the Toddler Classroom Assessment Scoring*

System (CLASS) tool is to be used during mentoring. Only 19 percent of mentors felt "very well prepared" to develop the QIPs, and 44 percent would have liked more training on the Toddler CLASS. Variations in both the number and the complexity of goals in the QIPs and a lack of consistency in whether local coordinators reviewed or supervised the development of QIPs indicate that this process needs critical attention as a centerpiece of the VSQI. While mentors used the Toddler CLASS to help establish goals with their providers rather than for ratings, the way they used it and the extent to which they conducted formal assessment varied. For future mentoring purposes, formal CLASS assessment administration and mentors attaining reliability on this measure may not be necessary, but it will be important for VSQI developers to clarify the range of acceptable practices for mentors using this tool and to provide guidance on how to maximize its rich utility with family child care home providers.

- *Reach out to train more bilingual mentors*. Twenty-six percent of the 75 pilot providers spoke a primary language other than English. Adequately helping these providers improve their child care practices requires that mentors at least be able to communicate well with them. Using monolingual English-speaking mentors with providers who are not fluent in English is an inefficient use of mentor resources. At a minimum, more bilingual Spanish-speakers are needed.

- *Develop a data security protocol and train personnel to use it.* The current decentralized approach to collecting and storing VSQI family child care home data means that personnel rely on local internal agency data protection standards or do not have any. Procedures for securely storing, sending, and disposing of this information need to be spelled out and personnel must be trained on them to guard against the data inadvertently or maliciously being seen by unauthorized persons. VSQI administrators could explore the possibility of having all field staff—mentors, LCs, but particularly raters—work on and store data on a secure remote server that they log into, obviating the need for data to be stored on local computers or personal laptops. Attention would need to be paid to internet access issues in some Virginia locations to determine whether this would work for all regions.

Several matters emerged during the process evaluation that were beyond the scope of the evaluation but are important to explore further. They include the following:

- Specific cultural barriers that may prevent different family child care provider populations from engaging in or optimally profiting from the VSQI;

- Details of the mentoring component, particularly in characterizing mentor activities and determining how and to what extent QIP goals that are met correspond to changes in Star Quality ratings;

- The feasibility of a state-level VSQI rater or rater-and-mentor system to maintain high levels of quality control over the VSQI process; and

- Possible extension of the period in which family child care provider Star Ratings are not published until further evaluation of the VSQI is conducted.

Introduction

The Virginia Department of Social Services Office for Early Childhood Development (VDSS/OECD) commissioned the Virginia Early Childhood Foundation (VECF) to design and conduct a pilot demonstration project to expand the Virginia Star Quality Initiative (VSQI) to home-based child care providers (also referred in this report to as "family child care home providers"). The VSQI is a developing quality rating and improvement system (QRIS) for early child care and education across the Commonwealth of Virginia. Begun in 2007, the VSQI has focused on child care centers, including Head Start and public prekindergarten (Virginia Preschool Initiative) classrooms. Federal American Recovery and Reinvestment Act funds directed to the Virginia Department of Social Services enabled the long-anticipated expansion of the VSQI into home-based child care starting in the fall of 2010. Through a competitive process, VECF chose Virginia Tech to conduct a process evaluation of the pilot demonstration project. The evaluation charge was threefold:

- Assist VECF and VDSS/OECD in evaluating the Virginia Star Quality Standards for home-based providers
- Conduct a process evaluation of the pilot demonstration project
- Develop a short-term ongoing evaluation plan

This report represents the first and second charges. The report is organized into nine chapters. The introductory chapter provides an overview of the pilot goals and procedures, the administrative structure of its management, and briefly reviews the evaluation questions and study design. Chapter 2 presents the Star Standards evaluation, which represents one component of a larger evaluation conducted by the VECF. The remainder of the report presents findings from the process evaluation. Six chapters review central components of the pilot program, including provider engagement, training, the rating and data gathering process, mentoring, data management, and stakeholder satisfaction. The concluding chapter summarizes findings and outlines recommendations for the future. The seven appendices provide summaries of the evaluation methodology, focus group summaries and survey

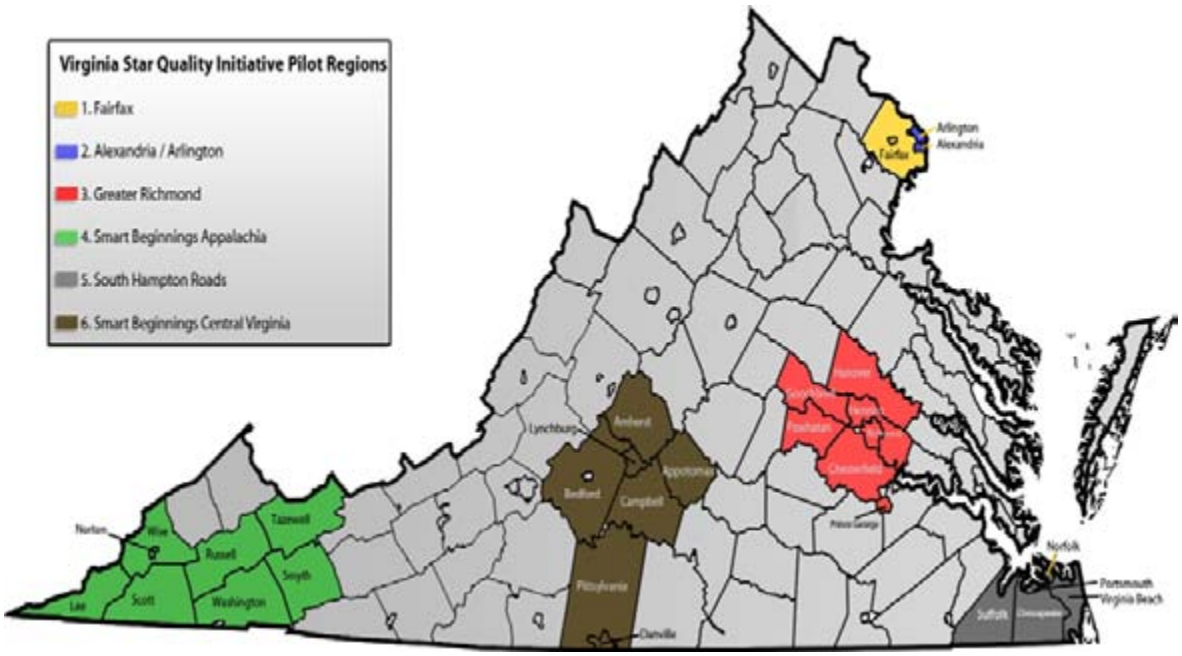
response data, examples of key pilot documentation, local coordinator suggestions for streamlining documentation, and a summary of demographic and out-of-home child care patterns of the local pilot regions. More detailed descriptions of the methodology and the instruments used in the study are included in a separate Technical Report.

Overview of the Pilot Goals and Procedures

The pilot demonstration project took place from October 1, 2010 through July 31, 2011, and consisted of three main phases: 1) training and recruitment; 2) ratings and provision of Summary Reports for home-based providers that gave them evaluative feedback on all strands of each of the four home-based VSQI Standards; and 3) mentoring for quality improvement. A public recognition ceremony on July 22, 2011, for participating providers and other stakeholders represented the formal conclusion of the demonstration project. An overview of the pilot timeline is presented in Appendix A.

VECF selected six regional agencies from an applicant pool of 10 to pilot the home-based provider demonstration project. Regions were selected for geographic and cultural diversity, as well as for the agency's estimated ability to manage the pilot's accelerated start-up and tight deadlines. The localities and their geographic niches are shown in Figure 1.

Figure 1. *Participant Regions for the Demonstration Pilot*



Each region was required to solicit 10 to 15 home-based child care providers for the pilot, for a total of 75 providers. LCs at each regional level administered the pilot for their area, with training, guidance, and technical assistance provided by VECF.

Virginia Star Quality Rating Procedures

VSQI raters were expected to visit family child care providers' homes in order to observe child care practices and to obtain documentation regarding the provider's education, training, and business practices. Paralleling VSQI procedures used with classrooms and child care centers, visits were to occur within a three-week window agreed upon with the provider, although the exact day of the visit was deliberately not specified. Raters used standardized measures to capture dimensions of quality. Rating scores were used to create a Summary Report, which provided detailed feedback to family child care home providers. The Summary Report was designed to provide the central structure for the Quality Improvement Plan (QIP) that mentors developed with providers. The following tools were used to measure home-based Star Quality:

- Education, qualifications, and training documentation (Standard 1)
- Family Child Care Environment Rating Scale, Revised Edition (FCCERS-R) (Standard 2)
- Counts of group size and staff-to-child ratios by child age (Standard 3)
- Business Administration Scale (BAS) (Standard 4)

Raters sent their completed Summary Reports within five days of their site visit to their LC, who was to review it and send it to VECF. To maintain fidelity to the standardized procedures, raters were required to join a colleague after the first three and then after every fifth rating to compare scores—a quality control procedure known as assessing inter-rater reliability. Raters were paid one fee for completion of each rating, which included making an on-site observation visit, checking providers' documentation, calculating scores, and writing the Summary Report.

Mentoring Procedures

Mentors were expected to log up to 30 hours of service per provider, beginning their services after the provider had received the rating-based VSQI Summary Report. For the pilot, mentors' responsibilities can be summarized as follows:

- Establish a good working relationship with the provider
- Provide on-site individualized coaching
- Develop a QIP with the provider
- Work on specific goals as outlined in the QIP

Following the rating and prior to the start of the mentoring phase, mentors were expected to conduct a formal assessment of providers' interactions with and educational support for the children in their care through the use of the Toddler Classroom Assessment Scoring System (Toddler CLASS), if providers agreed.[1] Mentors were to use initial scores on this measure, along with the Summary Report, to work with providers to develop a QIP with specific goals aimed at boosting future ratings. Mentors also facilitated the selection and purchase of new materials in support of the QIP. (Participation in the pilot entitled each provider up to $1,000 worth of materials for their business.) The expectation was that by the end of June 2011, providers would have achieved approximately 50 percent of their QIP goals.

The precise nature, timing, and frequency of the mentor visits were not specified by VECF, other than the upper limit on the total number of service hours. As detailed in the Mentoring chapter, mentors had considerable flexibility to conduct coaching as they judged best, a leniency that resulted in interesting and useful variations. Mentors completed monthly reports of their activities and were paid by the hour.[2]

Training Procedures

Training on most VSQI tools and procedures was conducted at the state level by VECF. This component included training on the FCCERS-R, BAS, Toddler CLASS, and rater and mentor visit protocols, as well as on how to write Summary Reports from rating visits. Mentors received training on a relationship-based coaching model and their overall role with home-based providers, and LCs received training on documentation and overviews of the pilot tools. Within their pilot regions, coordinators held group trainings for home-based providers on how

[1] Providers were asked to sign an agreement to allow mentors to conduct the Toddler CLASS. Providers who agreed to the Toddler CLASS received point credit toward Standard 2, Environment and Interactions. For details on the rationale behind this approach and how points are allotted, please see Appendix B.

[2] VECF granted agencies an hourly rate of $35 for a mentor's time; however, some agencies chose to use staff members and allotted the $35/hour received towards the employees' salary (M. Green, personal communication, July 12, 2011).

to self-administer the BAS. Providers were asked to complete their self-assessment prior to the rater visit.

For the main observational tool, the FCCERS-R, a two-level training procedure was employed. All raters attended a one-day workshop with Dr. Thelma Harms, who co-authored the FCCERS-R, and her colleagues. Raters designated as more experienced ("master raters") each visited three to four Richmond family child care homes with Dr. Harms and her expert colleagues, in order to further train and establish their reliability on the FCCERS-R instrument.[3] In a parallel process at the local level, novice raters were expected to establish consistency with a master rater by accompanying her on three local pilot provider observation visits. Once a rater was judged consistent with a master rater, he or she went on to complete solo ratings and write Summary Reports for those visits. In actuality, the local parallel process was seldom conducted for the pilot, due to a number of factors described in the Training and Rating chapters. (For further details on the pilot procedures, please refer to Appendix C.)

Administrative Structure and Management of the Pilot

The pilot demonstration was administered by VECF and coordinated by local staff of autonomous organizations. Five of the six organizations were lead agencies for local Smart Beginnings coalitions, which are spearheaded and partially funded by VECF.[4]

VECF provided the main funding, organizational structure, timeline, technical assistance, and overall administration of the pilot demonstration project, including providing training on the rating instruments and procedures, mentoring approaches, and communication documentation procedures. VECF also offered technical assistance to and coordinated regular phone conference calls with LCs. The coordinators were primarily responsible for provider and field staff recruitment, scheduling the three-week timeframe for unannounced rater visits, monitoring inter-rater reliability checks, administering the local mentoring component,

[3] Two local raters were also able to participate in the Richmond field rater trials with scale experts due to training slots becoming available because of late cancellations (M. Green, personal communication, July 12, 2011)

[4] Smart Beginnings coalitions are coordinated local groups dedicated to increasing children's school readiness and success (VECF, 2011). The single exception was Greater Richmond, which was administered by the local Resource and Referral (R & R) agency. One locality also subcontracted the project to their local R & R but acted as the fiscal agent (Smart Beginnings South Hampton Roads, 2010).

approving provider materials purchasing, tracking rater and mentor progress, and ensuring the adequacy and timeliness of reports sent to VECF.

VECF sent out all Summary Reports directly to family child care providers and filed copies of all QIPs. Mentors developed goals with providers and sent completed QIPs to their LCs, who was to edit them and send to VECF. Mentors and providers both retained copies of the final QIPs. LCs reported progress and expenditures to VECF through a monthly report and were reimbursed.

Communication across all levels of the pilot except with providers was conducted primarily through email. To facilitate secure and timely review of the many documents involved in the pilot, the evaluation team introduced VECF to a web-based communication tool, Scholar™, and trained staff and LCs on how to use it. This became a central vehicle for tracking and sharing documents amongst VECF, LCs, and evaluation team members.

Evaluation Questions and Design

This section outlines the overarching conceptualization and design of the pilot evaluation and presents the evaluation questions or areas. Appendix A presents a summary table of the evaluation questions, data sources, and other methodology used in the two evaluations. More detailed descriptions of the evaluation methodology and the measures used in the studies are available in a separate Technical Report.

Evaluation Conceptualization and rationale

The evaluation approach was guided by three central concerns: validity, reliability/feasibility, and sustainability. For the VSQI to produce desired outcomes and for it to be sustainable, its underlying conceptualization and organizational procedures need to reflect what is currently known about child care quality improvement and how high quality care promotes positive child development and school readiness. In addition, procedures need to be designed so that they are feasible and replicable, and their implementation can be assessed. Thus, three overarching conceptual questions guided our evaluation:

- Are the VSQI Standards valid for measuring home-based child care quality improvements?

- Are the procedures adequate to reliably implement the VSQI with home-based child care providers?
- Are the procedures implemented well?

The first two questions pertain to the conceptual and organizational structure of the demonstration project, whereas the third focuses on how well the procedures were carried out. Since the pilot demonstration represented the VSQI's first attempt to work systematically with home-based child care providers, it was expected that all procedures in this initial phase of system development might not be firmly established. Our process evaluation addressed aspects of organizational structure by describing procedures and identifying where they may profit from further systemization, or what procedures may still need to be developed.

While having procedures in place are necessary for smooth program implementation, alone they are not sufficient to ensure well-delivered services. How well procedures are carried out depends on many factors, such as the skill of the workforce, whether the procedures are well communicated, and whether the time frame for work completion is reasonable. The bulk of our process evaluation thus focuses on this second critical question of process implementation. If procedures were implemented well and cover the relevant and strategic components of the demonstration pilot, the VSQI will be better poised to undertake a meaningful outcome evaluation in the future. Implementation evaluation is thus a critical early step in developing a viable, sustainable system of service delivery.

Star Quality Standards for Home-Based Child Care Evaluation

The Virginia Tech evaluation of the draft Family Child Care Star Quality Standards was undertaken in parallel with several complementary activities to examine the Star Quality Standards and procedures for both home- and classroom-based child care services. As part of the ARRA-funded contract between VECF and the VDSS OECD, VECF developed a strategic plan for the VSQI in the near future. While our evaluation focused exclusively on the draft Standards for family child care homes, the Strategic Plan encompassed Virginia's overall QRIS efforts (Virginia Early Childhood Foundation, 2011) and employed an independent consultant to lead

focus groups, develop and interpret surveys, and make recommendations based on extensive input from stakeholders.[5]

Three primary research questions guided the family child care home-based Star Standards evaluation:

1. Do the Standards reflect quality improvement identified in the research literature as predictive of positive child outcomes?
2. Are the Standards clear, comprehensible to multiple stakeholders, and closely tied to verifiable data?
3. Are the home-based Standards reasonable for family child care providers?

Measurement tools used to address these questions included document and research literature review, surveys and focus groups with a panel of national QRIS experts and another of LCs; on-line rater and mentor surveys; a telephone interview with providers; and analysis of pilot Star Ratings.

Process Evaluation

The process evaluation focused on the following six major facets of the pilot project:

- Provider engagement, including recruitment
- Training
- Ratings and data gathering
- Mentoring
- Data coordination and management
- Stakeholder communication and satisfaction

Specific evaluation questions and the ways each question are addressed for each component are listed in Appendix A. Measurement tools included a review of the VSQI pilot documents, including ratings, Summary Reports, QIPs and mentor monthly summary reports; training fidelity checklists; rater time logs; on-line surveys; executive telephone and in-person interviews; and mentor group interviews.

[5] Findings from the focus groups regarding the family child care home-based standards evaluation were shared with VECF on April 15, 2011, but the content presented here is independent of the Strategic Plan and not coordinated with it.

Virginia Star Quality Initiative Home-Based Standards Evaluation

Virginia is one of 27 states to develop and implement a quality rating and improvement system (QRIS) for early childhood care and education (Tout et al., 2010), and one of 25 to include family child care providers in their QRIS.[6] Quality indicators are commonly referred to within state QRIS systems as "Standards." In this chapter, unless otherwise noted, "Standards" refers to the broad class of quality indicators used for the Virginia Star Quality Initiative (VSQI). The four pilot home-based provider Standards at the time of the evaluation were as follows:

1) Education, Qualifications and Training (assessed by documentation)
2) Environment and Interactions (assessed by observation
3) Structure (assessed by observation)
4) Program Management (assessed by observation and documentation)

This chapter reviews the development of the draft home-based Standards, the degree to which they are founded on scientific literature, expert and Virginia stakeholder views on their validity, and the extent to which they appear fair to and reasonable for family child care providers. Data sources for this chapter included a review of VSQI documents, including meeting minutes from the task force that drafted the Standards; a brief literature review; surveys and focus groups with national QRIS experts and with pilot LCs; surveys with raters and mentors; a telephone interview with pilot providers; and pilot ratings. Survey responses and detailed summaries of the focus group discussions are provided in Appendix B for the national experts and local coordinators. Survey responses for raters and mentors are presented in Appendix D, and interview responses for family child care home providers in Appendix E.

Development of the Home-Based Standards

Virginia's process of developing Standards for home-based child care was extensive and involved stakeholders from many sectors of the child care community, including home-based providers.[7] A task force convened by Kathy Glazer, Chair of the Governor's Working Group on Early Childhood in Governor Kaine's administration, met regularly from Fall 2007 to Fall 2008 to address ways in which home-based child care differed from classroom-based care, to craft

[6] This report uses the terms "family child care providers," "family child care home providers," and "home-based providers" interchangeably. FOOTNOTE SIX IS MISSING

[7] Information is derived from meeting minutes provided by VECF to the evaluation team

research-supported Standards that would be attainable for family child care providers, and to determine how Standards would be measured. Minutes of the meetings identified four main interrelated principles that guided the discussions:

- VSQI classroom-based Standards would inform home-based Standards to the extent judged feasible and appropriate.
- Home-based child care differs in important ways from classroom-based care.
- Home-based child care has a much less extensive research base upon which to form decisions.
- Piloting and revising is essential to building sustainable and valid home-based Standards

The task force consulted other state QRIS developers and early childhood education researchers, assembled a research base, solicited feedback from home-based providers, and gathered information on accreditation and regulations from multiple relevant agencies, including the Virginia Department of Social Services Licensing division, Virginia local child care regulatory authorities, the National Association of Family Child Care, and the American Academy of Pediatrics. The group drafted five Standards but then disbanded when funding was not available for piloting (Governor's Working Group on Early Childhood, 2007-2008).

In fall, 2010, when American Recovery and Reinvestment Act monies enabled a pilot demonstration of the home-based Standards, VDSS and VECF staff again reviewed the Standards in consultation with Dr. Kelly Maxwell, the national QRIS expert of the Frank Porter Graham Institute for Child Development. As a result, the Standards were reduced to the four evaluated in this report. A key decision was also made to move one measurement tool, the Toddler CLASS (Pianta, La Paro, & Hamre, 2008) to the quality improvement component of the pilot rather than include it as a rating tool since the instrument was not designed for family child care and no research exists to support its use with this population (K. Maxwell, personal communication, September 28, 2010). The draft Standards are presented in Appendix B.

The pilot demonstration offered the anticipated opportunity to field test the draft home-based Standards. To assist the VECF in evaluating the draft-based Standards' merits, utility, and feasibility for Virginia, the evaluators addressed the following questions:

1. Do the Standards reflect quality indicators identified in the research literature as predicting positive children's outcomes?
2. What are national experts' and Virginia stakeholders' views of the validity of the draft Standards for measuring the quality of family child care?
3. Are the Standards clear, comprehensible, and closely tied to verifiable data?
4. Are the Standards reasonable for family providers?

1. Do the Standards reflect quality indicators identified in the research literature as predicting positive children's outcomes?

To address the first question, "quality of care" must be defined. Although some argue that "Quality is by its nature resistant to being standardized or universalized" (Lee & Walsh, 2005, p. 404), a large and growing research base indicates that some core features of children's experiences in early life predict better developmental outcomes later. "Quality of care" would thus reflect care conditions associated with better child development and the absence, or prevention, of conditions associated with maladjustment. Typically in state child care quality and improvement systems, the prevention of conditions that might be harmful or promote maladjustment is the purview of state licensure systems and represents the lowest level of "quality," while conditions associated with better child outcomes represent "high quality" care (Tout et al., 2010).

Home-based family child care has been much less extensively studied than center-based care (Layzer, 2007; cf. Child Trends, 2007). The decision of the Virginia home-based Standards development group to mirror the classroom-based Standards as much as possible means that some of the research base for home-based Standards rests upon the classroom-based research literature, although the development group focused on obtaining family child care research to support their decisions as much as possible (Governor's Working Group , 2007-2008).

Structural Factors: Staff Education, Qualifications and Training (Standard One) and Structure (Standard Three)

Early formative studies of early childhood care and education identified structural factors—such as staff education, training in early childhood education, and relatively low provider-to-child ratios—as important factors in predicting children's positive outcomes. The experimental or quasi-experimental studies of preschool (the Perry Preschool Project, the Abecedarian Project, and the Chicago Parent-Child Centers) upon which much of the impetus for supporting early childhood care and education is based, employed teachers with college education and specialized training in child development (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002; Reynolds, Temple, Robertson, & Mann, 2001; Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005). Community sample studies of center-based early care also found that teachers' education and training, as well as small group sizes and lower provider-to-child ratios, were linked to children's doing better in elementary school (Barnett, 1995; Peisner-Feinberg et al., 2001), although later studies are more equivocal (Early et al., 2007; Mashburn et al., 2008).

Many of these factors appear to be associated with family child care quality as well. Family child care providers with more education and child-oriented training provide higher quality care (Burchinal, Howes, & Kontos, 2002; Clarke-Stewart et al., 2002; Raikes, Raikes, & Wilcox, 2005; Weaver, 2002; Whitebook, Phillips, Bell, Crowell, Almaraz, & Yong Jo, 2004; cf. Morrissey & Banghart, 2007), and in one study, children receiving care from better educated and trained providers outperformed peers on language and cognitive assessments (Clarke-Stewart, Vandell, Burchinal, O'Brien, & McCartney, 2002). Providers who had more than a high school education and some specialized course work or training in early childhood demonstrated more sensitive caregiving as well (Howes, 1983).

Likewise, smaller group size correlates with higher quality care in some studies (Fosberg, 1981; cf. Burchinal et al., 2002; NICHD ECCRN, 1996, 2000), but not in others. In one large scale study of homes with small groups a *greater* number of children was associated with higher quality care (Kontos, Howes, Shinn, & Galinsky, 1995). Group size based on weighted estimates

from the National Association for Family Child Care found no relation between group size and the quality of care (Burchinal et al., 2002).

Findings regarding provider-to-child ratios are similarly inconclusive. Some studies indicate that the presence of more school-age children in the home is associated with lower quality of care for the younger children (Clarke-Stewart et al., 2002), while others find no relation between ratios, variously calculated, and family child care quality (Burchinal et al., 2002). In general, these structural factors appear less clearly associated with quality in family child care, perhaps because licensing regulations—which typically specify ratios and group size—create a floor effect, minimizing variability and therefore the ability to detect meaningful differences.

In summary, provider education and training appears to be associated with delivering higher quality child care. However, the level of education or precise type and intensity of training that predict quality remains unclear for family child care providers. Moreover, research findings are merely associational: it may be that family child care providers who are more committed to the field are more likely to both seek out more training opportunities and to provide higher quality care. Very little empirical work exists regarding child care assistants or substitutes in home-based care on which to base rating levels. Research on other structural variables such as adult-child ratios and group size are contradictory, with more recent studies suggesting these factors are not associated with higher family child care quality.

Environment and Interactions

Family child care has been likened to a hybrid between parent-child care and out-of-home center care (Porter, Paulsell, Del Grosso, Avellar, Haas, & Vuong, 2010). Research literature pertaining to parent-child interactions and teacher-child classroom interactions would appear to be directly relevant to family child care providers, as borne out by the few studies that specifically examined home-based providers (Porter et al., 2010).

A large body of literature attests to parental warmth, supportiveness, and high expectations together predicting children's adaptive behavioral control and high achievement (Baumrind, 1989; Houck & Lecuyer-Maus, 2004). Mothers who frequently talk with their

children, and who vary their syntax and vocabulary, are more likely to have children with well-developed communication skills (Hoff, 2006; Hoff, 2010; Weizman & Snow, 2001). Similar patterns are found for early childhood educators. For example, how classroom preschool teachers interact with children and manage daily programming and children's behavior predicts positive growth over a year of prekindergarten (Mashburn et al., 2008). Children whose prekindergarten teachers were warmer and more attuned to them developed better social skills across the year than peers whose teachers were less supportive. Children whose teachers used more complex language and encouraged children to talk and actively engage with materials showed more growth in pre-academic abilities, including language and early mathematical reasoning. Children in classrooms that scored higher on the classroom-based version of the Early Childhood Rating System, the same system used in this pilot to measure family child care quality, showed greater expressive language development than children in lower scoring classrooms (Mashburn et al., 2008). Other studies investigating more proximal or teacher-child interactions have found similar, though less specific, results.

In summary, direct and indirect evidence indicates that both interactions between providers and children and the home environment itself are important—perhaps central—components of providing high-quality care. Providing children with a developmentally matched, stimulating learning environment within the context of a warm, accepting emotional climate and supportive relationship appears to offer young children an optimal environment in which to develop prior to formal schooling.

Program Management

Other states include some type of business or program management in their QRIS Standards (Tout, Kirby, Boller, Starr, Soli, & Moodie, 2010; McCormick Tribune Center for Early Childhood Leadership, 2007), but due to the wide variation in what kind of information qualifies as "program management," it is difficult to quantify how many states incorporate this feature into their Standards. Only Illinois systematically measures family child care business practices as integral to its QRIS (Tout, et al., 2010).

Little direct study of business practices or program administration in family child care homes has been conducted. Indirect evidence suggests that this component of home-based care may be important to higher quality services. Two observational studies found that a family child care provider's professionalism, planning, and commitment to the field of child care was associated with her providing higher-quality care (Kontos et al., 1995; Weaver, 2002). Family child care providers who undertook a training program that included business practices showed modest gains in quality compared to those who did not take the training or who dropped out (Kontos et al., 1995). However, whether using business practices or training in these practices results in higher quality child care delivery is not currently known.

Summary

Two of the four draft Standards for family child care are supported by a robust or reasonably solid research foundation. Provider education and training as well as how providers interact with children and organize their sites are factors associated with higher quality care measured in several different ways across multiple studies. Inferential data suggest that how a provider manages her business *may* be important, but scant research has been conducted on this topic. Research on group size and ratios is mixed, with some more recent studies indicating that these factors may not be reliably associated with better child care in family child care homes.

2. What are national experts' and Virginia stakeholders' views of the validity of the draft Standards for measuring the quality of family child care?

Research support for quality rating and improvement Standards is important, but policy, practice and stakeholders' perceptions of the validity of the Standards are also key factors (Bryant, 2006; Zaslow & Tout, 2006; cf Child Trends, 2006). The primary evaluation focus concerned the validity and feasibility of the draft Standards for Virginia, which necessitated obtaining input from multiple stakeholders, as well as national quality rating and improvement (QRIS) experts. The evaluation team convened a panel of QRIS experts and a separate panel of pilot LCs to solicit their views of the home-based Star Standards. Participants were sent the

draft Standards and an on-line survey a week to ten days prior to the focus groups, and survey responses were used to guide more focused discussion. Panel discussions took place halfway through the pilot (early March 2011) using a web-based visual and audio conferencing tool (GoToMeeting ™).[8] Later during the pilot, the team solicited reactions to the Standards from raters and mentors using on-line surveys and from providers through a telephone interview. Survey, focus group and interview questions and responses are provided in the Appendices.

More extensive data were collected from the national expert and LC panels than from the raters, mentors, and family child care providers. For the panels, the central questions were expanded to cover the levels of progression through the Stars as well as the content of the Standards themselves. The full description of the focus group discussions, including more detail on Star levels and measurement, can be found in Appendix B. Here, we first summarize results of the panel surveys and focus groups and then follow with findings from raters, mentors, and family home-based providers.

National QRIS expert and pilot local coordinator views

In general, both panel groups concurred that the first three of the four Standards for family child care captured important aspects of quality, that the Standards lent themselves to developing quality improvement plans, and that how Standards were measured was generally satisfactory for quality improvement efforts. Experts agreed that the fourth Standard, *Program Management*, was important, but LCs were divided about this, with half endorsing it and the other half not sure or feeling this Standard was not clearly related to child care quality.

Although panelists in both groups agreed that Standard 1 (*Education, Qualifications and Training*) represented an important quality indicator, the specific requirements across different levels set out in the draft Standards motivated lively discussion in both groups. Most experts agreed that the levels of education and training set for providers was appropriate, and, since education generally is linked to higher child care quality, that higher standards sent an important message to providers and other stakeholders. A minority of experts wondered whether the education requirements were too high and/or not supported by research. The difference between levels "3" and "4" struck some as a "big jump in expectations" that might

[8] The Technical Report provides details on the procedures and specific questions asked.

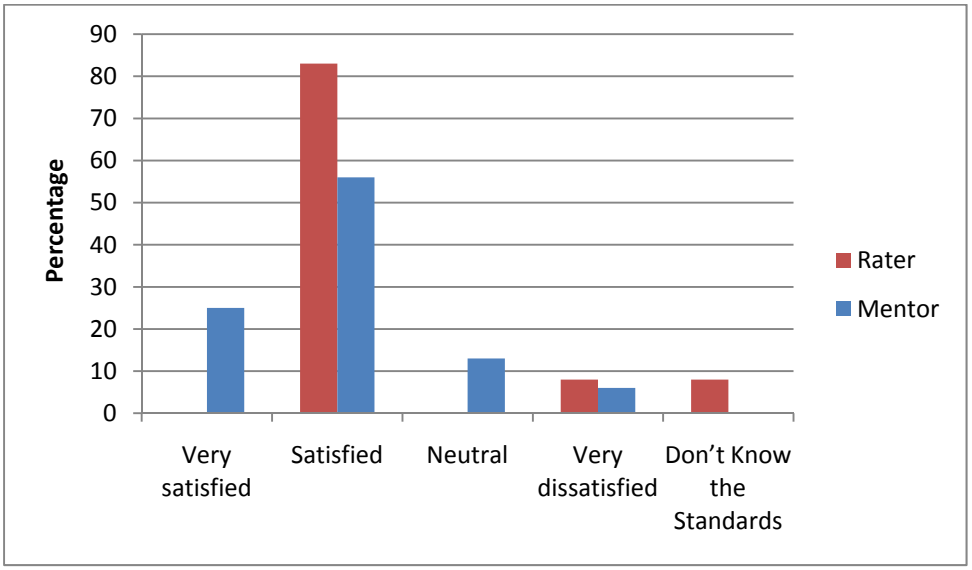
not be supportable without significant levels of technical assistance and accessibility of higher education degree-granting programs to home-based providers. Another expert noted that research is currently inconclusive regarding the precise level of education and degree of specialization in early childhood education that predicts higher child care quality and children's outcomes and that very little evidence exists regarding assistant teacher education and children's outcomes. Likewise, some coordinators believed the jump was too big between the higher levels (3 – 5) compared to the earlier levels and might discourage providers from continuing.

LCs were also divided about the importance of the *Program Management* Standard. Some participants expressed concerns regarding possible mismatches between some actual home-based child care and professionalization of family child care, and ways the Standard may inadvertently undermine important positive qualities of family child care. For example, for small family child care homes, program management as measured by the BAS may be beyond what providers feel is necessary for the successful operation of these businesses and can be overwhelming to providers. One participant noted that her region lost many interested providers when they learned about the BAS training requirement. Others observed that the BAS may penalize providers for offering flexible hours or related practices, one factor often cited by parents as a reason they prefer family child care. On the other hand, one coordinator reported good success with and positive provider feedback using the BAS.

Raters, mentors, and family child care providers' views

Raters, mentors, and pilot providers were also asked for their views on the draft Standards, although in considerably less detail. Raters and mentors were each asked whether they were familiar with the draft Standards for family child care providers and how satisfied they were that they accurately reflect the level of child care and family care business quality. All raters and 16 of 20 mentors (80%) completed the on-line surveys. One rater and no mentors reported being unfamiliar with the Standards, and most were "satisfied" that the draft Standards captured important components of family child care quality. Results are summarized in Figure 2 below.

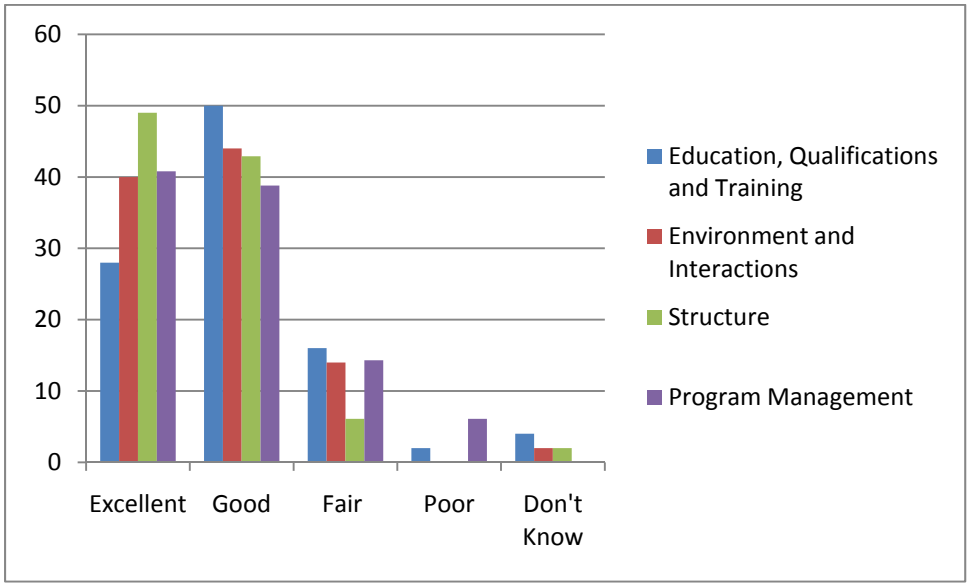
Figure 2. *Rater and Mentor Satisfaction with Standards, by Percent*



Raters and mentors were encouraged to elaborate on any dissatisfaction. One mentor expressed deep disappointment with the first Standard (*Education, Qualifications and Training,* shortened for clarity in this section to *Education*) and the fourth (*Program Management*), but she did not elaborate.

Family child care providers were also asked for their views on how important each Standard was to measuring family home-based child care quality. ("Do you think that this particular Standard is an excellent, good, fair, or poor way to measure the quality of child care?"). Fifty of 74 (68%) providers answered this question. Providers' responses are illustrated in the figure below.

Figure 3. *Providers' Views of How Well Standards Measure Quality (n=50)*



The majority of surveyed providers felt that each of the four Standards represented child care quality well. Seventy-eight percent felt that Education was an excellent or good quality indicator, 84 percent felt similarly about Standard 2 (*Environment and Interactions)*, 96 percent about Standard 3 (*Structure)*, and 79 percent about Standard 4 (*Program Management). Education* and *Program Management* were the only two Standards that rated as a "poor" indicator for some providers (2% and 6%, respectively). Sixteen percent also believed that *Education* was only a "fair" indicator, while 14 percent felt similarly for *Program Management*, and 13 percent for *Environment and Interactions*. Providers felt most confident that *Structure* was a strong quality indicator.

Summary

National QRIS experts and Virginia stakeholders agreed for the most part that the four draft Standards, with the possible exception of *Program Management*, represented valid indicators of family child care quality. Experts and LCs disagreed about particulars regarding Standard 1 educational or training requirements at different, predominantly higher, Star levels, but all agreed that the Standard itself was a valid and important quality marker. Raters and mentors reported being generally satisfied with the draft Standards, while a considerable majority of surveyed providers agreed that each Standard represented an excellent or good quality indicator. A handful of providers and one mentor felt that *Education* and particularly,

Program Management, as written in the draft Standards, were poor indicators of family child care quality.

3. Are the Standards clear, comprehensible and closely tied to verifiable data?

Clarity and comprehensibility of the home-based Standards

Expert and local coordinator panels

Seven of nine (78%) experts invited to participate in the panel discussion returned surveys prior to the focus group and their responses framed the discussion. Eight experts participated in the discussion, while the ninth mailed in her comments. For LCs, four of six surveys (66 %) were returned prior to the focus group and formed the basis for the discussion. (Another two were completed later so that the total survey response rate was 100%). All six LCs and a seventh co-coordinator participated in the discussion. Panel discussions were held separately on the same day at the VECF offices in Richmond.

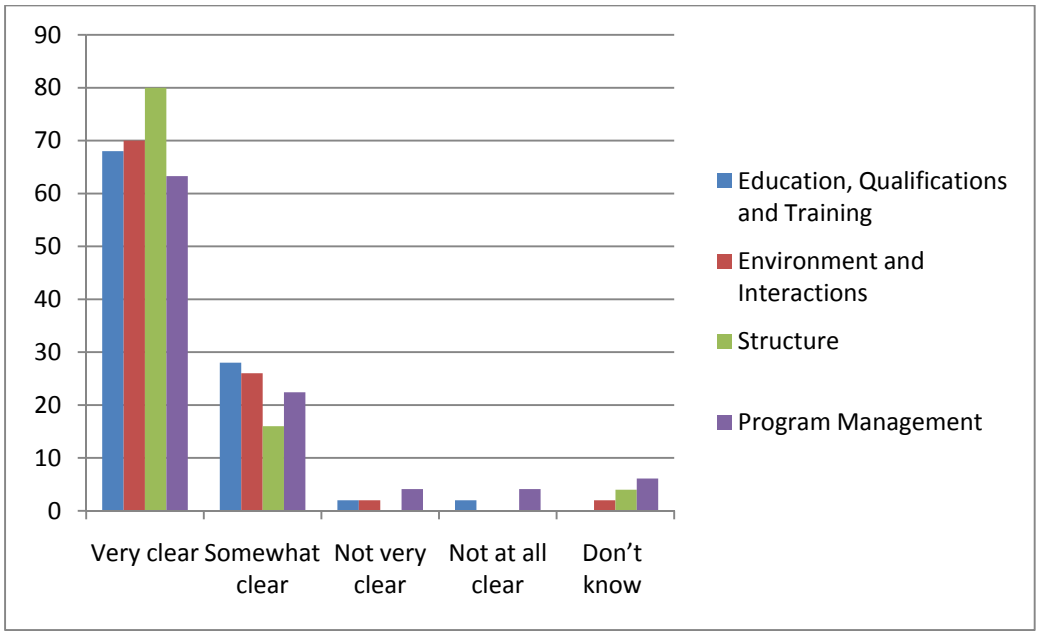
National QRIS experts and LCs agreed that the four draft Standards were generally clear to them, but the expert panel felt that as written, the Standards were too complex and technical for families to understand, and LCs wondered about how clear the Star calculations would be for family child care providers. Similarly, one expert pointed to how Stars were awarded along the third Standard, *Structure*, as lacking transparency. This Standard concerns age-weighted adult-to-child ratios and group size, with Star levels being awarded based on points tied to Virginia's child care licensing standards (Virginia Department of Social Services, 2010; VECF, 2010). Other experts commented that descriptions using scores on the tools used to measure Standards 2 (*Environment and Interactions*) and 4 (*Program Management*) may not resonate with parents and even providers, who are likely to be unfamiliar with the tools. In general, experts expressed concern that providers would have trouble communicating the meaning of specific Standard Stars to the families they serve.

Expert panelists noted that some states try to "message" the meaning of QRIS standards by focusing each level around a particular theme. Indiana, for example, focuses each level on familiar topics such as accreditation and curriculum that are easy for parents to understand and provides a conceptual ladder for providers. The group appreciated that Virginia has written

materials for providers to share with parents but thought that more still may need to done to help communicate the value of Star Quality rankings. For instance, some panelists noted that in a 5-star ladder system such as the VSQI, parents may consider a rank of "3" to be mediocre, while it in fact reflects quality considerably above state licensing requirements. More data over time will help answer this question, experts agreed.

Raters and mentors were not expressly asked for their views on the comprehensibility of the Standards. Pilot providers were asked how comprehensible each of the four Standards was to them ("To what extent is the [Standard name] clear to you?"). Responses of 50 of 74 providers (68%) are presented below.

Figure 4. *Family Child Care Providers' Views on Standard Clarity (n=50)*



The third Standard, *Structure*, was the clearest to providers, with 80 percent reporting that it was "very clear." This is perhaps not surprising, since this Standard rests on Virginia state licensing and local child care permit regulations for group size and adult-to-child ratios.[9]

[9] This Standard is included primarily to standardize adult-to-child ratios and group sizes between many different types of programs and because some Virginia localities have local ordinances governing child care that differ from those of the Virginia Department of Social Services..

The next clearest Standard was *Environment and Interactions*, with 70 percent agreeing that it was "very clear." Sixty-eight percent felt similarly about the first Standard, *Education*, followed by 63 percent for *Program Management* as measured by the BAS. The latter Standard was the least comprehensible to providers surveyed, with eight percent feeling that it was "not very" or "not at all" clear and another six percent uncertain.

The Standards are closely tied to verifiable data

The Family Child Care Home-based Virginia Star Quality draft Standards are anchored by objective documentation and standardized observational tools. Standard 1, *Education, Qualifications and Training*, is assessed through verifiable records, including educational transcripts, certification, and training certificates that document hours and content of professional development. Standard 2, *Environment and Interactions*, is measured by a reliable observational tool, the FCCERS-R, which requires extensive training and has manualized protocols for rating and establishing inter-rater agreement. Standard 2 also includes whether or not a provider agrees to allow a Toddler CLASS observation by her mentor, which can be verified by reference to a signed agreement. Standard 3, *Structure*, concerns staff-to-child ratios and group size limits which are assessed by an observer counting adult providers and children periodically throughout the rating visit (similar to Virginia licensing inspections). Standard 4, *Program Management*, is assessed by the BAS, which relies mostly on verifying or reviewing business plans and documents, with some observational components (such as observing the work environment). This scale is modeled on the suite of environmental scales of which FCCERS-R is a part. All of these methods to evaluate family child care homes are quantifiable and can be replicated by appropriately trained specialists.

While the Standards' overall measurement appears to be robust and reliable, the expert panel raised two questions about how the Star levels are quantified. Two national experts expressed caution about how cut-scores on the FCCERS-R and the BAS were used to differentiate Star levels for their appropriate Standards. Concerns were threefold: (1) the difference between ratings that yielded different Star level points was less than the reliability margin of error on the FCCERS-R; (2) research has not clearly determined that there are

meaningful differences in child outcomes related to differences in the middle range of FCCERS-R scores (as opposed to the very high and low ends of the scale); and (3) that if Star levels were tied to differential reimbursement rates, the state might open itself to appeals and even legal suits that would be hard to defend. On the other hand, most experts did not express concerns about this way of demarcating Standard 2 Star levels.

Whether or not to weight any Standard more than others was more contended. Survey responses indicated that 43 percent of the national experts initially favored weighting, 43 percent was not sure, and 14 percent was opposed to weighting. Those favoring weighting selected Standard 2, *Environment and Interactions*, as the Standard to weight. They argued that Standard 2 has the most evidence behind it and that weighing it more heavily would help mitigate potential provider concerns about Standard 1 (*Education, Qualifications and Training*). By the end of the discussion, however, most of the expert panel appeared to favor "waiting on weighting" until the issue could be examined empirically. LCs mostly favored weighting Standard 2.

Summary

The draft home-based VSQI Standards are assessed by verifiable and replicable methods, including reviews of education, training and business practice documentation, and the use of reliable observational measures. Some experts questioned how the observational measures were used to calculate Star points, and both experts and LCs expressed concern that Star calculations would not be clear to providers and parents. Most of the experts appeared to favor "waiting on weighting" until weights could be empirically tested, in part because weighting is also difficult to explain to the public. LCs mostly favored weighting *Environment and Interactions.* Surveyed family child care providers largely endorsed the Standards as clear, particularly *Structure*, though a handful felt confused by *Program Management*.

4. Are the Standards reasonable for family providers?

Panel views

The panel had many questions regarding how the VSQI's infrastructure actively supports quality improvement and whether the VSQI's primary goal focused more heavily on quality improvement or on accountability. While the group felt that the draft Standards are laudably

ambitious, many experts expressed concern that without substantial, stable investment in targeted quality improvement activities, family child care providers were unlikely to meet the higher ends of the quality continuum. Most panelists agreed that with an adequate support system in place—including training opportunities, mentoring, and financial incentives for pursuing higher education—home-based providers could make reasonable progress and reach high levels. One expert noted that his state has empirically defined "reasonable progress" as moving up a level every 24 months, a definition that corresponds to Virginia's classroom-based re-rating schedule.

On the other hand, if providers did not perceive the availability and benefits of supports, experts worried that they would not engage with VSQI. LCs also believed that, with sufficient mentoring and other support, providers could progress along the Star levels at a reasonable pace, but that it would be considerably harder to move beyond a 3-Star level than to reach the earlier levels. Most LCs expressed concerns that requiring a BS in a child-related field would also prevent most providers from reaching the top level of Star quality.

For LCs, the biggest concern about the Standards being reasonable for family child care providers focused on minimum rating thresholds. In the draft Standards, a provider could not move up from a Star level 1 on Standards 2 and 4 unless she achieved a specified rating on all subscales of the FCCERS-R and the BAS, respectively. *Space and Furnishings* and *Personal Care Routines* were two FCCERS-R subscales that LCs noted as frequently being difficult to score highly on for reasons that may be outside of a provider's control. For instance, providers who live in apartments may need to use city parks for outdoor play rather than their backyards, a limitation that could lower their score on the relevant FCCERS-R subscale. According to one coordinator, depending on the season and age of the children in care, the standards set by the American Academy of Pediatrics, which form the basis of the FCCERS-R *Personal Care* subscale, are excessive and can leave single providers with little time or attention to monitor or interact with other children. At least one other coordinator disagreed with this point, but most felt that requiring threshold subscale ratings may leave many providers "stuck" even though all other aspects of their care and business may warrant moving up the Star ladder. Most coordinators

advocated using average FCCERS-R scores and not requiring minimum subscale thresholds as being most reasonable for providers.

The LC panel also raised concern about the fairness to providers of the Standard ratings *process* if it meant that providers' initial, pre-mentoring Star Ratings would be published. (This was not the case during the pilot, but publishing initial ratings is the procedure with the VSQI classroom-based ratings). LCs expressed the strong and unanimous view that pre-rating coaching preparation was essential for VSQI to be sustainable with family child care providers. Coordinators expressed the opinion that the VSQI system was too complex and unfamiliar for home-based providers to take in all at once, and that publishing pre-mentored ratings without some coaching or initial self-assessment at least, was not fair to providers. Some coordinators felt that initial ratings should be considered baseline ratings that would never be published, but that would provide the basis for QIPs, with follow-up ratings then published after some specified period.

Baseline Star ratings

The second way the evaluation team addressed whether the draft Standards were reasonable for family child care home providers was to examine the range of raw FCCERS-R and BAS scores, Standard Stars, and overall Star Ratings that pilot providers earned through their verified documentation and on-site rater visits. Scores clustered at the bottom range may indicate that the Standards are set too high, particularly since some of the pilot sample had prior mentoring or quality improvement experience. A range with some providers hitting higher Star levels would suggest that the Star Rating system is reasonable for family child care providers; in other words, if some providers are scoring high prior to working with a mentor, with appropriate support others should be able to do so as well. Alternatively, if certain Standards carry range but others do not, the Standards with restricted ranges may point to areas where adjustments need to be made or where resources might best be directed.

Virginia's pilot procedure for assigning Star Quality ratings for family child care homes

Raters sent completed Family Child Care Calculator sheets, provider education and training documentation, and observed age-weighted group size and caregiver ratios to VECF,

where pilot staff assigned Star level points based on previously established pilot criteria (Virginia Early Childhood Foundation, 2011). Adopting the policy of "waiting on weighting" as advocated by much of the expert panel, VECF staff did not weight Standards in the overall Star calculation. Provider education was counted twice as heavily in calculating the first Standard, in recognition of providers' primacy over assistants, who may have much less time with children. Providers also were assigned points if they agreed to a Toddler CLASS observation during an initial mentor visit.[10]

Providers' highest education, assistants' and substitutes' qualifications, and documented training hours and membership in an early childhood professional organization are assigned points and averaged across four indicators (or fewer, if no assistants or substitutes are employed), with providers' education weighted as noted above. Total FCCERS-R scores and the Toddler CLASS agreement points are averaged as described earlier to constitute points for Standard two. Standard 3 points are calculated according to the age of children, with higher points assigned for younger children and lower adult-to-child ratios. Standard 4 points reflect the total score obtained on the BAS in conjunction with minimum thresholds for all subscales (Virginia Early Childhood Foundation, 2010). Star Ratings are assigned based on points, with prescribed cut-points distinguishing between Star levels.

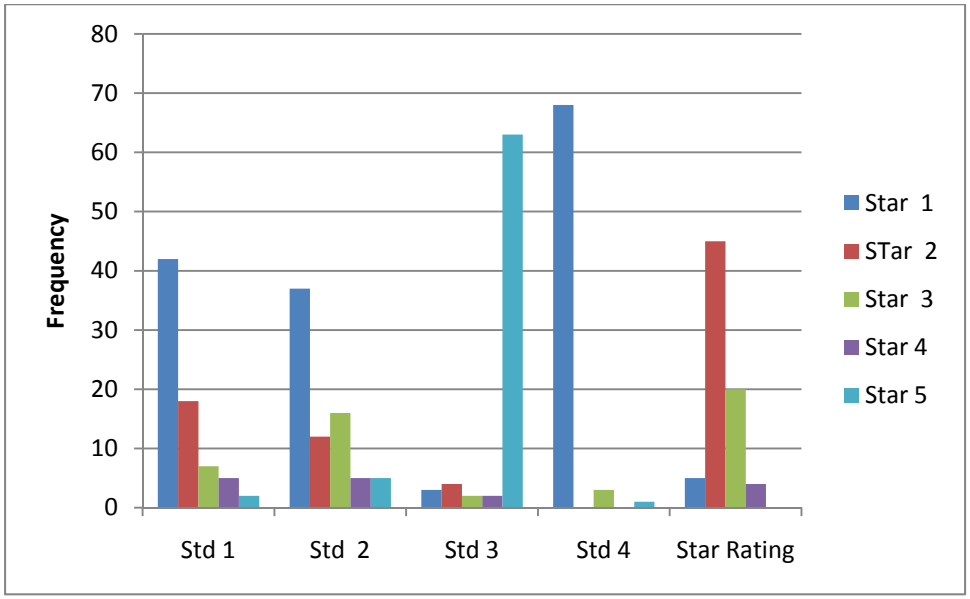
Seventy-five providers obtained Star level points, and 74 had sufficient points that they could be converted to Star Ratings.[11] As shown in Figure 5, below, baseline ratings indicated that pilot providers fared well with Standard 3 (*Structure*, or age-weighted group size and adult-to-child ratios), achieving an average Star Rating of 4.6 out of a possible 5 Stars. Average ranking for the other Standards were considerably lower: Standard 1 (*Education, Qualifications and Training*), 1.7; Standard 2 (*Environment and Interactions*), 2.05; and Standard 4 (*Program*

[10] If a provider had a "1" on the Standard 2 assessment (FCCERS-R), she earned 2 points by agreeing to participate in the CLASS. If she earned higher than a "1" on the FCCERS-R, she was assigned the same number of points again. For example, if she earned "3 star points" based on the FCCERS-R Total score, she would be given a "3" credit for agreeing to the CLASS; when her scores are averaged together, she would retain her star level FCCERS-R score and earn "3" Star points for Standard 2. Providers with a FCCERS-R score of "1" would bump up to a 1.5 on this Standard (average between FCCERS-R "1" and 2 points for agreeing to the CLASS) (V Virginia Early Childhood Foundation , 2011)

[11] Providers must be in good standing with their local licensing regulatory authority in order to achieve a Star Rating. Providers who are working toward licensing or regulatory compliance earn "Rising Stars" (Virginia Early Childhood Foundation, 2011).

Management), 1.14. Across all providers, Star rankings for all Standards except Program Management spanned the entire 5-Star range (from 1 to 5). Overall baseline Star Ratings averaged 2.31 and ranged from 1 through 4 Star levels.

Figure 5. *Standard Stars and Overall Star Rating, by Frequency (N=75)*



Note: Standard frequencies ranged from 72 – 75. If a provider earned less than 1 point on a Standard, no Star can be awarded for that Standard (VECF, 2011). The four Standards and overall Star Rating are displayed on the horizontal axis.

Of the 74 providers who achieved overall Star Ratings, 7 percent earned a 1-Star ranking, 61 percent a 2-Star, 27 percent a 3-Star, and 5 percent, or four providers, achieved a 4-Star level. No providers reached a 5-Star level. While these results reveal encouraging trends—namely, that some providers reached higher Star Rating levels, with the bulk of providers clustering lower but ranging across Star levels—low Star averages and ranges on individual Standards provide some data to evaluate whether each Standard is sufficiently reasonable or otherwise compelling to retain in its current form. The very low average *Program Management* Standard score (1.14) with limited range, coupled with the lack of compelling research to support this Standard and stakeholder ambivalence, suggests that program management skills and procedures may be better offered as needed through mentoring or other professional development, without direct ties to a Standard.

Adding weight to this conclusion are several indications from family child care home providers that program management as a quality Standard may be problematic. As reported earlier, 20 percent of surveyed providers felt *Program Management* was not a good indicator of child care quality, and business practices may not be directly relevant to all providers; for example, LCs reported hearing from their raters that some providers did not themselves manage their business affairs. These factors, coupled with the discomfort many providers expressed to raters in sharing financial information with them, suggest that the *Program Management* Standard could be retired or reworked. If the Standard is retained, it will be particularly instructive to follow progress along this dimension in the future, to further evaluate its links to other aspects of child care quality.

As anticipated by LCs, Star ratings on *Education, Qualifications and Training* was also low. This Standard is likely to be the most resistant to change, given the commitment necessary to obtain more formal training or a degree. Offering opportunities for obtaining a Child Development Associate (CDA) credential as part of mentoring, helping providers enroll in degree programs or access on-line courses, and facilitating approved training are all small steps that the VSQI can take to help providers along this dimension, as many mentors and LCs reported doing already (see the Mentoring chapter for details). Many stakeholders expressed the need for the Commonwealth to expand educational opportunities and outreach in early childhood development and education and believed that it will be difficult for family child care providers to achieve high ratings on this Standard without those institutional supports. Opportunities offered through the Virginia Department of Social Services to address this gap are reported below in the Summary section.

Observational environmental ratings

Of particular interest are the baseline ratings that providers achieved on FCCERS-R ratings conducted prior to any VSQI pilot mentoring (although some providers were already involved in personalized professional development from other programs). These baseline ratings provide a valuable glimpse into relative strengths and weaknesses in this sample of family child care providers. Table 1 presents descriptive information regarding the seven subscales and the total FCCERS-R scale score.

Table 1. *FCCERS-R Subscale Score by Mean, Median, and Range*

	1	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Mean (SD)	3.08 (1.09)	2.5 (.88)	4.2 (1.48)	2.7 (.92)	4.9 (1.65)	3.5 (1.83)	4.95 (1.24)	3.40 (.95)
Median	2.67	2.33	4.33	2.55	5.0	3.0	5.00	2.0
Range	1.33 – 6.0	1.0 – 6.5	1.0 – 7.0	1.0 – 4.8	1.0 – 7.0	1.0 – 7.0	2.0 – 7.0	1.33 – 5.68

As a group, providers fell into the mid-range on several FCCERS-R subscales. Both *Parents and Providers* (Subscale 7) and *Interactions* (Subscale 5) are almost tipping into the "5" range, with half the sample at or above this score and some providers reaching the scale ceiling. *Listening and Talking* (Subscale 3) is also mid-range, at 4.2, while the lowest subscales are *Personal Care Routines* (Subscale 2) and *Activities* (Subscale 4), both averaging in the "2" range with relatively little variation. Midway between these poles are *Space and Furnishings* (Subscale 4) and *Program Structure* (Subscale 6), at a "3" on the global FCCERS-R scale.

In interviews, many mentors discussed working energetically with providers on the two lowest scales, a fact also reflected by an informal review of mentor monthly reports. Mentors described working with providers to help develop activity centers, improve their book stock, and otherwise upgrade children's toys and learning materials. The pilot, with its explicit support for the Activities scale through the $1,000 materials stipend, may well be instrumental in helping providers improve dramatically on this scale.

Likewise, it was clear that hand-washing and diapering were common components of QIPs and mentors' activities with providers. How quickly and how far providers will be able to rise on this scale is less clear. Requirements for *Personal Care Routines* regarding hand-washing and diapering may be very difficult to achieve, depending on the ages of the children and the layout of providers' homes. *Space and Furnishings* may also be harder to adjust, since the ability to change physical layout depends upon a providers' space and other potential constraints. Mentors working with providers living in apartments discussed this frustration and

ways they are giving "little nudges" to try to assist providers in creatively using their sometimes small spaces to maximum advantage.

The relatively wide range and mid-high level scores on scales that measure adult-child interactions – which research indicates may be the most important component of high quality care –are very encouraging and suggest that with CLASS-based mentoring and other interactional strategies, these scales may reach solidly into the "high quality" range (generally, 5 and above). Paradoxically, it is also possible that progress may be harder to detect, given that baseline scores are starting relatively higher (so that there is less room for growth overall). Tracking how much time mentors spend working on activities related to these scales and the extent to which improvements in these areas is reflected in Star Rating gains will be very important information to gather in the future.

Summary

Overall, results from the pilot Standard Star Ratings coupled with research findings suggest that the draft Standards, with the possible exception of *Program Management*, are reasonable for family child care providers. Providers will require additional resources and support to improve their educational attainment, but given the weight of evidence indicating the importance of this first Standard, such improvement appears to be a worthy goal for the state and local early childhood communities to foster and advocate for. The Virginia Department of Social Services website provides a portal to access training and community college coursework (http://www.dss.virginia.gov/family/cc/professionals_resources.cgi), as does the Community College Workforce Alliance site: http://ccwa.vccs.edu/. Through a partnership with Penn State University, Virginia family child care providers are also eligible to take on-line courses for Continuing Education Units that can contribute to a Child Development Associate credential (K. Gillikin, personal communication, July 15, 2011). These resources, as well as local access to early childhood coursework, degree programs and training opportunities, can assist mentors and LCs in helping family child care providers attain more formal training.

Engagement

Engaging family child care providers in a systematic quality improvement process is the necessary first step in building and sustaining an effective system as well as the essential cornerstone of the VSQI for home-based providers. A process evaluation represents a useful means of exploring factors that may raise or lower the likelihood that family child care providers will engage in a sustained change process—that is, become interested in, apply for, enroll in, and sustain their participation in quality improvement efforts. This chapter focuses on recruitment strategies and explores providers' motivations for becoming involved in the VSQI. To describe engagement strategies and to assess the effectiveness and sustainability of these practices, we asked the following questions:

1. How were family child care providers recruited?
2. How successful was recruitment?
3. How many family child care home-based providers left the pilot study prior to completion of the pilot?
4. What motivates providers to participate or not?

In order to provide useful descriptive information about who ended up joining the pilot, we also present information on providers, their business characteristics, and their expressed motivations both for joining the pilot and for providing family child care. These sections are framed around the following questions:

5. Who were the providers who participated in the pilot?
6. Why do the participants provide home-based child care?

Data reported here were gathered through a survey and structured interviews with LCs , and from telephone interviews conducted with 87 providers (55 pilot participants,[12] 25 nonparticipants and 7 providers who began the pilot and subsequently dropped out.) The provider interviews were conducted by the Virginia Tech Center for Survey Research. All other surveys and interviews were conducted by the evaluation team.

[12] Interviews were initiated with 61 providers but were not completed in full with 11 providers. Four providers who completed the pilot were inadvertently not administered the entire interview due to the interview schedule skip pattern.

The provider interviews were conducted by the Virginia Tech Center for Survey Research (CSR). The survey instrument is provided in the separate Technical Report (Bradburn, Dunkenberger, Allen, & White, 2011). The CSR interview staff made at least six attempts to contact each family home provider (S. Willis-Walton, personal communication, July 18, 2011). Table 2 shows the responses rates by pilot participants, pilot dropouts, and a sample of providers who had been invited to participate in the demonstration but chose not to. Final dispositions reflect the result of the final contact attempt.

Table 2. *Family Child Care Home Provider Interview Dispositions*

Result of Call to Provider After Six Attempts	**Family Home Provider Status**			**Total**
	Dropped	***Nonparticipant***	***Participant***	
Busy Signal	1	0	1	2
Answering Machine	0	4	7	11
Callback	0	2	2	4
Language Difficulty	0	0	5	5
Soft Refusal	1	6	0	7
Hard Refusal	1	1	1	3
Disconnected Number	1	2	1	4
Temporarily Out of Service	0	2	2	3
Wrong Number/ Not a Provider	0	1	1	2
Complete	7	25	55	87
Total	**11**	**43**	**75**	**128**

Table provided courtesy of the Virginia Tech Center for Survey Research

1. How were family child care providers recruited?

Providers were recruited at the local level by pilot coordinators. LCs reported using several strategies to initially engage providers in the pilot demonstration project: (1) inviting targeted providers already involved in local initiatives; (2) issuing announcements and invitations to all eligible applicants (that is, all licensed or locally approved or permitted family

child care providers); and (3) combining these two approaches. Two of the six pilot regions—Fairfax and Richmond—used the first approach. Smart Beginnings Alexandria-Arlington exclusively used the second, all-inclusive strategy because of local ordinance requirements for Alexandria. South Hampton Roads and Appalachia started with the targeted strategy and then broadened their outreach when initially targeted invitees did not sufficiently enroll, while Central Virginia used a hybrid approach, inviting all 28 licensed family child care providers from DSS lists for one locality and then selectively inviting providers in other parts of the region.

Targeted invitations were extended mostly by telephone or in-person by local early childhood specialists known to the providers, including LCs, local licensing or permitting staff trainers, mentors from other programs and in at least one case, a pilot mentor. Pilot announcements were mailed to all eligible family child care home providers in Alexandria and Arlington.

LCs described factors that were important to them in recruiting. Administrators at the Fairfax Office for Children—which delivers specialist programs for infants, toddlers and children; the state publicly-funded prekindergarten program (Virginia Preschool Initiative); and Early Head Start in family child care homes—wanted to include a representative from each of their programs as well as providers not involved in these initiatives. In addition to wanting representation from their five localities, pilot personnel in South Hampton Roads worked to recruit at least one provider who was prominent in the family child care community and active in the professional association[13]in hopes that this provider would help publicize the program for the future. In Appalachia, with only 43 eligible family child care home providers across the nine localities from which to draw, the challenge was to engage enough providers to adequately pilot the VSQI for family child care. LCs noted that the short start-up and accelerated time frame of the pilot prompted most of them to use a more targeted, less inclusive strategy than they would have preferred.

After the invitation: Informational meetings

LCs were required to host an informational meeting for recruited providers (Virginia Early Childhood Foundation, 2010a). Most LCs hosted several group orientation meetings with

[13]The National Association for Family Child Care, or NAFCC

interested providers from different parts of their region, where they explained the pilot and offered application forms and other materials. The degree to which these meetings drew providers varied, even within a single region. For example, the informational meeting in Alexandria attracted 22 providers, compared to only eight in neighboring Arlington, according to the LC.

The form that informational meetings took also varied. In some regions, raters and mentors participated and were introduced to providers as well as to each other. Several LCs used these group sessions to demonstrate how providers could complete self-assessments on the BAS, prior to the rater visit. Other LCs reviewed the BAS, as well as other rating tools, with providers through additional meetings with enrolled providers, or personally. For example, in Appalachia, where long distances between family child care homes appeared to render group sessions impractical, the LC and other pilot staff delivered the application forms and other pilot materials to family child care homes. The LC stated that she used this approach to personally champion the benefits of participation and review the procedures. At least one other LC hosted a second orientation meeting for pilot providers once they were enrolled, where she introduced the raters, reviewed the rating procedures and tools, and arranged three-week window periods for rating. Despite variation in how informational meetings were conducted, LCs reported emphasizing the goals and benefits of the pilot, including the specific incentives of personalized mentoring and a substantial materials stipend. Several LCs noted that they underscored training in business practices as a particular benefit of participating in the family child care demonstration project.

2. How successful was recruitment?

With one exception, all localities eventually enrolled their expected number of providers, for a total sample of 74 family child care providers.[14] The degree of difficulty with initial provider enrollment and retention varied, however, and some localities were not fully enrolled until March, two weeks to one month later than anticipated. Others lost providers to attrition, so that they had to replace them and extend the rating period beyond the original timetable. Four of the six regions lost providers during the demonstration.

[14] Seventy-five providers completed ratings; one provider withdrew after mentoring had commenced.

Several recruitment strategies succeeded in enrolling providers. During interviews, nine providers explicitly pointed to a recommendation or encouragement from their "social worker," department of social services employee, or other professional as the reason they joined the pilot. Mailing announcements to all eligible providers in one region resulted in a "great response" in Alexandria, in the local coordinator's estimation, with 22 providers attending the informational meeting (though this strategy was much less successful in Arlington). LCs stated that the informational meetings were often effective recruitment events, with many providers completing the application enrollment forms at the meetings.

Many reasons appear to have played a role in recruitment challenges, including the depth of licensed (and therefore eligible) providers available, the complexity of pilot procedures, the short and accelerated time period of the pilot, the timing of initial recruitment around the winter holidays, other coincident family child care provider initiatives, and language and cultural barriers. Central Virginia and Greater Richmond experienced fairly efficient enrollment, but each lost providers, necessitating renewed recruitment efforts. Fairfax also lost providers, but because this region exceeded initial enrollment quotas, no replacement was needed. Three localities —Alexandria/Arlington, South Hampton Roads, and Appalachia— encountered particular challenges enrolling providers, according to LCs, though for apparently different reasons.

In Alexandria, local ordinances require that professional opportunities are publicized and made available to all who are eligible to participate. To be consistent, the LC also used the same approach in Arlington. Announcements were mailed to every licensed or locally-permitted family child care provider, with follow-up falling exclusively to the providers. This process resulted in slower initial enrollment, according to the local coordinator; recruitment may have been additionally delayed because mailings were sent out around the winter holidays. However, response was very positive—Alexandria had a waiting list of interested providers, and all providers who enrolled completed the demonstration project.

South Hampton Roads experienced unexpected hesitation from their licensed family child care providers who were uncertain whether they would continue with licensure due to

changes in regulations, rendering potentially fewer eligible providers.[15] The LCs noted that other factors may also have played a role in sluggish initial enrollment; simultaneous recruitment for *Al's Caring Pals*, a socio-emotional curriculum offered for family child care providers, and paradoxically, earlier local quality improvement efforts left some providers wanting to practice what they had learned before starting in with a new program, according the the LC. Recruitment remained a challenge over the course of the pilot for this region, necessitating ever broadening target pools and extensive work on the part of local pilot staff as four providers eventually withdrew from the pilot and required replacement; the local staff recruiter reported that she placed more than 100 calls, each of which lasted 30 minutes or more, to enroll or replace home-based providers

Appalachia also experienced significant difficulty recruiting providers, resulting in one slot short of the required ten despite strenuous efforts by the local pilot staff. This difficulty is most likely attributable to several factors, the most formidable being the relatively low number of licensed family child care providers across a large geographic area. Culturally, too, this region appeared less initially receptive to a program like the VSQI. Providers have had much less experience with quality improvement efforts than the other pilot regions, according to the local coordinator, and do not know what to expect or how a program like the VSQI might benefit their business. To illustrate some of the challenges for this region, for example, several providers were reported to have believed the pilot informational announcement to be "a hoax," as the $1,000 materials stipend from the Commonwealth seemed "too fantastic" to believe. Once providers enrolled, however, all nine completed the pilot.

3. How many home-based child care providers left the pilot study prior to program completion?

In total, 86 providers were recruited into the pilot, with 12 providers eventually dropping out and 74 completing the pilot. In the Greater Richmond, Central and South Hampton Roads regions, providers who dropped out were replaced with other providers. Fairfax had two providers withdraw who were not replaced, with one provider dropping out in

[15] According to the LC, many providers who had previously been active in local improvement efforts were considering switching to voluntary registered status due to the cost of changing to the new licensing standards enacted in 2011.

late April after mentoring had commenced. (Fairfax had overenrolled by two providers.) Appalachia and Arlington/Alexandria retained all their providers.

Reasons for lack of follow through on the part of the providers, according to both LCs and mentors, included factors that were out of the control of the pilot, such as medical or other emergencies; a lack of understanding of what was involved in the pilot; and providers' feeling overwhelmed, particularly by the BAS in some localities. Seven providers who withdrew from the pilot participated in the telephone interview and substantiated LC and mentor reports. In addition, one provider stated that several children had dropped from her care and she was "revamping" her program and

> *...using this time to put into practice the things [I] have learned. [I] have been given so much information [I] want to implement what [I] have already been given.*[16]

4. What motivated providers to participate?

Information about pilot participant motivation is presented, followed by data gathered from providers who chose *not* to participate in the demonstration pilot.

Participant provider motivation

According to LCs and mentors, providers wanted to join the VSQI for three principal reasons: to obtain materials for their business, to improve the quality of their business, and to meet other providers. Provider interviews substantiated most of these understandings. The potential to improve their business topped the list, with 82 percent of provider respondents rating this as "very important" in their decision to enroll in the pilot, followed by "obtaining supplies," (79%), "coaching or mentoring" (77%), and "obtaining written feedback (67%).

Prior to forced-choice interview responses, providers were asked, "What are the primary reasons you initially decided to participate in the Virginia Star Quality Initiative pilot?"

[16] An important question is the degree to which pilot participants are representative of family child care providers in Virginia, and whether providers who chose not to participate or who dropped out were fundamentally different from providers who completed the pilot. Statistical tests revealed only two differences between participants and non-participants. Providers who agreed to an interview but who did not participate in the pilot were less likely to be African American and more likely to own rather than rent their homes. No differences emerged between drop-outs and participant completers. The findings tentatively suggest that completers may be slightly less prosperous than those who chose not to participate. However, this difference could well be an artifact of the pilot process rather than indicative of family child care providers more or less interested in quality improvement, and the very small number of providers precludes any strong conclusions.

Responses generally fell into eight clusters (with some answers falling into more than one category). By far the biggest reason spontaneously identified by providers was to improve the quality of their child care.

Always looking for ways to improve the services [I] provide.

To learn more and be able to provide better care for children

I feel that I need more knowledge.

While most described wanting to generally "improve" or chose to participate "for quality," some providers expressed specific areas they wanted to grow professionally.

[I] wanted to get away from [my] approach of only using teacher-initiated activities. [I] was happy they could help [me] make [my] children more socially developed.

…It was a good opportunity to get one-on-one advice and be able to make some positive changes.

[I] wanted to have [my] facility be a reflection of [my] abilities for teaching and preparing children for pre-k.

Other reasons for participating in the pilot included being asked or encouraged to participate (16%), professional altruism (11%), to improve business (11%), for the materials grant (9%), VSQI's positive reputation (7%), love of learning and creativity offered through the program (7%), and to "see how I am doing" (5%).

[My] social worker told [me] it would be a good idea.

…to help it get going so the program is available statewide.

[I] knew this pilot was very important to the future of home childcare and [I] wanted to be able to help pave the path for the future of the program and for at home childcare.

...to have the distinction of going through the program. It would be beneficial and helpful in promoting [my] business.

Receiving grant money to purchase items for the children.

To get ideas for improving [my] program and to have the $1000 grant to make improvements. The idea that the suggestions would be paid for made a big difference.

…because of the program's creativity and high quality standards for child care.

[I] heard it was a really good program.

For professional growth and curiosity.

[I] pride myself on providing quality childcare and wanted to participate in the pilot to ensure that [I] am providing quality care.

…to make sure [I] was on the right track and providing the type of childcare that [I] want.

Non participant provider motivation

Twenty-five of 43 (58%) providers who were informed of or invited to join the pilot but who chose not to responded to the telephone interview. Half of this group did not recognize the name Virginia Star Quality Initiative pilot. Those who did recognize it cited various reasons for not enrolling, including that they were closing their business, wanted to "give other people a chance," did not have young children in care, or were not interested. As described earlier, local coordinators also reported reasons that providers told them for not joining included the complexity of pilot procedures, the short and accelerated time period of the pilot, not wanting or having time to think about it during the winter holiday season, other coincident family child care provider initiatives, and language and cultural barriers.

5. Who were the providers who participated?

To be accepted into the pilot demonstration pilot, family child care providers completed an application form that asked for basic information regarding themselves and their child care business (see Appendix C for a copy of the form). From the pool of 75 providers who received ratings, application information revealed a diverse, all-female group with a wide range of experience in running a family child care business. Providers had a high school degree or its equivalent (43%) with more than half holding a CDA (18%), Associates Degree (22%) or higher degree (17%). A sizeable number (26%) spoke a primary language other than English, with

Spanish being the most common (15%). Many reported opening their child care business long ago (three in 1978), with 46 percent having more than 10 years experience. The range was one to 33 years.

Providers typically reported working very long hours. Most opened at 6 or 7 a.m. and operated for an average of 12 hours, with many staying open into the evening (range: nine to 24 hours). Three providers reported operating 24 hours. Most operated only during the work week (86%) but a sizeable minority also worked on Saturday (12%). Four providers reported being open daily. Slightly less than half currently also provide care for their own children or grandchildren (44%). The majority have one (30%) or two (24%) assistants, while a sizeable minority (42%) work alone. Pilot providers were more likely to care for children younger than four. Sixteen of 70 providers (23%) reported that they were accredited by the National Association of Family Child Care (NAFCC), an organization dedicated to promoting high quality family home-based care. Select provider and business characteristics are presented in the table on the following page. Frequencies and percentages refer to providers, unless noted in the heading directly above each section.

Table 3. *Provider and Child Care Business Characteristics*

	N	Frequency	Percentage
Education	72	Providers	Providers
High School		31	41.3
CDA		13	18.0
AA		16	22.2
BS/BA		11	15.3
Master's		1	1.40
Language	74	Providers	Providers
English		55	74.3
Spanish		11	15.0
Other		8	10.9
Assistants	74	Providers	Providers
None		31	41.9
1		22	29.7
2		18	24.3
4		3	4.10
Non-Fee Income Sources	70	Children	Providers
DSS Subsidy	70	35	50
Head Start	73	8	10.9
VPI	73	3	4.1
USDA	72	40	55.5
Years Open	72	Providers	Providers
1 – 5		23	31.9
6 – 14		37	51.3
15 or more		12	16.6
Days Open	74	Providers	Providers
M –Thursday		1	1.3
M – Friday		64	86.4
M – Saturday		5	6.7
M – Sunday		4	5.4
Hours Open	73	Providers	Providers
9 – 10		25	34.2
11 – 12		35	47.9
More than 12		13	17.8
Ages Served	70	Children	Providers
0 – 15 months		48	68.6
16 – 23 months		47	67.1
2 years		53	75.7
3 years		50	71.4
4 years	69	35	50.7
5 years		22	31.4
School Age		32	45.7
Child Characteristics		Children	Providers
ESL	69	33	10
Special Needs	73	18	18

6. Why do participants provide home-based child care?

Responses to the provider telephone interview question, "What are the primary reasons you choose to provide child care?" indicated that providers enjoy children and teaching, want to help children grow, and value the ability to stay at home and earn income. Overwhelmingly, respondents described loving and "having a passion" for children. Many started their business so they could be home with their own children (24 %) or because they were dissatisfied with the child care in their area (11 %). Helping children learn and preparing them for school was another common reason providers spontaneously identified as motivating their business. Being their own boss, enjoying running a business, and feeling they were contributing to their communities as well as the next generation were additional themes.

[I] love to see children develop and meet milestones.

[I] want to help parents that have to work by providing good child care.

[I] have a passion for children. [I want] To train young minds, and to let parents know that their children can be somewhere and with someone who really cares for them.

[I] like the excitement of seeing a child learn.

…if [I] can have an impact on the children and having prepared them to enter school, it makes [me] feel good. [I] enjoy the feedback from the community and families about their happiness with [my] facility.

[I] got into it initially to pay [my] bills. I looked at it as babysitting, but once I got into it, I realized it was preparing children for the future.

[I] love working with children and enjoy the fact that [I] have my own business.

Summary and recommendations

LCs successfully recruited 75 family child care providers for the pilot using several different strategies. Strategies were largely motivated by the short pilot time frame and local conditions. Recruited providers represented a diverse group with a range of experience in the

field. More than half had at least one assistant, and approximately one quarter spoke a primary language other than English. Providers who withdrew early appeared to do so for personal reasons or because they had not realized the extent of pilot involvement. While all regions eventually recruited their approximate target number of providers, the process was slow for half and arduous in at least two regions, requiring staff to spend many hours reaching out to eligible providers. Reasons providers chose not to join varied, but according to local coordinators, the short pilot timeline and recruitment around the winter holidays were factors for many providers. The following recommendations are offered based on the pilot experience.

- *Plan recruitment initiatives at times that do not coincide with other major activities*. The timing of the pilot was forced by factors outside of the developers' control, but lessons learned can be applied to future expansion efforts. Heavy recruiting around holidays should be avoided. Likewise, active enrollment efforts should be done at times that do not coincide with other family child care quality improvement initiatives or events that may reduce the pool of eligible participants.

- *Offering incentives is likely to be necessary for broad participation and sustained growth.* Many providers were initially motivated to participate in the pilot because of the materials they would receive. Materials, educational scholarships, free language or business training, and other resources that clearly benefit a provider's business are potent incentives to participate in a comprehensive and involved quality improvement program like the VSQI. Once they have become engaged and worked with a mentor, providers are more likely to understand the value of the opportunity, but initially more tangible motivators may well be needed.
- *Develop a suite of provider engagement strategies tailored to different provider and regional characteristics.* Regional strategies and goals should be designed for different regions depending upon the context of the base of family child care providers. For instance, in areas where quality improvement areas have been introduced, taking providers to higher quality levels of engaging new providers should be the focus. In areas where quality

improvement initiatives have not existed, providing broad scale outreach and preparatory technical assistance should be the focus. VSQI materials will need to be translated into languages of groups of family home-based providers to effectively recruit non-English speakers.

- *Licensing could represent an important recruitment and advocacy partner.* Several LCs recommended developing stronger ties with licensing. However, care would need to be exercised to help providers understand that the VSQI is distinctly different from licensing.

Training

The demonstration pilot provided several types of training aimed at different audiences. Eighteen raters participated in approximately 60 hours of training, and 20 mentors completed approximately 40 hours (and more for those who took multiple reliability tests on the Toddler CLASS). LCs participated in 12 hours of training as part of a two-day orientation to the pilot process. Examining what these processes entailed, how reliably they were carried out, and how personnel responded to their training are important components of assessing program implementation fidelity, effectiveness, and feasibility for the long term. Three main areas or questions regarding training guided this inquiry:

1. What was the rater and mentor training procedure for the pilot?
2. How much did training follow prescribed procedures, and how well prepared were raters and mentors?
3. How reliably did raters score the FCCERS-R and mentors score the Toddler CLASS?

Data for this chapter came from multiple sources at different phases of the pilot. Immediately following training, recipients completed surveys developed by the evaluation team to assess training fidelity where a training protocol was available and to report how adequately participants thought topics were covered. Rater and mentor reliability scores were reported by scale trainers to VECF staff, who shared the information with the evaluation team. In the spring of 2011, raters and mentors were surveyed about their perceptions of how well prepared they were for their pilot work. LCs were also asked their thoughts during the final process interview.

1. What was the rater and mentor training procedure for the pilot?

Training on most Star Quality tools and procedures was conducted by VECF. Preparation included training on the FCCERS-R, BAS, Toddler CLASS, rater and mentor visit protocols, and on how to complete documentation, such as writing Summary Reports based on rating visits. Mentors also received training on a relationship-based coaching model and on their role with home-based providers. At the local level, coordinators held group trainings for

home-based providers to instruct them on how to self-administer the BAS. Providers were asked to complete their self-assessment prior to the rater visit.

Rater training

For the main observational rating tool, the FCCERS-R, a two-level procedure was employed. All raters attended a one-day workshop with scale author Dr. Thelma Harms. Raters designated as more experienced ("master raters") spent the next three to four days visiting Richmond family child care homes with Dr. Harms and her Environment Rating Scale Institute (ERSI) colleagues in order to establish a consistently high level of agreement with them, a process known as becoming "reliable" on an instrument through demonstrating high inter-rater agreement with expert raters. In a parallel process at the local level, novice raters teamed up with local master raters to establish their reliability on the FCCERS-R. Once a rater established requisite reliability with the master rater, she went on to complete solo ratings and write Summary Reports for those visits. All raters also completed training in Richmond on documentation and the BAS, the tool used to measure Standard 4 (*Program Management*).

Mentor training

Mentors had five days of training in Richmond. Three days focused on an overview of the FCCERS-R and BAS; how to mentor home-based providers; and how to complete necessary documentation, including developing QIPs with providers. The other two days were devoted to Toddler CLASS training from one of the scale developers. Participants reviewed the scales, watched videotaped illustrations of scale dimensions, learned how to rate the scales, and took a reliability test. If a mentor did not meet reliability standards (80% agreement within one point on each scale), she was able to review video clips from the Toddler CLASS website (www.teachstone.org) and had two more opportunities to take a reliability test at a later date.

Rater and mentor training took place in November and early December of 2010. Training had near-time implications for raters in that many of them began rating within one month after training. Most mentors did not start working with family child care providers until the providers had received their Summary Reports in March or April, 2011 (though a few began mentoring in January, 2011).

2. How much did training follow prescribed procedures and how well prepared were raters and mentors?

This section reviews how well the training conformed to protocol and how participants evaluated the training both immediately after receiving it, and after they had worked with providers. Participants completed training fidelity and evaluation checklists in fall 2010, immediately after each training day. To assess how prepared they felt for their pilot work, raters were surveyed in March, after they had completed their visits and Summary Reports. (Two raters still had one visit apiece outstanding at the time of contact, due to provider turnover and newly recruited replacements.) Mentors completed a survey and spoke with the evaluation team in May. LCs were also interviewed individually in May.

Rater training

There were four main components to rater training for the pilot, as reported above: a one-day FCCERS-R overview with scale author Dr. Harms, on-site practice training with Dr. Harms and her colleagues, local field training, and learning the BAS. (Documentation training will be covered in a later section.) Immediately afterward, participants generally reported that training covered the appropriate material in sufficient depth, or, in the case of on-site visits, following prescribed procedures, with some exceptions. The next section reviews the first two rater training components, followed by unique mentoring training components. Training on the BAS and on documentation is then reported for raters and mentors together.

FCCERS-R overview day: In general, rater trainees reported that critical components of the FCCERS-R were adequately covered and were "satisfied" or "very satisfied" with this aspect of training. However, raters felt that several core items from the *Personal Care Routine* subscale were inadequately addressed, despite receiving handouts for these critical components. The table on the next page summarizes raters' views on how well key concepts of the FCCERS-R were covered during the one day overview.

Table 4. *Trainee Judgments of FCCERS-R Components Training*

FCCERS-R Item	***Well-Covered***	***Inadequately Covered***
Meals	X	
Playgrounds	X	
"Much of the day"	X	
"Many"	X	
Hand washing		X
Table washing		X
Diapering		X

On-site training with the scale author or ERSI staff: Participants reported that on-site rater trainings, in which small groups went into volunteer family child care homes with Dr. Harms or one of her ERSI colleagues to practice using the FCCERS-R, for the most part followed prescribed procedures for conducting home observations. Three-quarters of rater trainees reported good fidelity to all rater procedures as outlined in the author materials (Frank Porter Graham Institute, 2010). The remaining 25 percent reported occasional fidelity lapses. Specifically, on one visit a group leader failed to remind trainees not to discuss scores outside of the observation, to allow sufficient time for trainees to complete preliminary scoring, to provide mock questioning, and failed to include all individual scores on the inter-rater reliability Summary Sheet prior to discussing discrepancies. However, despite occasional deviations from protocol, the on-site training visits appeared to be well-conducted and valuable to trainees. One rater commented,

> *Going out with the North Carolina team leaders was **extremely** valuable. That Is where the learning takes place.*

Mentor Training

Toddler CLASS training. Immediately following training, participants were generally satisfied with the training (mean = 3.26, range 2 – 4) and most reported that individual training components were adequately covered. While all felt that "how to score dimensions" was covered completely, 18 percent nonetheless felt that not enough time had been spent on this,

and 29 percent wanted more time devoted to practice scoring.

Role of the Mentor and the QIP. Two trainers led mentors in a five and a half hour mentoring workshop. The model taught was based on a consultation and relationship coaching model (Buysse & Wesley, 2004). Two different groups were trained. Satisfaction ran very high across both groups (mean general satisfaction = 3.9, on a 4-point scale). The QIP training was embedded within a three hour training that also included documentation, policies and procedures. Most mentors felt that the QIP training was adequate, but twenty-one percent felt that *Learning How to Set Realistic and Appropriate Goals for the QIP* should have received more time or was only partially covered, and 15 percent reported that *Reviewing the QIP* was only partially covered.

Rater, mentor and local coordinator training

BAS training*:* All three groups received training on the BAS. The BAS is modeled on the Environmental Rating Scales format, with content specific to child care business practices. This four-hour training was provided by local trainers based on the manual. Unlike with the FCCERS-R, none of the pilot participants had prior experience with the measure. Most LCs, mentors, and raters who received the training reported that it completely covered how to administer and score the measure. A few trainees, across different training sessions, felt more time could have been devoted to scoring practice and two would have liked more training on how to interact with caregivers while reviewing documentation. However, the great majority of participants felt the training prepared them to administer and score the BAS and were satisfied with the training (mean = 3.5, no scores lower than 3).

Documentation*.* VECF staff provided a three-hour review of pilot demonstration project procedures, documentation, and related paperwork. General satisfaction with this training was high (mean = 3.5, range 3 – 4) and for the most part coverage was judged complete. There were a few isolated reports that components had been only partially covered, but the only clear pattern was associated with *Reviewing Procedures for Rater Inter-Rater Reliability*, in which two of 11 (18 %) who responded to this item wanted more time devoted to this topic.

Summary of trainee evaluations of training fidelity and comprehensiveness immediately following training

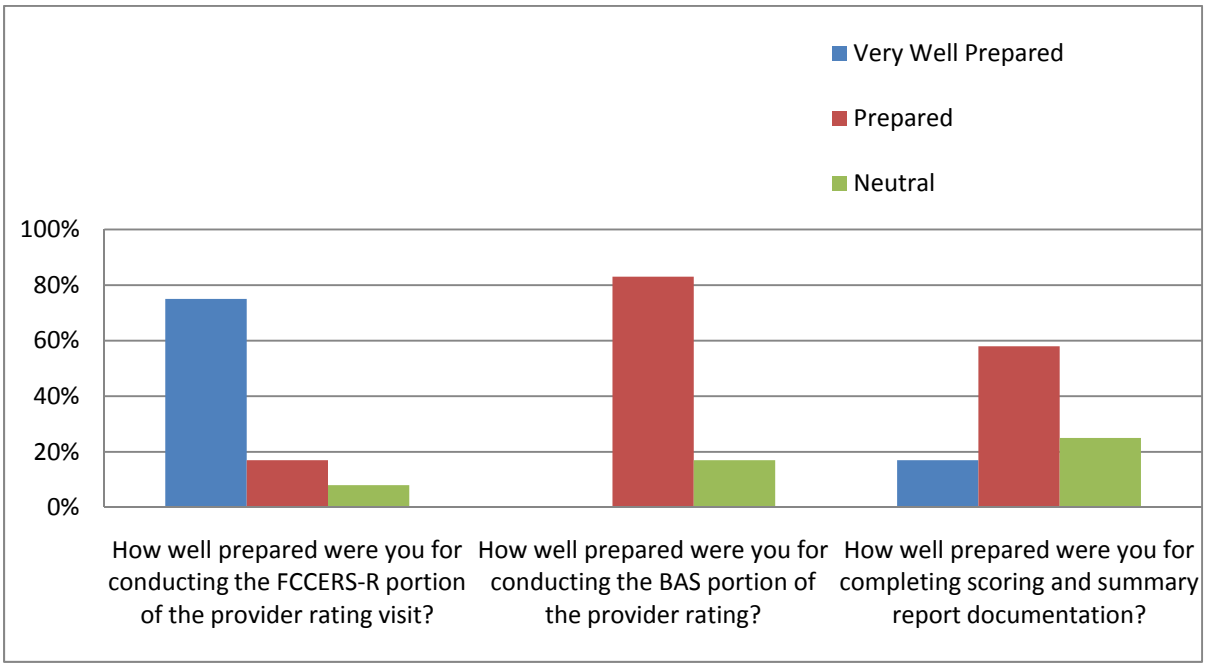
Raters, mentors, and LCs felt that overall, their training had been comprehensive and followed training protocols where protocols existed. Areas identified as needing additional or more extensive coverage across all trainings were not uniformly endorsed, but a minority of trainees felt that the following areas were not completely covered by FCCERS-S and Toddler CLASS experts and VECF staff: *Personal Care Routine* items, procedures for inter-rater reliability, scoring the Toddler CLASS, setting QIP goals, and reviewing the QIP. Three-quarters of rater trainees reported that all on-site training protocols were consistently followed.

To ascertain whether post-training perceptions held through the demonstration pilot in the spring of 2001, the evaluation team asked raters, mentors, and LCs to report the extent to which they felt they (or, in the case of the LCs, their staff or contracted employees) had been well prepared to carry out the required pilot tasks. The next section reports these results.

Reflections on training after working in the field

Raters. Survey responses completed by all 12 raters revealed that overall, raters felt they had been prepared or very well prepared for their tasks, as shown in the figure below.

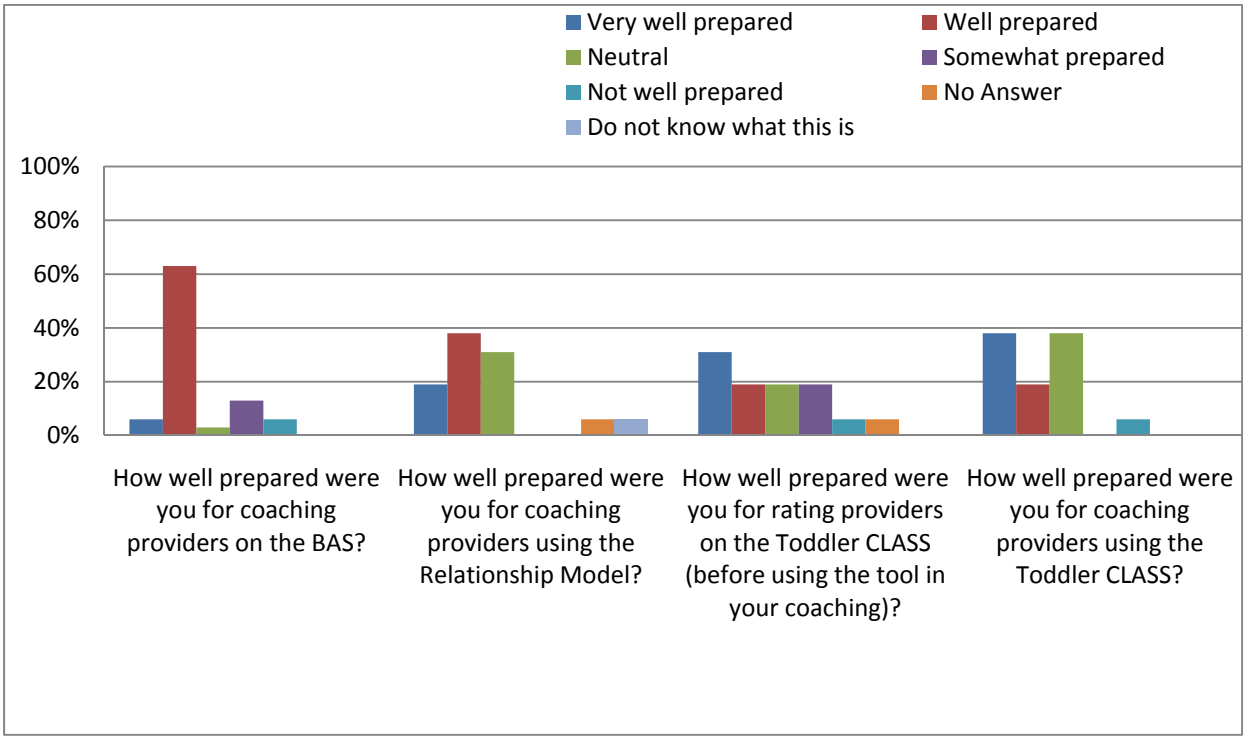
Figure 6. *Degree of Rater Preparedness, by March Rater Survey (N=12)*



A large majority of raters felt prepared or very well prepared for administering the observation visits and tools. Two novice raters commented during follow-up interviews that they would have liked more practice time in family child care homes to feel fully confident on the FCCERS-R, despite having reached acceptable reliability with their trainers. Raters also felt generally prepared to score the FCCERS-R and BAS and write the Summary Report, though as a group they expressed somewhat lower confidence about these tasks. Seventeen percent felt very well prepared, 58 percent felt prepared, and 25 percent felt neutral. In general, after completing the pilot rating process, raters who were more experienced tended to feel better prepared and more satisfied with training; however, no raters reported being actually unprepared for any of their rating responsibilities. Raters reported mixed reviews of the FCCERS-R overview training day, with some feeling that day had not helped prepare them well (34% were neutral or felt it was unhelpful). On the other hand, the field training with the ERSI team members was seen as very helpful by those who attended this training.

Mentors. Sixteen of 20 mentors (80%) responded to the on-line survey in May, and all mentors participated in group interviews with the evaluation team. Although for most tasks a majority of mentors felt prepared or very well prepared, responses indicated that as a group, mentors felt less prepared for their tasks than did raters. Conducting the Toddler CLASS was an area that only half the group felt prepared for. Survey are pictured on the next page.

Figure 7. *Degree of Mentor Preparedness, by May Mentor Survey (n = 16)*



Lack of Toddler CLASS preparation was reflected in how the Toddler CLASS was conducted in the field and in nearly one-quarter of the mentors not becoming reliable scorers on the instrument. Of the 68 Toddler CLASS scores reported by mentors, 25 percent were based on fewer than the required four observation cycles. Six Toddler CLASS scores were based on three rating cycles, one on two rating cycles, and 10 on only a single rating cycle, according to VECF records. In only two pilot regions (Arlington/Alexandria and Greater Richmond) were all Toddler CLASS assessments conducted as taught.

Part of the difficulty may have been in the relatively long time lag — four months for most mentors—between Toddler CLASS training and actually performing these assessments with providers. At least three mentors and their local managing staff appeared not to have understood the structure of the Toddler CLASS, which differs markedly from the FCCERS-R and other early childhood education observational measures in using a repeat-cycle, time-sampling method (Pianta, La Paro, & Hamre, 2008). On the other hand, starting the mentoring relationship off with providers who were upset regarding their Summary Reports (see next two

chapters), may have led many mentors to cut short the Toddler CLASS. Since the Toddler CLASS was designed to be used as a mentoring rather than as a rating tool, the essential structure of the pilot process was not compromised by these modifications. In the future, however, it will be important to decide how this instrument will be best used by mentors.

Mentors also indicated that they would like additional training in key process areas, including administering the Toddler CLASS (44%), developing a QIP (38%), completing required paperwork (25%), coaching providers on business practices (25%), and accessing resources (25%). Echoing reactions immediately following the QIP training, many mentors noted that developing the QIP was a confusing process for them.. Central components of developing and using the QIP are described more fully in the Mentoring chapter, but as a central blueprint for guiding the quality improvement process, it appears that the QIP may require more training. One mentor reported wanting an entire day devoted to it.

Documentation and related paperwork in general appears to be the area that personnel felt least prepared for, as shown in Table 5 below.

Table 5: *Rater and Mentor Reports of Documentation Preparation*

Perceptions of Preparation for Completing Documentation	***Raters (N =12)***	***Mentors (N = 16)***	***Total (N = 28)***
Very well prepared	17%	6%	11%
Prepared	58%	25%	39%
Neutral	25%	25%	25%
Unprepared/Somewhat prepared	0%	25%	14%
Very unprepared/Not well prepared	0%	6%	4%
Not sure what this is	0%	6%	4%
No answer	0%	6%	4%
Total	100%	100%	100%

Reflections from local coordinators

During interviews toward the end of the pilot, LCs reported mixed views of the pilot training. In general, LCs thought their raters and mentors had been well trained, except in documentation. For LCs with prior experience with the VSQI or similar projects, their own training was generally satisfactory. However, LCs with less experience reported needing more overview of the entire implementation process. Several noted that in the future, training should not be approached as a "one size fits all," but tailored to the experience and knowledge of the rater, mentor, and LC.

Two LCs felt that important requirements, such as ensuring that raters conducted inter-rater reliability visits, were not communicated well by VECF. (The timeline and procedures for inter-rater reliability were detailed in the Rater Guidelines.) LCs who were not themselves trained on the rating and mentoring tools (particularly the FCCERS-R and the Toddler CLASS) stated they were not able to effectively edit Summary Reports or recognize whether or not procedures were being correctly followed and scored. Consistent with some raters' views, most LCs agreed that raters needed more training on how to write Summary Reports. Most LCs commented that in hindsight, they would have preferred more training themselves to administer the pilot most effectively.

3. How reliably did raters score the FCCERS-R and the Toddler CLASS?

This question addresses one type of inter-rater reliability, which reflects a rater reaching a criterion degree of agreement with master raters (or, in the case of the Toddler CLASS, with a consensual "gold rating" for videotaped segments). Regularly achieving high rates of agreement (or "establishing reliability") with scale authors or master raters signifies mastery of the rating system. Once a rater is reliable with an expert, he or she can conduct independent ratings.

FCCERS-R. Ten master and two field raters participated in on-site observation FCCERS-R training with the scale author and ERSI colleagues. Four groups of between two and four raters (one expert rater and one to three trainees per group) visited four different Richmond-area providers who volunteered to allow training in their family child care homes. Master rater

trainees were required to do three on-site visits with author trainers; nine completed three visits and one did four. Group members were expected to score independently and then compare their ratings to one another and to the ERSI expert rater. The percent agreement between themselves and the expert rater constituted the trainee's reliability score. A trainee's scores across all site visits were averaged to yield a reliability score; eighty-five percent is considered "reliable" on the FCCERS-R (Harms, Cryer, & Clifford, 2007). Ratings within one point are considered within the reliability range. Expert trainers provided their group's scores to VECF along with reliability calculations for the trainees. All trainee raters achieved at least 85 percent agreement across their site visits with the expert leading their group (range: 86 – 97 %), after which they were considered reliable FCCERS-R raters.

Locally, master raters trained other raters to consistency. Typically raters would accompany a master rater on three visits and the field raters' scores would be compared to those of the master rater. Of an initial pool of 13 local raters, four trained this way. Two of the four reached reliable consistency with a master rater after three visits, one reached consistency after four visits, and one did not reach consistency after five. Consistency averages across the visits ranged from 86 to 93 percent. The other nine, from the original local rater group, failed to complete consistency training and were dropped from the pilot. Known reasons for non-participation included unwillingness to conduct training per bono, lack of a master rater in the local area to provide training, and dismissal of one rater from a participating agency.

Toddler CLASS. Twenty mentors, one of whom was also a local coordinator, took a reliability test upon completing the Toddler CLASS training. They were shown video clips and asked to rate the sections. Eighty percent agreement within one point of the master expert ratings is considered "passing" on the Toddler CLASS, certifying the mentor as reliable on the measure (Pianta et al, 2008). Of the 20 trainees who took the initial test, seven (35%) passed, and another six (30 %) passed on a second attempt. Five mentors (25%) did not pass reliability. (The test was conducted virtually by Teachstone™.) Due to the time frame and expense, expert BAS reliability training was not conducted for this pilot.[17]

[17] Four VSQI personnel did attend BAS reliability training in Illinois in March 2011.

Summary and recommendations

It is clear that extensive time and resources were invested in training family child care VSQI raters and mentors, and available evidence indicates that trainings were mostly well-delivered and well-received, particularly for and by the raters. Immediately afterward, raters reported that trainings covered topics adequately or completely, with the exception of three items on the FCCERS-R subscale, *Personal Care Routines*. FCCERS-R experts followed training protocols for on-site reliability visits completely for three-fourths of the rater trainees, making minor or occasional protocol lapses with the other trainees. After completing field ratings, raters reported feeling they had been well-prepared to conduct rating visits.

Unlike with the raters, the mentor portion of the pilot was not concluded by the time of the evaluation interviews, so fewer conclusions can be drawn. However, it is clear that the administration and use of the Toddler CLASS in mentoring needs to be better articulated. If actual scores will be used in some capacity (for example, in tracking provider changes), more prolonged training on this tool is imperative. Given the difficulties mentors had in achieving reliability on this tool, a better use of it may be to focus on the concepts behind the Toddler CLASS scales, which mentors could incorporate into their coaching.

More guidance around and examples of how to prepare cornerstone documents, such as the Summary Report and QIP, appears warranted. For LCs to act as effective quality managers, they will require training on the measures they are asked to review in reports. With these recommendations for the future noted, it is also the case that for the most part, raters and mentors reported that training was comprehensive and prepared them to adequately administer the pilot. The next chapter, Rating and Data Gathering, describes what happened during that pilot rating administration. The following chapter, Mentoring, reviews the mentoring process and elaborates on mentors' experiences developing QIPs with providers. Recommendations for addressing QIP training are more fully addressed in the final chapter, Conclusions and Recommendations.

Rating and Data Gathering

Rating visits were intensively trained for and the information collected through them represents one of the two pillars of the VSQI system. Although Virginia has been conducting ratings for several years in classrooms and child care centers, important differences exist between conducting ratings in centers or classrooms compared to in family child care homes, particularly as the site functions both as a child care business and a personal home. To understand how this procedure went during the pilot, the evaluation team asked the following questions:

1. What was the procedure for on-site visits?
2. How reliably were rating procedures followed?
3. What challenges were encountered?

Information for this portion of the process evaluation stemmed from rater time logs completed after each Summary Report; on-line surveys administered to raters following the conclusion of their pilot visits; a follow-up telephone interview to ask for elaboration on selected items from the surveys; executive interviews with LCs regarding their experiences managing the rater phase; and interviews with key VECF staff responsible for checking reports and mailing them to providers.

Response rate was excellent for the surveys and interviews, with all 12 raters completing the survey and nine of the 12 elaborating on their responses through an interview. Five LCs and one local pilot manager[18] were interviewed. One LC sent in written responses to the interview protocol ahead of time. Response rate was poor for completion of rater time logs; five raters completed at least one log, with the majority of all logged responses originating from three raters across several regions. The low time log compliance may have been due to the fact that it was not a written part of the rater protocol, but rather something collected specifically for the evaluation. Regardless of the reason, results based on that measure should be considered only suggestive.

[18]One locality hired an additional staff person to help administer the pilot

1. What was the procedure for on-site visits?

Family child care providers participating in the demonstration pilot received an observational home visit from raters lasting four or more hours. During the visit, raters used the FCCERS-R to rate environmental quality and the BAS to assess business practices. During training, raters were given guidelines ("Rater Guidelines") to follow for these visits. Once the visit was completed, raters scored the instruments and wrote a Summary Report. Raters submitted the Summary Reports within five days to their local coordinator, who sent them on to VECF for final review.

Scheduling ratings followed procedures identical to those used in the classroom-based VSQI. LCs contacted providers by phone or email to establish a three-week period during which the home observation could occur. No specific dates for the observation were given to the provider, but the provider could identify up to three dates that she would be unavailable during the rating window. LCs assigned raters based on their location and availability to individual providers. Raters were to contact their provider at least a week prior to the three week rating window, introduce themselves, confirm the window and ages of children served, and determine whether any conflict of interest existed for either party (for example, if they knew one another). No conflicts of interest were found in any of the pilot ratings. If one had arisen, the LC would have had to assign the provider a different rater.

Raters were to arrive at provider homes by around 8:30 a.m. to allow for three to four hours of observation time. After introductions and an explanation of the visit procedures, including that the rater would not interact with the children and try to remain inconspicuous, the rater observed what went on in the family child care. Once the FCCERS-R observation portion was completed, the rater asked the provider additional questions if providers were available and not engaged with the children. If providers were unavailable, providers scheduled a return visit or a followed up with a phone call. Courtesy and professionalism was emphasized in training and expected during visits (Virginia Early Childhood Foundation, 2010a).

After reviewing and checking FCCERS-R/BAS scoring sheets for accuracy, raters submitted scoring calculator sheets to VECF and Summary Reports to LCs within five calendar days. For purposes of the pilot, raters also scanned, faxed or mailed their raw FCCERS-R and BAS sheets

to VECF and were asked to complete a short time log documenting the length of time it took to complete core components of the observations, such as scheduling, travel, scoring, and Summary Reports. A general question asked how well they were able to follow the rater protocols outlined in the Rater Guideline document.

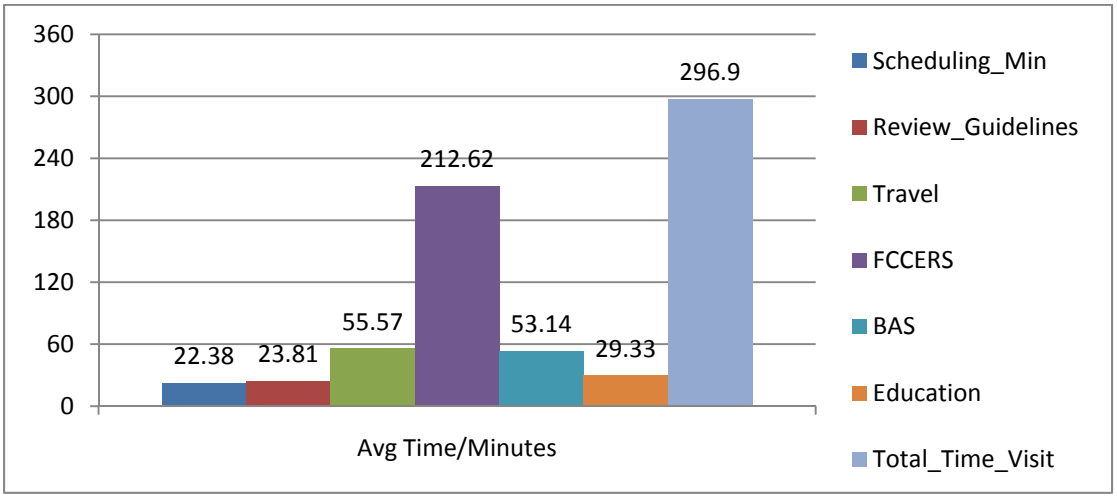
Inter-rater reliability on the FCCERS-R was to be measured on the third home visit and every fifth visit thereafter. For these reliability checks, raters were expected to arrange for a "buddy visit" with another rater. This visit could count as an inter-rater reliability check for both raters, but only one would complete the Summary Report. The primary rater was to be paid 70 percent of the rater visit fee and the "buddy" the remaining 30 percent of the fee. Both raters' score sheets were sent directly to VECF for review. If raters were found to be inconsistent, they were assigned a master rater to accompany them on a second inter-rater visit.

2. How reliably were rating procedures followed?

This section focuses on scheduling and rater visits, maintaining quality standards through inter-rater reliability, and scoring and reporting accuracy. A complete set of responses to the rater surveys are presented in Appendix D.

Rater visits and scheduling. Most raters (83%) found the Rater Guideline document outlining visit procedures helpful, and the majority (75%) felt that their rating visits went smoothly. With the exception of one visit, rater visits were accomplished according to protocol, as reported on rater time logs (but recall that only 21 rater visits were time-logged, representing 28% of all rater visits). A review of rater logs and FCCERS-R face sheets confirmed that raters spent, on average, about five hours at a providers' home, ranging from 3.5 to 6 hours per home visit, with the majority of time being spent administering the FCCERS-R and the BAS and the rest of the time educating the provider. Figure 8 below shows raters' estimations of time breakdown for different observation visit activities.

Figure 8. *Average Rater Time Spent on Tasks, in Minutes (n=21)*



The most significant deviation from what raters expected during home visits concerned gathering data from providers, particularly for the BAS. Through survey and interviews, raters reported several difficulties with this portion of the visit, including that the documentation they were instructed to collect did not enable them to score some of the BAS items, or that providers often did not have the relevant documents available, necessitating later follow-up. Several providers who had initially agreed to complete the BAS portion of the visit chose not to do so during the home visit. In the future, raters recommended that providers be better informed about the BAS prior to the rating visit.

LCs also reported that collecting materials for the BAS was challenging for some raters for several reasons. In some cases, husbands or co-workers managed the finances. Others providers expressed discomfort about showing financial documents and were confused about how their financial records related to child care quality.

Scheduling. In general, LCs adhered to the three-week scheduling window protocol. However, there were approximately eight instances when providers were given specific rater visitation appointments one hour to one day ahead of time, according to LCs. This occurred when raters had to travel outside of their home areas in snowy or other adverse conditions within a specified time period, in the case of a quarantined home, or when visits were made to apartment buildings that required entry permission. Based on the feedback from raters, the

evaluators estimated that the "three-week window" protocol was followed 85 to 91 percent of the time. Raters also noted some scheduling challenges that are reported in the next section.

Inter-rater reliability ("buddy visits"). Observational rating data provides some of the richest, most sensitive data on child care quality, but is subject to "rater drift." That is, raters often develop their own norms or patterns of rating as they build up a repertoire of observational experiences. This tendency is commonplace and does not imply rater inadequacy. However, it does require that raters continue to compare their ratings with others. This ongoing inter-rater reliability process means that at specified intervals, two raters rate the same family child care provider and the percent to which they agree represents one index of inter-rater reliability. If they continue to agree 85 percent (for FCCERS-R) or more of the time, rater drift has been avoided.

Seven raters— six master and one local—completed one FCCERS-R inter-rater reliability check after three home visits, and two master raters conducted a second check with one another after an additional three visits. All percent agreement checks but one were high (92 – 97% agreement, with an average of 95%). The exception was between a master and a local rater, which resulted in an 82 percent level of agreement. As protocol dictated, a second master rater conducted another reliability check with the local rater, with whom the local rater also agreed only 82 percent of the time.

Two master raters and two local raters did not complete inter-rater reliability checks as outlined in the Rater Guidelines. The two master raters completed four and nine ratings, respectively, and the two local raters completed four and five ratings. Reasons for non-compliance appeared to include a lack of understanding by the LC that this was required, difficulties with scheduling in the context of the rapid turnaround time, and the availability of only one rater in some regions. Raters reported that it was difficult to find a time when both raters were available since many raters had other jobs. One of the pilot areas had only one local rater, which meant it would have been very costly to bring in another rater from outside of the region.

Scoring accuracy. There are several scoring steps involved in the FCCERS-R that leave room for error. Raters score FCCERS-R and BAS on paper worksheets and must calculate item

scores, scale scores, and finally, the total score.[19] To cut down on errors, raters typed their scores into an electronic score calculator created for this project. Impressively, raters made very few errors both in original scoring on the paper worksheets and in transferring their scores to the calculator. A random draw of 21 percent of FCCERS-R score sheets revealed only two mistakes, an error rate of 0.33 percent (calculated by dividing errors from 38 FCCERS-R items multiplied by 16 ratings).

3. What challenges were encountered?

Fifty percent of the raters indicated that they encountered circumstances in scheduling or conducting ratings that felt especially challenging. Challenges included providers being insufficiently prepared for the visit, providers not understanding the scheduling structure, feeling intrusive during their visits to providers' homes, and completing the work within the allotted time frame.

For instance, raters cited providers not being available during the three-week window time period, requesting specific rating dates, and not understanding that the ratings would not be scheduled in advance. One provider would not allow a rater into her house. Raters further reported that if providers had not previously participated in a similar project, there was too much information for them to absorb. A lack of English proficiency for some of the providers made communication between the rater and providers particularly challenging. For one rater who traveled to another region to conduct ratings, illness in the providers' home prevented ratings to take place as planned. Raters mentioned that unlike centers, rating in a provider's home could feel intrusive, especially in the often limited space in which observations had to occur. Some reported difficulty putting providers at ease during a process that felt unfamiliar to the providers without compromising the integrity of the rating.

Other challenges were related to the tight time frame of the pilot. Inclement weather prevented some field rater trainings to take place on a timely basis, which in turn delayed the scheduling of visits. Some of the raters had other obligations that made it difficult to schedule rating visits in the shortened pilot time frame. Coordinating multiple schedules—including the rater, provider, and "buddy raters" for inter-rater checks—proved especially challenging,

[19] In fact, at least one trainer from ERSI made scoring errors during site visit training.

particularly for those working on a contract basis. In fact, one field rater had to drop out of the pilot as a result of not being available when the master rater could conduct consistency visits.

When raters withdrew from of the pilot, other raters' caseloads increased, making it hard to be timely within the compressed pilot time frame. Provider attrition also caused some delays, as new providers needed to be enrolled. Some raters stated they did not have a clear understanding of the time commitment involved in participating in the pilot. Despite this, 92 percent of raters indicated that they wanted to continue with the VSQI in the future.

Raters who cited no challenges to scheduling or conducting ratings attributed this to their LCs' flexibility in scheduling rater windows around raters' schedules and preparing providers well for the rating visits.

Challenges with documentation, paperwork, and compensation

Other challenges mentioned included the short turnaround time for Summary Reports, some difficulties with the format of the forms, and "excessive paperwork." Due to the demonstration pilot's compressed timetable, raters were required to submit their completed Summary Reports within five calendar days, a deadline that often meant they had to work on weekends. Despite this short turnaround time, 92 percent of raters submitted their Summary Reports on time, according to VECF staff. However, the accompanying documentation, e.g., score sheets and time logs, was often submitted much later.

Most raters (66%) reported being satisfied with the Summary Report format, though two noted it had no place to provide positive comments. Several raters commented on time lost due to difficulties entering information into the preset computer form that did not expand with comments. Raters with limited access to a scanner found it difficult to email FCCERS-R score sheets to VECF promptly. Raters generally noted the amount of paperwork required exceeded the administrative support available to them.

Finally, while half of the raters felt the $250 fee was adequate compensation, one-quarter felt it was insufficient and another quarter was uncertain whether it was a fair rate. The lack of payment for consistency training visits for locally trained raters and for at least half payment to the "buddy" rater during inter-rater reliability visits, as well as time lost to scheduling mix-ups and electronic re-writes, reflects a potential point of vulnerability for future

family child care rating. Raters who traveled long distances noted the importance of reimbursing mileage.

Summary and recommendations

The available data indicate that ratings were largely conducted according to protocol, scoring errors were minimal, and despite impressive challenges, raters were able to complete visits and provide Summary Reports for all providers. The lack of widespread and regular inter-rater checks, coupled with the slightly lower inter-rater agreement for one "buddy pair," underscores the importance of establishing a solid system to ensure that raters continue to maintain consistency over time.

While there were some deviations from precise protocols, in most cases these appeared to be minor and primarily attributable to the pilot's time frame rather than to the VSQI program design. However, in some cases more serious protocol violations occurred that could have ramifications for the future rollout of the family child care VSQI.

Besides the inconsistent inter-rater reliability checks, the most potentially compromising deviation from prescribed procedures lay in LCs occasionally letting providers know a little ahead of time that the rater would be visiting, instead of leaving visits completely unannounced (within the three-week window). Although the reasons appeared to be reasonable in the context of the compressed pilot rating frame, this practice is not sustainable and could jeopardize the integrity of the rating system. In point of fact, the "appointment ratings" were not noticeably elevated, but in the future, it will be critical to maintain the standard protocol. If in the future providers are unlikely to participate in the VSQI with "drop-in" observations, it highlights the need for a preparatory orientation phase prior to ratings, as recommended by LCs during the Standards focus groups. In some regions, parents too may need to be better informed about the purpose and benefits of their family child care providers participating in the VSQI, since raters observe children when they are in providers' homes.

Challenges encountered in the pilot highlight ways to strengthen the rating process for family child care. Those related to the accelerated pilot time frame may not be of concern, but others will require some modification. Relatively simple but important adjustments include correcting how text is inputted to the Summary Report document, enabling positive comments

to recognize providers' strengths in the Report, and extending the deadline for the Summary Reports. More challenging difficulties highlighted in the pilot — such as maintaining rating system integrity through regular checks, reassignment of raters when unexpected changes in raters or provider participation occur, and scheduling difficulties due to using part-time contractors or raters with primary other full-time jobs—suggest that systemic changes in the rater administration may need to be made. A recommendation to explore creating a statewide VSQI rater system is described in the last chapter as a way to stabilize and render sustainable this lynchpin of the VSQI process.

The LC role appeared particularly important in smoothing the rating process by preparing providers for what to expect and in otherwise coordinating the rating process. Given the importance of this management role, and the fact that the recruitment and education of providers as well as the scheduling process was very time-consuming in some localities, additional resources at the local level may be required for smooth functioning if the bulk of the rating process remains decentralized.

Finally, raters should be reimbursed for miles traveled to conduct visits. This reimbursement might be prorated based on how far they need to travel, or kick in after a certain number of miles, but to ensure that providers in remote locations are served, compensation for travel time, fuel, and car use will need to be assured.

Mentoring

This chapter of the report focuses on the mentor component of the pilot. The mentoring process was to take place for a maximum of 30 hours per provider, following providers' receipt of the Summary Report. Pilot tasks included administering the Toddler CLASS, reviewing the Summary Report with providers, developing a QIP based on these two assessments, and working with the provider to achieve QIP goals. Mentors were required to write or edit the QIP and complete monthly Summary Reports describing their activities and the amount of time spent doing them. Mentors sent the QIPs to their LCs, who forwarded them to VECF.

The earliest mentor contact was in January, 2011, but most mentors did not begin working with providers until March or April. Mentoring continued through June 30, 2011. Twenty mentors coached 74 providers, with the number of providers each mentor worked with ranging from one to six and most coaching between two and four providers. Coaching occurred primarily at the providers' homes, but some mentors conducted group meetings or workshops, and many had email and telephone contact with providers between scheduled visits.

Data for this chapter was obtained through ongoing monitoring of the pilot process by the VECF staff and the research team; surveys completed with the mentors in May; small group interviews, which were conducted with mentors in each region in May; reviews of monthly mentor Summary Reports and QIPs uploaded to Scholar; and when necessary to follow-up on missing information, contact with LCs. Sixteen of 20 (80%) mentors completed surveys, and all local mentors but one participated in group interviews. Evaluation questions for this component were as follows:

1. How were mentors matched with family child care providers?
2. What curriculum, approach, or coaching procedure did mentors use?
3. How often did mentors meet with providers?
4. How successful were mentors? What challenges did they experience?

1. How were mentors matched with family child care providers?

Local providers matched mentors with providers by logistical factors, personality factors, provider or mentor preference, roles, and experience. Logistically, both providers and mentors were dispersed across wide geographic areas, particularly in Appalachia, South Hampton Roads, and Fairfax; for instance, some mentors reported traveling as far as 43 miles each way to reach a provider's home in the Appalachian Region, while another mentor reported that the provider lived "over 100 miles away." LCs described often pairing within the same jurisdiction to the extent possible. Another logistical factor was language; one mentor was bilingual and was paired with a provider who spoke the same language.

In many cases, LCs tried to match according to what they knew of providers' personalities and the characteristics or experience of their mentors. Coordinators described placing more seasoned mentors or those with particular communication styles with providers who they anticipated might require more nurturance or more coaxing through the process. Sometimes LCs knew the providers, and in other cases they obtained a sense of the provider from orientation sessions or other recruitment contacts. In at least three localities, most of the mentors and providers had previously worked together, were already working together, or knew each other well enough for a provider to request a particular mentor. Cultural considerations also played a role, with coordinators estimating easier acceptance of the pilot by mentors with more similar backgrounds to the providers.

In Fairfax, Alexandria, Central Virginia and Greater Richmond, mentors often had a prior working relationship with a provider due to other initiatives or programs in which the providers were involved. For example, in Fairfax, family child care providers can be approved to offer public prekindergarten (VPI) and Early Head Start services, for which they receive regular training and monitoring. The early childhood professionals working in these roles were trained to conduct the VSQI and encapsulated their 30 VSQI hours within their ongoing mentoring relationships.

Finally, some logistical matching occurred as was necessary due to unexpected changes, such as a provider withdrawing, so that mentors could maintain a balanced case load and the pilot timeline could be maintained. However, this type of matching appeared to occur less

frequently than the more deliberative logistical or relationship approaches. Mentors were satisfied with how their LCs assigned them providers (56% of survey respondents were very satisfied and 38% were satisfied).

2. What curriculum, approach or coaching procedure did mentors use?

Mentors were very pleased with the relationship building training they had received and noted they had used many of the strategies and tips presented during the training in their work with providers. No mentors relied on any other specific *mentoring* curricula, but some did focus efforts on helping providers adopt program curricula, such as Creative Curriculum, Portage Developmental Curriculum, or versions of High Scope. Methods mentors used to build relationships with providers included:

- Instilling a sense of control and empowerment with the provider;
- Reviewing the theory, purpose and research justification for the rating system;
- Modeling behavior and interactions with the children;
- Offering frequent positive feedback and encouragement
- Engaging in active listening
- Faciliating provider networking

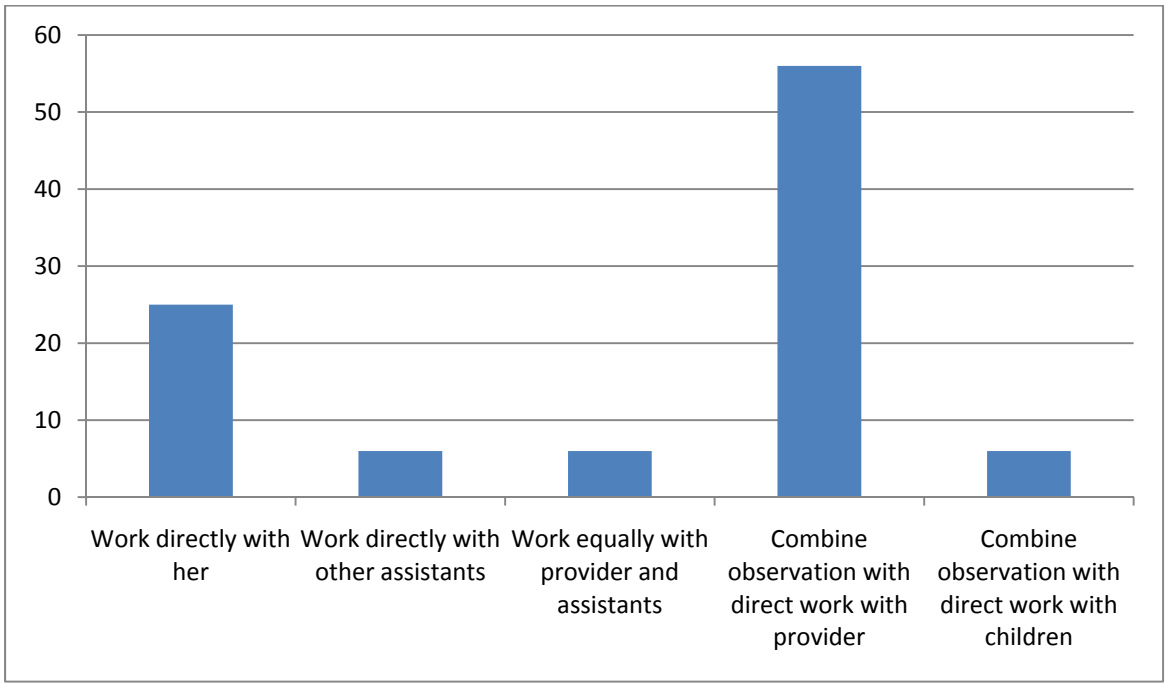
Mentors described several phases in their work with new providers, including an introductory phase focused on meeting the provider, conducting the Toddler CLASS and reviewing the Summary Report together. Due to providers' distress about the Summary Reports, this phase also entailed a lot of active encouragement and "reframing." The next phase, developing the QIP, helped build rapport in most cases, under the skillful management by mentors. One commented,

> *I was nervous going in right after they received the Summary Report, but after going in and building relationships they let their guard down a bit.*

Mentors spent most of their allotted 30 hours helping providers work toward the goals outlined in their QIPs. Survey responses indicated that mentors most commonly used an approach that combined observation, followed by direct work with the family child care

provider on what was observed (56%) and direct work with the provider and assistants (31%). A breakdown of how mentors spent time during mentoring visits is provided in Figure 9.

Figure 9: *Mentor Estimation of Time Spent on Activities, by Percent (n=16)*



Mentors described some of their approaches:

> *I take my shoes off, play with the kids, try to model behavior for providers.*

> *When you explain what is developmentally appropriate, some providers just say "no, not doable." I try to give new strategies and also say, "This is your program, but I challenge you to try XYZ for just one day."*

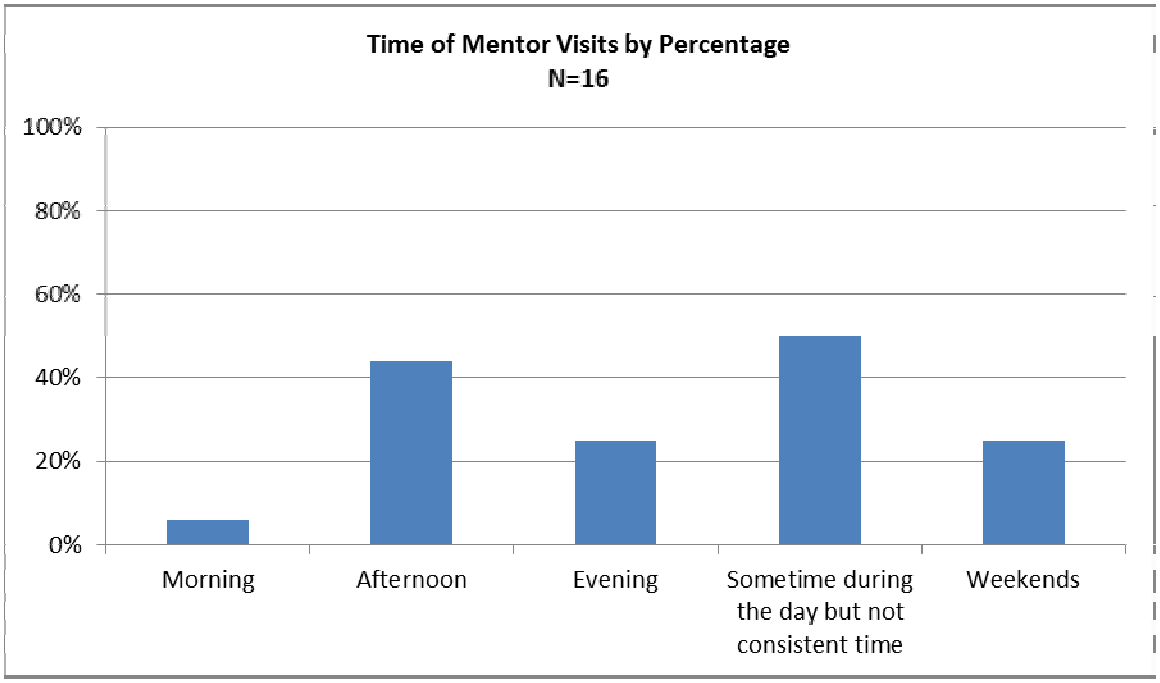
Some mentors formed networking or training groups with their providers in addition to meeting individually. They encouraged and facilitated provider groups for networking as well as for training. One provider met weekly with her provider group at meetings hosted in turn by different providers in their homes. Another mentor's provider group expanded to form an area network with additional providers in order to advocate for children and family child care.

3. How often did mentors meet with providers?

A review of mentor monthly summary reports and survey responses revealed that the frequency and length of on-site visits varied greatly across regions and mentors. In general, mentors with long travel times to providers' homes spent more time on each visit. Survey results showed that by May, 15 of 16 surveyed mentors had made at least one visit with each of their providers, while more than half had six or more visits. Visits lasted between one and four hours. Mentor summary reports and follow-up confirmation with LCs indicated that mentors spent an average of 26 hours per provider on quality improvement activities (including preparation, follow-up and conducting group trainings, as well as site visits and telephone and email contact), ranging from 10 to more than 30 hours per provider. According to LCs and mentors, factors affecting mentors spending less time coaching particular providers included starting mentoring late due to late ratings; difficulties coordinating mentor and provider schedules; and in a few cases, language barriers or personal difficulties in providers' lives reducing their availability.

Meeting times varied considerably, although most mentoring occurred during the day, particularly in the afternoon. Figure 10 provides a summary of when mentoring occurred.

Figure 10: *Time of Mentoring Visits, by Percent (n=16)*



4. How successful were mentors? What challenges did they experience?

Overall mentors expressed feelings of success and satisfaction in helping providers develop the awareness and adopt the strategies required to improve the quality of their child care.. They worked with providers to craft an average of 18 goals per provider (range, 7 – 36), and 90 percent of providers met at least 50 percent of their goals by the end of the pilot, according to QIP records. Of the 16 mentors who responded to the survey, 15 (94%) reported that the mentoring experience was "rewarding" or "very rewarding." During interviews, mentors described observing progress.

> *Other providers have called to ask if they too could join the program; we also see the children's excitement with changes and the new books, etc.*
>
> *I have seen a lot of improvements in a short time.*
>
> *We are changing mindsets.*
>
> *I noticed that parents were spending more time when they picked up their kids. The rearrangements of the rooms really seemed to help them feel more interested and comfortable.*
>
> *When [my provider] called me on my cell at 8 am Saturday morning and said, "I'm here at Lowe's, picking out outdoor play things" – asking my advice – I knew we were really on to something.*

The rest of the chapter describes mentors' reflections about several key components or phases of the mentoring process: administering the Toddler CLASS, reviewing the Summary Report with providers, developing and implementing the QIP, and documentation.

*Administration of the Toddler CLASS***.** The Toddler CLASS was to be administered on the initial visit with the provider before the mentor and provider reviewed the Summary Report together. As reported in the chapter on training, CLASS administration procedures were often irregular, perhaps due to providers' intense reactions to the Summary Report (see below) and other factors.

Many mentors reported that administering the CLASS gave them better insight into what the raters reported on the Summary Report, while others indicated that conducting formal ratings could compromise the mentor relationship. A few indicated that they mitigated this tension by incorporating the deficits found through the CLASS into the QIP without overtly such an intent. One mentor reported,

> *I did… the CLASS observation because the rater and I had different views, but when I did the CLASS it gave me a quick window to see why the rater gave a certain rating.*

Mentors noted several challenges regarding the CLASS. In addition to administrative protocol difficulties described in an earlier chapter, mentors reported that most providers were so surprised and distressed by the Summary Report that mentors had to review the reports with providers immediately, before conducting the CLASS. Some mentors also had great difficulty completing or did not complete the CLASS because of language barriers, absence of age- appropriate children in providers' care, or, in one case, because parents did not send their children to the family child care when the mentor was scheduled to conduct the CLASS. Three providers declined to allow the Toddler CLASS, while one who initially refused later agreed to it. Sixty-eight full or partial CLASS assessments were conducted.

Summary Report Review. Many mentors reported that their first visit with a provider was spent mitigating the emotions created by the Summary Report. Whereas a minority of providers viewed the report positively as a recipe for changes they could make, the great majority appeared very upset, according to mentors in all regions. Mentors reported providers' expressing they felt "demeaned," "devastated," and discouraged by the exclusive focus on what they were not doing well and many wanted to quit the program. In a comment echoed by several mentors, one noted,

> *One of my providers was INCENSED. When I got there, she was going through the report with a pen, "Liar," "Liar," "Liar,"…it was all I could do to hold onto her. She gradually came around, but I don't know how really invested she is after that…*

LCs also reported receiving telephone calls from providers angry and distressed about the reports, and at least two providers contacted VECF to complain. Mentors and LCs commented that family child care was different from classroom-based care, in which teachers may be buffered by their director, who can frame the report and provide context for them. Said one mentor,

> *For the family providers, this is very personal. The report is all about them, about their business, and even about their home. They reacted pretty strongly to the observer reports.*

Mentors needed to use considerable skill to interpret the Summary Report in a positive, energizing manner just as they were starting to establish a relationship with a provider, and also be extremely encouraging for providers to continue their investment in the pilot.

Strategies mentors reported using to support providers were creative and varied.

- Mentors contextualized the report by reviewing the FCCERS-R manual with providers, pointing out all the places they had received a "5" or above on the FCCERS-R.
- They used the report to tailor provider group training sessions that addressed specific areas where providers needed to improve.
- They broke the report down into small chunks that showed the provider how she could quickly move up on some of the items.

Mentors noted,

> *The providers were hurt and angry. I told them, "It's just a rating scale; we're going to use it, it's not going to use us!"*

> *I said to my providers, "Let's just take this report like a piece of fish and keep the good and get rid of the bones."*

Quality Improvement Plan (QIP). Almost all mentors (94%) were satisfied or very satisfied with the final QIP product and found the QIP structure helpful (88%), but they expressed lower satisfaction rates with the process of developing QIPs (75%) and the feedback from LCs they received on them (50%). Given the centrality of this document and the novelty of developing

one with family child care providers, in the following section we explore how mentors went about developing and implementing the QIPs as well as their evaluation of how well this process worked.

*Development of the QIP***.** The QIP was to be developed to address providers' goals in the context of VSQI Standard areas identified by the Summary Report and Toddler CLASS scores as most needing improvement. Mentors described different strategies to develop the QIP. Some worked collaboratively with providers, others took on more of it themselves, and a few relied more heavily on the provider to fashion the QIP.

> *I looked at the [Summary Report] and created training based on the results. I used background information about the children… for training, too. [My] providers had similar goals (hand washing, personal home care), which helped.*
>
> *I read the Summary Report and create goals that I [feel]t they needed to achieve. Then I go to the provider and sit down with [her] and go from there. I'm a fixer.*
>
> *[It was important that the providers felt] they had the control; they were scared and anxious. I said, "Please, tell me how I can help you."*

A potential tension in quality improvement programs lies between areas of improvement identified through a rating process, and providers' personal goals for professional improvement (Porter et al., 2010). Mentors experienced some of this tension. Whereas 13 of 16 mentors (81%) reported that providers' goals appeared consistent with areas identified in the Summary Report, only 31 percent of providers' own goals were reported as being consistent with CLASS results. Some found it difficult when the providers wanted to include items in the QIP that were not connected to the CLASS or Summary Report. Mentors handled this conflict in different ways.

> *I created my own personal checklist of items to work on [including items not listed in the QIP]; I would rather not write on paper goals providers don't feel good about working on.*
>
> *We looked at all the items [that were noted as needing improvement] and I had the provider identify what was the most important to [her]. We did baby steps.*

Mentors described taking a relatively long time to develop the QIP. Reasons why included that it took time to help providers connect the Summary Report to the QIP when they were so frustrated by the Report; a lack of clarity regarding what was required in different sections of the QIP; lack of clarity regarding the number of goals to set and whether the time frame should end with the pilot or extend beyond it; difficulties inputting the actual form; and having to complete the QIP in fragmented time slots when the provider was not engaged with children in her care.

On the other hand, mentors used the experience of developing the QIP to help ease providers into a process of making changes.

> *I was willing to step outside the box about meeting times…we sat down with dinner and we looked at the report and highlighted items that we could accomplish very easily. Then at the next meeting, I asked the provider to look at the report again and identify items she thought she could maybe fix…just step by slow step.*

> *I explained that some things we will be able to change, some we can't. We can't change it all right away; we took time to move on.*

Review of QIPs showed that, with the possible exception of two mentors, all developed goals relevant to the appropriate Star Standards. One mentor appeared to misunderstand the third Standard, *Structure,* evidenced by including goals related to arranging rooms or otherwise structuring programming, rather than working on appropriate group size or caregiver ratios. The other mentor once included non-educational or training goals under Standard 1. Goals ranged in complexity and the extent to which they could be achieved during the pilot period. Examples included meeting regularly with a mentor, making environmental improvements, practicing communication feedback loops with children, developing an employee handbook, and enrolling in Child Development Associate certification or college early childhood education programs to start in fall, 2012.

Implementation of the QIP. Mentors estimated that most of their direct contact time was spent addressing goals specific to the QIP, as shown below.

Table 6. *Mentor Estimation of Time spent on QIP Goals, by Percent (n=16)*

How much of your time with providers is spent addressing goals specific to the QIP	Percentage Response
Most of the Time	31%
Three-fourths of the time	50%
Half	13%
One-quarter of the time	0%
Less than one-quarter of the time	6%

Mentors reported helping providers work on goals by using a combination of positive encouragement, role modeling, watching for "teaching moments," listening, and gentle pushing. In most pilot areas, mentors reported that using these techniques and spending time with providers seemed to increase providers' trust in them and the VSQI process, which facilitated providers' engaging in the QIP process. In Northern Virginia and the Appalachia regions, however, cultural differences between VSQI personnel and providers appeared to require additional time and skill to build good working relationships. English is a second language for most of the family child care providers in Fairfax, Arlington and Alexandria, where communication barriers made implementing the QIP particularly challenging. In Appalachian localities, gaining providers' trust and helping them understand the basic tenets of VSQI and rationale for improving the quality of family home child care were marked challenges. However, according to the LC, once providers slowly started to engage, most became enthusiastic; by the end of the pilot, providers in this region had met between 56 and 100 percent of their QIP goals.

Documentation forms and administrative processes. Most mentors and LCs were generally pleased with the QIP format, commenting that the document was coherent, easy to work with, and that all parts were useful. One group expressed less enthusiasm about the research justification section, noting that finding justifications took up time they preferred to spend working directly with mentors. At least one LC reported developing a list of research citations for their mentors to draw from for common goals.

Mentors reported they felt somewhat unclear about pilot expectations for documentation and other administrative processes. Document formatting presented difficulties: several mentors described spending hours re-typing goals and rationales to fit into the computer-prescribed boxes. Many reported feeling a bit overwhelmed with paperwork, partly because they were not sure how much detail to include and when reports were due. Summarizing this aspect of the mentor's job, mentors felt that documentation procedures could be streamlined and that greater clarity regarding QIP expectations and deadlines could have been helpful.

Final considerations

Although training was extensively covered in an earlier chapter, here we present types of training that mentors reported wanting more of after having been in the field, as a way to summarize what appears to have gone well and what could use additional consideration for future administration. Table 7 represents the additional training requested by the responding mentors, with the Toddler CLASS, developing the QIP, coaching business practices and completing the required paperwork listed as top priorities for mentors.

Table 7: *Additional Mentor Training Needs, by Percent (n=16)*

I would have liked more training on/in :	Percentage Response
Toddler CLASS	44%
Developing a QIP	38%
Completing required paperwork	38%
Business practices	25%
Coaching providers on accessing resources	25%
Other	25%
Working with a QIP	19%
The Relationship coaching Model	13%
Family Child Care Environmental Rating Scales-Revised	13%
Coaching providers on working with challenging behaviors	13%
Coaching providers on parent communication	6%
Establishing rapport with providers	0%
Scheduling Visits	0%
Coaching providers on how to refer a child for evaluation	0%

Summary and Recommendations

The mentoring phase represented a challenging but exciting element of the demonstration pilot. Despite considerable challenges stemming from providers' reactions to Summary Reports, mentors managed to establish relationships, construct QIPs with providers, and help providers work toward or achieve QIP goals. By the end of the pilot, 90 percent of providers had met or exceeded the objective of completing fifty percent of their QIP goals. While some goals were easy to change – such as rearranging furniture – others reflected investment in ongoing quality improvement, such as enrolling in college courses or a CDA program.

Mentors expressed enthusiasm about the process and had already observed changes in some cases. The fact that no provider left the pilot because of the Summary Report is a

testament to the skill of this group of mentors, as well as the LCs and VECF pilot staff who supported them. At the same time, mentors experienced other challenges, particularly in pilot regions where many providers were not fluent English speakers or found the entire process foreign and hard to grasp. For all that, pilot findings are encouraging in that, once into the quality improvement mentoring phase, mentors reported themselves and their providers as engaged and enthusiastic about making positive changes.

One of the clearest recommendations to emerge from the pilot experience is to reformulate the Summary Report to balance the negative elements with positive feedback, and to better prepare and support providers in receiving and interpreting the Report. Additional training on preparing the QIP also appears warranted, as mentors and LCs had differing interpretations regarding specific elements, including how many goals to set and at what level of difficulty. The Toddler CLASS difficulties were reviewed in an earlier chapter, but some of the lack of protocol adherence may be due to language difficulties or otherwise reflect some of the relational and communication challenges noted between mentors and some providers. Because the mentor component was abbreviated in many instances and the evaluation team had less time to explore important questions regarding how mentors operated and in what ways did meeting QIP goals link to changes in Star levels, another primary recommendation is to continue to study this "intervention" in detail as the next phase of VSQI for family child care providers unfolds.

Below are listed specific recommendations, to consider for the future.

- *Consider beginning the mentor relationship prior to provider receipt of the Summary Report*. Mentors could help orient the provider to the process during an initial rapport-building phase. This will be more expensive, so developing a menu of mentor options tailored to provider level of quality improvement may be necessary. However it is accomplished, it is clear that most family child care providers need much more preparation for all phases of VSQI, including orientation to rating process, tools and standards prior to rating. A DVD mock procedure for both rating and mentoring might help providers, particularly those with less facility in English, better comprehend what the program entails.

- *Provide additional training and continuing education opportunities for mentors*. Training should be tailored to levels of mentor experience and knowledge. For example, provide extra CLASS and FCCERS-R training for mentors who have not had experience with rating; this will not be necessary for mentors who also function as raters.
- *Separate prescribed formal ratings from the mentor function.* While a mentor might plan to use a structured assessment tool with a provider for quality improvement, starting off the mentoring relationship with a Toddler CLASS (or other type of) rating complicates an already complex undertaking.
- *Offer training and additional guidance for mentor and LCs on developing and using QIPs*. Creating a casebook of examples that provides specific ways to link Summary Report indicators to operational and manageable goals could be useful.
- *Develop a QIP form* that is compatible across different computer applications and allows for continuous lines of text.
- *Create templates for QIPs* that allow mentors to quickly supply research rationale for different goals or use drop down menus for this purpose.

Data Coordination and Management

This chapter first describes the procedures for collecting, transferring, storing, protecting, checking the reliability of, and communicating about data and then reflects on what procedures worked well and what may need revision in the future. *Data* refers to information routinely collected as part of the pilot, including information provided by family child care providers (such as the application enrollment form, agreements, and educational training record summaries), data collected by raters (ratings, score calculators, Summary Reports) and mentors (Toddler CLASS assessments, and QIPs), and tracking forms used by LCs and VECF pilot staff to monitor progress and aggregate information.

Communicating, coordinating, and managing this volume of documentation are vital administrative functions. To describe and assess these processes, the evaluation asked the following questions:

1. How were data communicated to and from field staff, LCs, and VECF staff?
2. What were the data protection and cleaning procedures?
3. How well did these procedures work?
4. How much personnel time was spent on data entry?

To provide a reference point for documentation, the table on the following page lists the documents used in the pilot. Tools designed and used exclusively for evaluation purposes are listed.

Table 8. *Pilot Reporting and Tracking Documentation, by Who Completes It*

Pilot Documents and Tracking Forms	**Completed by:**
Administration, Recruitment and Enrollment	
Memorandum of Agreement – Administration	LCs, VECF
Monthly Progress Reports	Local Coordinators
Application for Family Child Care Homes: 2010 – 2011	FCCH Providers
Memorandum of Agreement	FCCH Provider, VECF
Recruitment Strategies (pilot only)	Local Coordinators
Rater and Mentor Compensation Chart (pilot only)	VECF
Rating Documentation	
Waiver for Conflict of Interest Provider	FCCH Provider
Waiver for Conflict of Interest Rater	Rater
Family Child Care (FCC) Home: Education, Qualifications, and Training Form	FCCH Providers
Family Child Care (FCC) Home: Education, Qualifications, and Training Form for FCC with Multiple Assistants	FCCH Providers
Family Child Care Environmental Rating Scale – Revised	Raters
Family Child Care Environmental Rating Scale – Revised Scoring Calculator	Raters
Business Administration Scale	Raters
Business Administration Scale Scoring Calculator	Raters
Summary Reports	Raters
Rater Time Logs (pilot only)	Raters
Mentoring Documentation	
Toddler CLASS Agreement Form	FCCH Provider
Toddler CLASS Scoring Sheets	Mentors
Quality Improvement Plans for Family Child Care Home Demonstration	Mentors
Mentor Monthly Contact Summary Form	Mentors
Tracking forms	
Raters and Mentors Reliability Tracking Sheet	VECF
Rater Scheduling Spreadsheet	LCs
Rating Checklist	LCs, VECF
FCCH Provider Application Spreadsheet	VECF
Family Child Care Scoring Calculator Spreadsheet	VECF

1. How were data communicated to and from field staff, LCs, and VECF pilot staff?

Primary data

Raters and mentors sent their raw data (ratings, educational documentation, score calculators, Toddler CLASS assessments) and provider agreement forms (for the BAS and Toddler CLASS) directly to VECF. They sent their written products (Summary Reports and QIPs) to their LCs, who were expected to review and edit them before sending them on to VECF.

All pilot personnel communicated data electronically for the most part, either through email or by uploading information to the data repository. When raters and mentors could not scan their raw ratings sheets or other paper copy materials, they faxed them to their LC or to VECF. LCs also sometimes faxed or mailed provider applications and memoranda of agreements to VECF.

Tracking and monitoring data

To help LCs administer the pilot locally, VECF staff gave LCs tracking forms for scheduling, documenting mentor activities, and reporting overall progress and activities, including expenditures (the LC progress report). LCs were required to complete monthly progress reports and to send them to VECF. They also needed to collect monthly mentor Summary Reports and upload those to a project data repository. Mentors were to send monthly Summary Reports of their mentoring activities, which included estimates of time spent on different coaching components to their LCs. LCs also reported their program progress through four telephone conference calls coordinated by VECF to check on progress and troubleshoot any difficulties.

Data repository

The evaluation team introduced VECF staff to Scholar™, a web-based project management tool that enables information sharing through the use of electronic announcements and data storage. The team trained VECF staff and LCs how to use Scholar™ to upload reports and download training and procedural documents. Each LC had her own folder accessible only to herself or selected local staff, VECF, and the evaluation team. Raters, mentors, and providers did not have access to Scholar™ . VECF staff uploaded all primary documents, such as ratings, Summary Reports, QIPs and Toddler CLASS assessments to Scholar™ . LCs were asked to upload their mentors' monthly Summary Reports and their progress reports.

2. What were the data protection and cleaning procedures?

Data protection

LCs reported storing primary data and tracking sheets, as well as project-related email, in computer files, on Scholar™ , and, for two LCs who retained paper copies, in file drawers in locked offices. LCs used data protection procedures mandated by their agencies; most noted that they were unaware of particular cyber security procedures other than using a password to log onto their computers. One LC noted that, per her agency's policy, she shredded all faxes after uploading them to her computer; another commented that she worked from home using a laptop and an external hard drive. LCs who kept paper copies reported storing them in file drawers located in offices that were locked at night. VECF pilot staff reported that all pilot electronic information was kept on a secured server and protected by a password log-in. Paper copies of pilot materials were kept in locked office drawers.

Data uploaded to Scholar™ were protected by a password log-in to the site, which was administered and supported by Virginia Tech. Based on recommendations from Virginia Tech Scholar™ support staff, personally identifying information, such as information that linked provider names with their addresses or social security numbers,[20] was not stored on Scholar. Instead, VECF staff and the evaluation team used a secure cyber dropbox system, also hosted by Virginia Tech, to communicate this type of information.

Data cleaning

Data cleaning refers to checking information for consistency, comprehensiveness, and accuracy. For the pilot, data cleaning was accomplished by individuals at several different levels of the system. Raters and mentors were expected to double-check their work, particularly in transferring FCCERS-R and BAS ratings to the electronic scoring calculator, and in writing Summary Reports and QIPs (VECF, 2010). LCs were expected to review Summary Reports and QIPS before sending them to VECF. At VECF, a staff member reviewed all Summary Reports, checked them against the raw score sheets, suggested rewording when necessary, and returned said Reports to the LC that were unclear, incomplete, or poorly worded. According to

[20] Many family child care providers use their social security number as their business tax identification.

VECF staff, sometimes several iterations were undertaken before VECF approved the Summary Report and mailed it to the provider.

3. How well did the communication, data protection and data cleaning procedures work?

Data communication and coordination procedures worked relatively well, according to the LCs and VECF staff. Data protection and cleaning procedures were more fragmented or unclear.

Data communication and coordination

Overall, LCs reported liking most of the tracking forms, particularly the scheduling tracker. Several commented that the mentor monthly time sheet for the family child care VSQI was more helpful than the classroom-based form. Some LCs favored the development of a single form that would track all aspects of a family child care home provider VSQI, including scheduling, rating and mentoring documentation, mentor hours, purchasing, and expenditures. For example, one coordinator described how she modified the monthly report to reflect everything she needed to track, including ensuring that mentors were not exceeding their 30 hours and creating a purchasing form. Additional LC suggestions for how to communicate and coordinate primary and tracking data are listed in Appendix F.

LCs also liked Scholar™ , noting that having all documents in a single place helped them monitor their own progress. One LC noted she thought all VSQI personnel should use it, commenting,

> *Mentors would probably be able to use this tool, but not providers. Only 50 percent of my providers have internet access; mentors wanted a message board so it would have been nice for mentors to have used it, and raters too.*

On the other hand, LCs noted a few difficulties using the tool. Two LCs described having difficulty locating documents, and one reported being infrequently notified when a new VECF document was uploaded, so that she was unaware until she came across it in Scholar™ that a new form had been added. A third LC "loved" the tool, but difficulties with her region's broad-band precluded her from being able to use it regularly.

Data protection and cleaning

Standard data protection procedures were in place at VECF, but the full extent to which this was true across all the pilot regions and all the raters and mentors is much less clear. Most raters and at least half of the mentors were contract employees, presumably working off their own computers, and most LCs knew of no agency policies regarding how to store or dispose of data, beyond using password-protected computers. Data protection policies that cover the entire the VSQI family child care provider program appear to be lacking.

Data cleaning is an area that may also require additional attention in the future. It appears that raters followed instructions to double-check their work, as reflected in the very low error rate comparing FCCERS-R face sheets to score calculators (reported in the Rating and Data Gathering chapter). A review of monthly mentor Summary Reports, however, showed that while almost all mentors described specifics of their work, approximately one-fifth failed to record the amount of time they spent in direct contact with the provider, as required. At least half of the LCs reported that they lacked the knowledge to effectively edit Summary Reports, as they were unfamiliar with specifics of scoring the FCCERS-R, which accounted for much of the Report. (LCs attended training in Fall, 2010, that reviewed the FCCERS-R, but only two LCs had themselves used the instrument).

4. How much time did field personnel spend on data recording/entry?

While it was clear that all VSQI personnel spent substantial time completing paperwork, quantifying that time was difficult. Data based on rater logs from 28 percent of home visits showed that these raters spent an average of four hours completing their scoring sheets, entering their raw scores into a FCCERS-R score calculator spreadsheet, and completing additional documentation related to rater protocols.

Table 9. *Average Time Raters Spent on Documentation, in Minutes (n=21)*

Scoring FCCERS-R and BAS	Writing Summary Report	Other Documentation	Total Time
58	135	47	240

Mentor monthly forms did not ask for time spent on documentation or paperwork. Anecdotally, mentors stated that they felt they initially they spent "a lot" of time on documentation, between the Toddler CLASS and the QIP, but it is not clear whether once those records were completed, they felt the paperwork was burdensome. One LC suggested that mentors complete these activity forms quarterly rather than monthly, which would cut down on mentor paperwork and enable her to "actually read" the logs to learn what mentors reported doing with providers. Likewise, LCs tracked progress on several forms (scheduling, mentor monthly Summary Reports, progress reports) and keeping track of the back-and-forth between VECF and raters was time consuming for some LCs. In fact, one LC suggested creating a single tracking sheet that coordinates all the exchanges for Summary Reports and QIPs between the local and state levels. LCs also noted that the more streamlining of documentation and data flow, the more manageable the program would be to administer within allocated resources. Additional specific suggestions made by LCs regarding documentation are presented in Appendix F.

Summary and Recommendations

The family child care demonstration pilot required large volumes of documentation. Many of the document templates, tracking sheets and methods for communicating data appeared to work well for raters, mentors and LCs, although everyone expressed feeling burdened by paperwork. Creating a comprehensive progress monitoring form for LCs and modifying mentor monthly summary reports to more easily obtain necessary information should help LCs "clean" their information and track local VSQI activities. Developing a standard data protection policy will be important for future VSQI administration. Specific recommendations include the following:

- Continue the use of a web-based project communication tool like Scholar™ to help organize files and share information securely.
- *Develop a data security protocol and train personnel to use it.* The current decentralized approach to collecting and storing data means that local field personnel rely on internal agency data protection standards or do not have any. Procedures for securely storing,

sending, and disposing of VSQI information need to be spelled out and personnel trained on them, to guard against data inadvertently or maliciously being seen by unauthorized persons by means of theft or hacking. VSQI administrators could explore the possibility of having all field staff (mentors, LCs but particularly raters) work on and store data on a secure remote server that they log into. That way, no information is stored on local computers or personal laptops, yet is accessible to field staff. Attention would need to be paid to internet access issues in some Virginia locations to determine whether this would work for all regions.

- *Reconfigure mentor reporting and coordinator tracking documents to streamline data entry for easy reporting and automate as much as possible*. Service delivery activities that need to be regularly tracked and reported for program monitoring should be built into a single reporting form designed to capture the information in a timely fashion. Currently, for example, if a mentor offered group training, pilot coordinators often had to add up monthly mentor summary forms and synchronize these with mentor payment invoices in order to track and report mentor hours per provider, since one form addresses hours spent by mentor, and the other hours spent per provider. Building in automated reminder notices and linking mentor to coordinator forms would make timely activity tracking easier and reduce paperwork.

- *Consider purchasing Tablet PCs* that are programmed to record and score FCCERS-R and other ratings to reduce rater burden and keep scoring and transfer errors low.

Stakeholder Satisfaction

Stakeholder experiences related to and satisfaction with the demonstration project offers critical insight into what worked well, what procedures may profit from adjustment, and how sustainable the VSQI may be over time with family child care providers. In this chapter, we address the following questions:

1. What were providers' experiences of the rating and mentoring visits?
2. What were providers' reactions to the Summary Report and QIP?
3. How were stakeholders satisfied and not satisfied with the pilot?

Data to answer these questions came from rater and mentor on-line surveys; individual interviews with raters and LCs; group interviews with mentors; and individual telephone survey interviews with family child care providers. Narrative survey responses and transcripts of interviews were coded for common themes and illustrative quotes selected. (Details on the coding process are reported in the Technical Report). The bulk of the chapter focuses on the provider viewpoint, as expressed during telephone interviews. The last part of the chapter includes the perspective of all stakeholders, which includes raters, mentors, LCs, and VECF administrative staff, as well as family child care providers.

Overall, stakeholders were pleased with the demonstration project and many expressed particular appreciation for the inclusion of family child care in the state's quality improvement efforts for early child care. Most stakeholders indicated that they desire to continue to participate in the initiative (Raters, 92%, Mentors, 81%, and Providers, 74% "very likely," 20% "somewhat likely"). While particular facets of the program were criticized by stakeholders for being rushed, unclear, overly complex or insensitive to the realities of home-based care,, the overriding sentiments were a strong desire to continue the initiative and high enthusiasm for the goals of the program.

1. What were providers' experiences of the rating and mentoring visits?

Providers were extremely satisfied with their mentors and less uniformly pleased with the rating visit. Much of the discomfort with the rating procedure appeared to stem from

providers' lack of clarity regarding what to expect from the visit. For example, one provider commented,

> *I did not know that some of the things that were looked into would be considered…*
>
> *…I felt like I did not have enough time to prepare for it…if more time I would have been more prepared and would not have been surprised.*

Some providers appeared to be uneasy that the raters did not talk to them for long stretches as they observed, and that they had expected them to play or otherwise interact with the children. Some raters reported that providers seemed to equate them with licensing inspectors, which appears supported by provider comments:

> *[I] have had very few things needing to be corrected in [my] years of providing child care.*
>
> *I have had very few write-ups; I was shocked [by the Summary Report].*
>
> *I was surprised because for some of the things I was not rated very well. The standards might be a little too high. Especially compared to the Social Service standards.*

Despite some providers' disquiet, most providers were very (44%) or somewhat (36%) satisfied with the Star Quality rater visit. It is possible that much of the unhappiness of those who expressed considerable dissatisfaction with the rater visit (12%) was based on the results of the visit communicated in the Summary Report, rather than the rating visit itself. Raters reported being warmly welcomed into all but a few homes, and mentors commented that for the most part, providers stated their rater was professional and friendly.

Mentoring was a more uniformly positive experience for the family child care providers. Providers praised their mentors and overwhelmingly felt very satisfied with them (96% were "very satisfied" with their relationship with their mentor). The length, frequency and timing of mentor visits worked well for most providers. Eighty-six percent felt the length of visits was about right, 88 percent were happy with the frequency, and timing of visits was very (88%) or

somewhat (12 %) convenient. Ten percent believed visits were too long, and six percent felt their mentor did not visit enough.

Satisfaction with the mentoring relationship and the coaching process overall ran high:

…[My] mentor will ask [my] opinions and always offers to help [me] do things. [I] am thrilled with the support aspect—it was awesome!

[My] mentor was very professional and she really helped [me] open my eyes to new things and new ways to do things.

She was really good about responding quickly to any calls. She went out of her way to be helpful. She understood the program well and could guide [me] through it.

It's been really good for [my] knowledge and [my] children have benefitted from all the new things, new items and technology.

The mentor is really good at what she does. She calmed [me] down quite a bit. The mentorship helped [me] see what [I] did need to make improvements in some areas.

…[N]o matter what the meeting entails, [her mentor] always leaves by telling [me] something positive. That was very encouraging…and even when [my] mentor asked for [me] to change things she explains why.

Although no respondent reported being dissatisfied overall with her mentoring experience, a few expressed disappointment with what they perceived as a shortened time period or lack of initial clarity regarding how many visits or contacts the provider could expect to have with her mentor. Only one person expressed any real conflict with her mentor relationship, noting that she felt her mentor was "hard to talk to" and more concerned with program goals than with the provider's feelings. Family child care providers expressed deep appreciation for the mentoring component of the pilot, with most stating that this was the best part of the pilot for them.

The biggest [part] is the mentorship and being able to get with someone one-on-one and get help.

It's helpful to interact with adults in the business to give you advice and look at things with fresh eyes. The program has given [me] a new zest for what [I] do.

2. What were providers' reactions to the Summary Report and QIP?

When interviewed, all providers had received a copy of their Summary Report and only two (3.3%) had not yet completed their QIPs. A consistent theme during mentor group interviews was the negative reaction of providers to the Summary Reports. By the time of the provider interviews (May and June 2011), however, the majority of provider respondents reported being generally satisfied with the Summary Reports. Eighty-six percent reported being very or somewhat satisfied with their Summary Reports, while 12 percent were somewhat or very dissatisfied with them. Seventy-two percent agreed that they were surprised by content of the Report. Providers expressed a range of reactions:

I was surprised at how much detail they went into about how I did certain things.

[T]hings that were noted didn't seem correct and it was hard to understand the Summary Report without having someone there to explain it.

[I was surprised]…because of the negativity and the inaccuracies. I know the point is to make improvements but the whole thing was negative.

The rater noted things that she could not possibly have known.

I was really surprised at how low my scores were.

I was surprised I did as well as I did. I thought I couldn't compete with a center but it wasn't like that at all.

It was just a real eye-opener.

[T]here were times when [I] feel like I am on task…with [my] facility. [But after receiving her Report], I see that I wasn't in some places. I wasn't offended and was very happy to get as much feedback as possible.

I was surprised at some of the information and observations that were made that I was not aware of. I thought it was very helpful.

Quality Improvement Plans (QIPs).

Providers were happy with the way they developed their QIPs: 90 percent of interviewed providers were "very satisfied," with the QIP planning process, with the rest being "somewhat satisfied." As noted in the Mentoring chapter, mentors used a variety of strategies

to develop these plans, ranging from the mentor completing the document based entirely on each item from the Summary Report, to the provider and mentor together selecting goals from the Summary Report and/or CLASS ratings, in the context of what the provider herself was most anxious to address. While many mentors focused exclusively on goals they felt could be accomplished within the time frame of the pilot, others deliberately included more ambitious goals that the provider could continue to work on after the demonstration pilot had concluded. Providers themselves stated that they had an average of 11 goals in their QIPs (range, 3 –22) and on average, anticipated meeting nine improvement goals by the end of June (range, 2 – 22).

3. How were stakeholders satisfied and not satisfied with the pilot?

Stakeholders refer to personnel who carried out the pilot—raters, mentors, LCs, and the VECF pilot administrative staff—and the family child care providers. Families utilizing family home child care are a vital constituency who should benefit from the VSQI, but they lie outside of the scope of this evaluation.

Overall satisfaction was high amongst all groups surveyed or interviewed. Particularly exciting for LCs and mentors was observing provider changes in attitudes toward the pilot, reflected in the growing willingness of many to experiment with new methods of working. One LC said,

> *At this point [in the pilot], they are excited; in the beginning, they would have like to have blown me up, but for the most part they are pretty happy.*

Providers also commented on ways they have become more open to the VSQI, to trying new teaching strategies, and starting to better understand concepts like "age appropriate" and developmental concerns. Ninety-three percent believed that participating in the VSQI improved their child care services "a great deal" (58%) or "somewhat" (35%). Most (74%) are "very likely" to want to continue with the program even if it means publishing Star Ratings, and 78 percent are "very likely" to recommend it to other child care providers.

Raters, mentors, LCs, and VECF pilot staff agreed that the rating process for family child care providers needs some adjusting, part of which could involve more cross walking between the different instruments for mentors and LCs who engage with all of them, even if they do not

conduct ratings. More detailed training on the QIP was another common theme, as was the need to amend the process in which providers receive their Summary Reports. Reactions to whether the Toddler CLASS "worked" were more mixed, as reported earlier from mentors. It may be that if a smoother, more gradual preparatory or orientation provider phase were introduced, using it as intended during the pilot—to help mentors become acquainted with providers' practices and to use this information as part of a QIP — may be feasible. However, mentors will need more training to use this tool if reliability is still required.

Another lesson from the pilot that was broadly recognized was that the family child care VSQI was much more challenging to administer in some regions of the state than in others. As described in previous chapters, basic regional or population differences—such as the ability to access the Internet, the overall educational background of providers, providers' fluency with English and their comfort with the rating procedures—indicate that tailored strategies for engagement and perhaps delivery of quality improvement services are necessary, at least in this early stage of VSQI implementation. As the program grows and becomes more widely recognized and accepted, some of the hesitation or suspicion that some LCs, raters and mentors encountered may soften.

Finally, VECF pilot staff played an invaluable role managing, coordinating, and troubleshooting the pilot, according to LCs, who praised their promptness in responding to their questions. Coordinators commented,

> *VECF staff was very helpful and offered a lot of guidance.*
>
> *[The VSQI director] was a great resource.*
>
> *[The pilot manager] was great about getting back when I had a question; she did a good job turning around summary reports quickly and she assisted with revising reports but never changed the intent of the content.*

Summary

Toward the conclusion of the family child care demonstration pilot, it appears that all stakeholder groups left it with largely positive perceptions and most wanted to continue their

involvement. Despite glitches that provided important "lessons learned," the pilot offered many indications of planting an important seed in Virginia's family child care community. Hurdles related to the compressed pilot time frame will presumably not be relevant in future renditions, but they serve to highlight the competency of the VECF and local personnel in administering and carrying out a very complex, ambitious undertaking. That providers became so enthusiastic about their mentoring is an extremely positive indicator for future sustainability, given sufficient resources to compensate and retain qualified staff. Recommendations for the future family child care VSQI are presented in the next and final chapter.

Conclusions and Recommendations

The pilot demonstrated that with sufficient resources, Virginia currently has the capacity to execute and manage a complex quality improvement system for family child care providers. Despite impressive constraints, most notably the accelerated timetable, 75 home-based providers received written feedback from well-trained raters on their child care and business practices, and for all but one, an incremental, goal-oriented plan for improvement. Mentors formed supportive and helpful relationships with providers and helped them address goals that were tailored to raise quality. Providers received materials that supported these goals, and some providers enrolled in formal education programs and began forming networks with other family child care providers.

Pilot personnel—raters, mentors, LCs and VECF staff—appeared well qualified for their roles. Most had educational specialization in a related field and extensive relevant experience; they also received intensive training as part of the pilot. Family child care providers expressed tremendous appreciation for their mentors as well as other facets of the program. Despite challenges, a large majority of raters, mentors, and providers expressed enthusiasm for the program and want to continue with it. Overall, despite some glitches, the pilot demonstration appeared to be reasonably well-implemented and to set the stage for future system development, both by showing that with sufficient resources it is feasible to execute and can be well received by family child care providers; and by highlighting ways to amend the program to address specific challenges encountered during the demonstration pilot.

Many important "lessons learned" emerged from the multi-method process evaluation that frame our recommendations for future implementation. Key recommendations related to recruitment, training, rating, mentoring, and data management are described in detail below; other recommendations are presented in the relevant chapters. We conclude the Report by reminding the reader what this evaluation was able to accomplish and how its limitations may temper some of the conclusions.

To maintain an efficient and long-term quality improvement system, stakeholders must trust that the process is fair and well-delivered and that the results are worth the investments expended. Findings from the process evaluation indicate that several changes to the rating procedures are indicated to uphold high quality service delivery and to address the perceived fairness of the system. The suggested changes are as follows:

Institute a formal provider orientation phase as the first step into the Star Quality system. Pilot personnel in every region made this recommendation, and evaluation findings regarding important misunderstandings regarding what to expect from the rating visit and the Summary Report adds weight to this suggestion. Local pilot staff suggestions included offering a four-to-five session class that teaches providers the BAS and the fundamentals of both the FCCERS-R and CLASS, as well as why these tools were chosen to measure child care quality; providing a preparatory mentoring component that would help establish a relationship between a provider and mentor prior to rating; and offering tools to providers that would help them conduct preliminary self-assessments prior to rating. The degree to which providers differed in their familiarity with family child care quality improvement programs, their comfort with having observers in the home, and their facility with English suggests that a flexible suite of orientation options might be the best alternative to address specific provider needs.

An orientation *phase*—as opposed to a single meeting—to the VSQI should assist both program staff and providers to more accurately gauge providers' readiness for this level of intensive professional development, helping to offset attrition and saving money. This more thorough orientation, with a review of the rating tools and procedures and how they are linked to both QIPs and Star Ratings, should also address some of providers' initial concerns regarding the perceived accuracy of their ratings. Even if providers decide not to formally enroll in the VSQI, the orientation phase itself can constitute low-level professional development and plant a seed for later participation or "spreading the word" to friends and colleagues.

As part of an introductory preparatory period, consider offering an informal rating or self-assessment phase prior to conducting official ratings that will be published. Some aspects of the home-based child care environment and business practices can be readily adjusted by

providers without extensive guidance from a specialist, if they are given the right tools and reasonable justifications for doing so. Learning how to examine their environment and child care practice prior to an unfamiliar professional doing so could go a long way toward home-based providers trusting and engaging with the VSQI system, resulting in better retention rates and more targeted use of mentors' expertise. Initial improvements may also accelerate positive changes for the children in care and their parents. While it is inadvisable, as well as financially unrealistic, to train providers how to score themselves on actual standardized tools (such as the FCCERS-R), self-assessment forms could be developed that convey the content of items with rationales for why they are important. This is particularly true for specific procedural practices, such as health and safety items, as well as some environmental and business items. If adopted, this phase would need to be very carefully thought through to maximize payoff and minimize providers opting out of the mentoring phase altogether, or falling prey to making surface-level changes without understanding why the changes are recommended.

Alternatively, initial ratings could be conducted for feedback and accountability purposes that are not publicly linked to a family child care home. In this model, providers would complete an orientation phase, undergo formal rating and receive a Summary Report (modified, as described below) and then commence mentoring. At this stage, a provider could display a certificate or official symbol recognizing her membership in the Virginia Star Quality Initiative, without a formal Star rating. At a prescribed period following a mentoring phase, she could receive an official Star for publication. The unpublished rating could be used by VSQI administration to track baselines and progress related to mentoring, reporting aggregate data to funders and other stakeholders.

Provide additional training on and guidance for developing the QIPs. Across and within the pilot localities, mentors and LCs had different understandings of how many and what types of goals should be set in the pilot QIPs, and hence, how many goals might actually be met within a given time frame. Guidance from VSQI administrators is necessary to ensure that the QIP is and remains a viable blueprint for providers and a manageable tool for mentors. While complete

standardization may not be optimal at this stage, some general expectation of the number of goals per mentoring phase, the types of goals, and how it can lead to progress in Star levels is needed.

Establish a reliable system for assessing rater fidelity to observation visit protocol, including maintenance of rating reliability. Assuring stakeholders and the public of the integrity of the Star Rating system is critical for a sustainable Virginia quality improvement system. Not only must raters be well-trained and certified as reliable on assessment instruments, they must also demonstrate that they are upholding these standards over time through regular checks. Paying the "buddy" rater at least half of the full rater fee for inter-rater reliability visits and requiring administrators rather than raters to schedule the necessary checks are first steps toward ensuring that inter-rater reliability tests occur in a timely manner. Particularly when a rater is new, an early check is critical to ensure she is correctly administering the rater tasks, but ongoing and regular inter-rater monitoring is critical for all raters.

Other factors may be more difficult to control without a cadre of state-administered VSQI professionals. To stay reliable, raters typically need to conduct a moderate to high volume of observations at regular intervals, which may not be feasible in rural areas if a rater is exclusively local. If a rater is the only one within a region, she also has no one close by to conduct inter-rater reliability visits with, as was the case in the pilot. Both of these constraints would be alleviated with a state-administered rater system in which raters remain local to an area but occasionally travel to boost rating volume or to check themselves against a master rater. A unified system would also help maintain high quality: raters would conduct sufficient ratings that they keep "limber," inter-rater reliability visits would be more readily built into rating schedules, and using master raters to address dips in inter-rater reliability in a timely fashion would be more feasible than in a locally-administered system.

Modify the Summary Report to reflect positive aspects of providers' child care as well as the challenges. The biggest hurdle during the demonstration project lay in providers' reactions to the Summary Report. Although later in the pilot many providers judged it to be helpful, across all localities mentors reported expending considerable time, resources, and effort to allay

provider concerns, soothe distressed feelings, and prevent participants from quitting the pilot. Given the uproar created by the Reports as described in interviews with mentors and LCs, it is a testimony to the skill of the pilot mentors, LCs and VECF pilot staff that no provider formally withdrew based on the Report. However, this tension can be reduced if not alleviated by reformulating the Report to include positive comments and encouragement and better preparing providers for what to expect.

Provide support and interpretation for providers upon receipt of the Summary Report. Even with positive comments, the amount of detail in the Summary Report may be confusing and overwhelming to a provider. Consider introducing the mentor relationship prior to receipt of the Report—or even before the rating visit, as part of the orientation phase—in which case the mentor could review the Report with the provider and help her interpret it.

Reach out to train more bilingual mentors. Family child care is the preferred parental choice for many populations, and 26 percent of the 75 pilot providers spoke a primary language other than English. In order to adequately help these providers improve their business, mentors at least need to be able to communicate well with them. Using monolingual English-speaking mentors with providers who are not fluent in English is an inefficient use of mentor resources. At a minimum, more bilingual Spanish-speakers are needed.

Develop a data security protocol and train personnel to use it. The current decentralized approach to collecting and storing data means that personnel rely on internal agency data protection standards or do not have any. Procedures for securely storing, sending, and disposing of VSQI information need to be developed and personnel trained on them to guard against the data inadvertently or maliciously being seen by unauthorized persons. VSQI administrators could explore the possibility of having all field staff—mentors, LCs, but particularly raters—work on and store data on a secure remote server that they log into. That way, no information is stored on local computers or personal laptops, yet it is accessible to field staff. Attention would need to be paid to internet access issues in some Virginia locations to determine whether this would work for all regions.

Additional considerations to be explored

Several issues were raised during the process evaluation that were beyond the scope of this study but are important to explore further. They include learning more about specific cultural barriers to engaging in or profiting most from the VSQI; conducting further analyses of mentor activities and determining how and to what extent QIP goals that are met correspond to changes in Star Quality ratings; and conducting a cost/benefit analysis of establishing a state-level employee system for rating and perhaps mentoring as well.

Significant differences between providers of different cultures exist and need to be better understood in order to most effectively expand the VSQI into areas of high need. Providers reacted differently to quality improvement outreach in different areas of the Commonwealth. For example, in some localities family child care providers have friendly relationships with their licensing or permitting inspectors. In fact, at least nine credited their enrollment to encouragement from their local early childhood specialist. Providers in other regions may view licensing more as a threat than an ally. Similarly, attitudes providers hold toward state versus local authority, how comfortable they are allowing strangers into their homes, and the degree to which women manage financial affairs are examples of cultural factors that may impact important components of a successful VSQI. For instance, how willing a provider is to engage with the VSQI, whether networking early on might succeed or be alienating, whether a provider will allow raters or mentors into her home, whether parents will think well or ill of provider involvement, what kinds of assistance she may need or be looking for, how likely it is she will continue once enrolled, whether financial aspects of the business are relevant for the provider may have cultural as well as personal underpinnings. Engaging selected providers from different regions across the state as "cultural informants" to help VECF explore these differences may help VSQI developers devise different strategies to effectively engage different provider constituencies.

Conduct additional in-house or formal study of the mentoring component to better understand factors that support measurable quality improvement. Learning more about the mentoring component will inform future resource allotment and planning. Individually-tailored

and delivered mentoring is the key "intervention" used in the pilot (and in Virginia's current quality improvement system overall), but pilot timing precluded full exploration of this central piece in the current evaluation. In particular, not all mentors appeared to have had time to deliver the anticipated 30 hours of quality improvement service to providers, and re-ratings were not conducted to measure change. Critical questions, such as the degree to which QIP goals that are met successfully move a provider along the Star Standard continuum, whether some goals provide more Star-rising power than others, how long it takes for goals to be met, and whether specific mentoring techniques or activities are associated with more or faster change than others all need to be examined to maximize resource efficiency and eventual outcomes. Of particular interest is how mentor concentration on provider-child interactions, which research suggests is most pivotal to children's outcomes and was of central concern to mentors, reveals itself in Star levels for family child care providers. Interactions play only a relatively small part of the overall FCCERS-R score, which constitutes the primary basis for Standard 2 (*Environment and Interactions*). Taking a more in-depth look at what mentors do and the relation between mentoring activities, QIP goals, how often mentors meet with providers, and provider progress along the Star Quality continuum will be important future steps in continuing to evaluate home-based VSQI.

Consider not publishing family child care ratings for a longer early system development period. Given that the family child care home VSQI is still very new, that the Standards have been revised in the wake of the pilot, and that family child care providers may be hesitant to engage in the VSQI, a prudent course would be to retain ratings as internal data to further evaluate the system rather than publishing them at this stage in VSQI development. Much is still not known, and publishing ratings may add unnecessary complexity to an already complicated enterprise.

Conduct a cost/benefit analysis of the possibility of a state-administered network of early childhood professionals to rate, mentor, and provide professional development training. Both to address concerns raised above regarding ongoing rater reliability and to ensure the integrity of the mentoring component of the VSQI, raters and mentors must have the time and be

adequately compensated and supervised to consistently deliver high quality professional development services. While some pilot raters and mentors were employees of local agencies, with their pilot work covered by the agency, others worked on contract, sometimes in addition to full-time jobs. For key personnel to rate and mentor as a second job means they may not always have the requisite time, energy, or scheduling flexibility to conduct on-site visits convenient for providers and complete timely documentation. In short, it is not a sustainable arrangement. Clearly this model represents a fundamental commitment at the state level to child care quality improvement that will require substantial resources. A cost/benefit study would help determine what those costs might be compared to the current locally-coordinated, contract approach.

Strengths and limitations of the pilot evaluation

The evaluation was comprehensive, exploring central aspects of the proposed home-based Star Quality Standards and covering six key components of the family child care demonstration pilot judged to be informative for future VSQI planning. Gathering information from each important group of pilot players—providers, raters, mentors, LCs and VECF staff—enabled a rich descriptive picture to be drawn of what happened (or did not happen). Other methodological strengths include the use of both qualitative and quantitative data, and interviewing a group of providers who made an active choice not to participate in the family child care pilot to better understand potential barriers to engagement.

Two important limitations of the study should be noted. Only two-thirds of participating providers completed the telephone interview, and it may be that providers who did not finish it or who were not interviewed were less enthusiastic about the program than those who undertook the entire interview. Although only one participating provider refused the interview while the rest could not be reached despite numerous attempts, and while mentors and LCs reported that most of their providers appeared to be actively engaged, the reactions of the providers who did not record their opinions is unknown. Secondly, due to lags in receipt of monthly mentor summary reports, analysis of mentoring activities was not possible. Future

analyses that examine activities in relation to provider gains, not possible in this study, will be particularly informative.

Final Reflections

This report describes Virginia's family child care QRIS at its initial stage of design and implementation. Several consultations regarding the VSQI took place concomitantly, of which this report represents a part. As a result of funding deadlines and other evaluations completed earlier, changes to Virginia's VSQI have already been made by the submission of this report. We encourage VSQI administrators and stakeholders to continue to view the system as in its early stages of development and to continue to monitor and evaluate its implementation as it develops. Findings from the pilot suggest that Virginia family child care providers are receptive to and enthusiastic about this professional development opportunity, and that in years to come, the VSQI may have a potent impact on raising home-based childcare quality for the benefit of children and their families.

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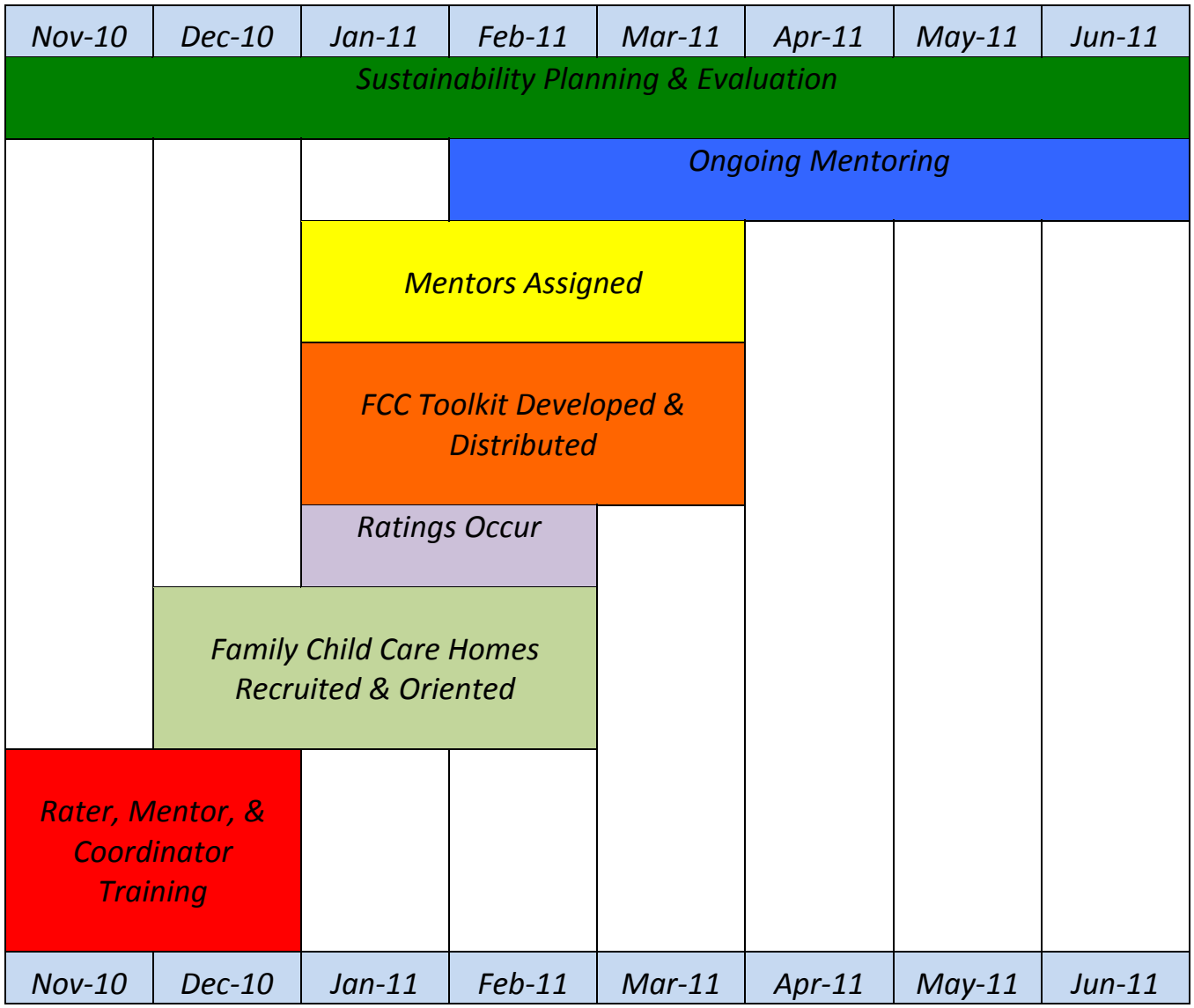
Appendix A
Evaluation Summary

Family Child Care Demonstration Pilot
Process Overview



Evaluation Summary Tables
Standards

Research Questions, Indicators, and Measurement Tools to Evaluate Virginia's Star Standards for Home-Based Child Care

Research Questions	Indicators	Measurement tools
Do the standards reflect quality improvement identified in the research literature as predictive of positive child outcomes?	Descriptions of QRIS standards	1. Review of VSQI internal documents related to the center pilot, decision-making around standards, and other relevant documents; 2. Review of literature; 3. Focus groups with QRIS experts; LC Standards Group Interview
Are the standards clear, comprehensible and closely tied to verifiable data?	1. QRIS implementers agree on the meaning of the standards; 2. Family providers state they understand the standards and express little confusion with them. 3. Standards are measured by data that can be checked and replicated.	1. Survey or groups interviews with raters, mentors, trainers, VA QRIS developers, and local site coordinators; 2. Interview with family child care providers 3. Record review of VA's VSQI standards & measurement tools
Are the standards reasonable for family providers?	1. Family providers earn a range of standard levels, including high levels across all standards. 2. VSQI implementers agree that family child care providers can reach high Star levels. 3. Knowledgeable VSQI implementers believe the Standards are valid for their populations	1. Analysis of pilot family ratings. 2&3. Rater and mentor field surveys; Mentor Group Interview 3. LC Standards Stakeholder Interview

Evaluation Summary Tables
Process Evaluation

Pilot Activity	*Procedures*	*Research Questions*	*Indicators*	*Data Sources*
Engagement Recruiting family home providers and engaging them in the VSQI home-based child care demonstration project.	• Develop a chart for tracking recruitment for LCs to complete. • Interviews with implementers and providers will be conducted in person or by telephone. • Provider interviews will be administered and statistically analyzed by the VT Survey Center. Open-ended Qs will be content-analyzed by evaluation team.	1. How did LCs recruit home-based child care providers? 2. How successful was recruitment? 3. How many home-based child care providers left the pilot study prior to program completion? 4. What motivates providers to participate or not?	1. Description of recruitment. 2. Required number enrolled; reflections on recruitment process. 3. The number and percentage of providers who did and did not complete the pilot. 4. Interview themes.	1. Local coordinator recruitment chart. 2. Reflections in *LC Field Process Interview.* 3. LC records, provider interview. 4. Semi-structured telephone interviews with pilot family providers and a small sample of providers who chose not to participate.
Training Training raters, mentors and other key personnel on VSQI home-based demonstration	• Develop and distribute training fidelity surveys to participants • Analyze inter-rater reliability documentation provided by VECF	1. What was the rater and mentor training procedure for the Pilot? 2. How much did training follow prescribed	1. Description of the training procedures. 2. Training followed protocol with 90%	1. Review of pilot VSQI documents related to training raters, mentors, local coordinators; 2. Participant training surveys.

Pilot Activity	*Procedures*	*Research Questions*	*Indicators*	*Data Sources*
procedures	• Download documents from Scholar and compare Summary Report scoring to rater field rating sheets.	procedures? 3. How reliable were raters with each other? 4. How reliably did raters score the FCCERS-R ?	accuracy. 3. Raters achieve 85% agreement on observation measures 4. Raters are 90% accurate in their scoring on both measures.	 3. Simultaneous ratings made by two raters on the same family child care providers 4. Scoring Calculator scoring and external scoring by VECF from rating forms.
Ratings and Data Gathering	Raters will be asked to complete a very short log after each solo rating visit that documents time spent on each activity and estimation of global protocol adherence that LCs will collect and upload to Scholar. VECF will upload scanned rating sheets to Scholar.	1. What is the procedure for on-site visits? 2. How reliably were procedures followed by raters? 3. What were they challenges encountered?	1. Description of the on-site procedures. 2. On-site visits generally followed protocol. 3. Description of challenges raters presented	1. Pilot Rater Guidelines document. 2. Rater Visit Log; FCCERS face sheet; LC Process Interview. 3. Rater Field Survey, Rater Follow-up Telephone Interview; LC Process Interview

Pilot Activity	*Procedures*	*Research Questions*	*Indicators*	*Data Sources*
Mentoring Matching mentors to providers and otherwise executing the mentoring (QI) component	• LCs will be asked to participate in a one hour process interview at their location. Questions will be sent ahead to facilitate discussion. • All documents will be uploaded by LCs or VECF to Scholar where they can be assessed by the evaluation team.	1. How are mentors matched with FCCHPs? 2. Is matching process related to quality improvements?[2] 3. What is the curriculum, approach or coaching procedure used by mentors? 4. How often did mentors meet with providers? 5. How successful were mentors? What were challenges mentors experienced?	1. Description of matching process 2. Associations between matching and QI ($p < .05$)[2] 3. Description of mentor activities and degree used 4. Percentage of time coaching to time expected to coach 5. Rating changes [2] and mentor reflections.	1. VSQI Pilot documents and surveys with local coordinators. 2. Pilot documents linked quantitatively to changes in environmental ratings.[2] 3. Pilot documents; mentor records. 4. Mentor monthly summary reports. 5. Pilot pre- and post ratings[1] and focus groups with mentors.

[2]. Research questions using pre- and post-ratings were originally proposed, but post-mentor ratings were not conducted as part of the demonstration pilot. These questions could thus not be addressed or addressed using the methods outlined here.

Pilot Activity	*Procedures*	*Research Questions*	*Indicators*	*Data Sources*
Data Coordination and Management Collecting, transferring, storing, protecting, managing and checking the reliability of data.	• Review data procedures for communication and coordinated between field staff, LCs and VECF staff; and for protecting and cleaning data. • Conduct executive interviews with LCs, referring to specific tracking/communication tools such as the Rater Scheduling chart and Scholar. • Mentor Monthly Reports will be content-analyzed for time spent on documentation.	1. How are data communicated to and from field staff to local to VECF staff? 2. What are the data protection and cleaning procedures? 3. How well do the procedures work? 4. How much rater, mentor and staff time is spent on data recording/entry?	1 & 2. Procedure and protocol descriptions. 3. Data managers are satisfied with the efficiency and security of data management. 4. Number of hours of staff time spent on data entry and documentation.	1 & 2. Pilot documentation; LC Field Process Interview; discussion with VECF staff. 3. LC Field Process Interview; discussion with VECF staff. 4. Rater Visit Logs; Mentor Monthly Reports; Mentor reimbursement records; [2] discussion with VECF staff.
Stakeholder Communication and Satisfaction Communicating results of on-site ratings, Quality Improvement Plan (QIP), and the Star Standards to	• Administer surveys and follow up with interviews with implementers for elaboration and detail. • Include several open-ended Qs in provider interview to better capture their experience. • Triangulate responses to	1. What were providers' experiences of the rating and mentoring visits? 2. What were providers' reactions to the Summary Report and QIP? 3. How were stakeholders	1. Providers are more satisfied than not with rating and mentoring visits. 2. Description of providers' responses to the Pilot QIP products. 3. Stakeholders'	1. Family Child Care Home Provider Interview; Rater Field Survey; Mentor Group Interview. 2. Family Child Care Home Provider Interview 3. LC Process Interview;

[2] Mentor reimbursement records were not provided so were not used in the final evaluation analyses.

Pilot Activity	*Procedures*	*Research Questions*	*Indicators*	*Data Sources*
providers; provider and implementer satisfaction with procedures and the Pilot	key Pilot components between implementers by comparing across groups.	satisfied and not satisfied with the Pilot?	satisfaction with the pilot process and their suggestions for improvements	Rater Field Survey; Mentor Field Survey and Group Interview.

Appendix B

Star Quality Home-Based Standards

A Quality Rating and Improvement System

VIRGINIA STAR QUALITY INITIATIVE

PERFORMANCE STANDARDS

Standard 1: Education, Qualifications, and Training (assessed by documentation)

Standard 2: Environment and Interactions (assessed by observation)

Standard 3: Structure (assessed by observation)

Standard 4: Program Management (assessed by observation and documentation)

- In order to achieve Star Level 1 or higher, participating programs must be in good standing with all requirements of the regulating authority (e.g. Virginia Department of Social Services Standards for Licensed Family Day Homes, Local Ordinance, or licensed Family Day System) including, but not limited to, those set forth in this document. In good standing indicates that while there may be noncompliance with one or more standards that represent a minor or minimal risk or violation, compliance clearly and obviously exists with the standards as a whole.
- The regulating authority establishes the foundation for operating, and programs that meet those requirements are recognized as Star Level 1 in the Virginia Star Quality Initiative. The higher Star Levels recognize programs for exceeding basic standards and implementing practices that research shows are best for children.
- In all standard areas, if minimum requirements of the regulating authority are more stringent than those set forth by the Virginia Star Quality Initiative (VSQI), those set forth by the regulating authority supersede the VSQI requirements.

STANDARD 1: EDUCATION, QUALIFICATIONS AND TRAINING (Assessed by documentation)						
Part 1: Staff Education and Qualifications						
	Rising Star	**1**	**2**	**3**	**4**	**5**
		★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★★☆	★★★★★
Teacher[3] (Family Child Care Provider) Qualifications	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• Child Development Associate or equivalent 120-clock-hour child development credential OR • Community college certificate in child-related[4] field with a minimum of 12 total credit hours OR • A.A., B.S./B.A. degree or higher with 12 total child-related[2] credits	• One-year community college certificate in child-related[2] field with a minimum of 30 total credit hours OR • A.A, B.S./B.A. degree or higher in field with a minimum of 30 total child-related[2] credits	• Associate degree or higher in child-related[2] field	• B.S./B.A. degree or higher in child-related[2] field

STANDARD 1: EDUCATION, QUALIFICATIONS AND TRAINING (Assessed by documentation)						
Part 1: Staff Education and Qualifications (continued)						
	Rising Star	**1**	**2**	**3**	**4**	**5**
		★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★★☆	★★★★★

[3] A "Teacher" is defined as an adult having the primary responsibility for the direct supervision of children and for the delivery of the curriculum and instruction through the activities and services for this group of children.

[4] Child-related fields include, but are not limited to, early childhood education, elementary education, early childhood special education, child or early childhood development, human development, child care, or a Baccalaureate degree in any discipline with at least 30 credit hours in those four areas.

Assistant Teacher[5] Qualifications	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• Minimum High School Program Completion • 20 clock hours or more of approved[6] training	• Minimum High School Program Completion • 48 clock hours or more of approved[4] training	• Child Development Associate or equivalent 120-clock-hour child development credential OR • Community college certificate in child-related[2] field with a minimum of 12 total credit hours	• One-year community college certificate in child-related[2] field w/minimum of 30 total credit hrs OR • Associate degree or higher in child-related[2] field
Substitute Teacher [7] Qualifications	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• Minimum High School Program Completion • Current CPR & First Aid Certification, appropriate for ages of children in care	• Minimum High School Program Completion • Current CPR & First Aid Certification, appropriate for ages of children in care • 4 clock hours of approved training[4] above current VDSS licensing standards, including training related to at least one of the following areas: child development, behavior management, curriculum, health & safety, nutrition, and regulatory requirements	• Minimum High School Program Completion • Current CPR & First Aid Certification, appropriate for ages of children in care • 8 clock hours of approved training[4] above current VDSS licensing standards, including training related to at least one of the following areas: child development, behavior management, curriculum, health & safety, nutrition, and regulatory requirements	• Minimum High School Program Completion • Current CPR & First Aid Certification, appropriate for ages of children in care • 12 clock hours of approved training[4] above current VDSS licensing standards, including training related to at least one of the following areas: child development, behavior management, curriculum, health & safety, nutrition, and regulatory requirements

[5] An "Assistant Teacher" is defined as an individual who works under the direct supervision of a teacher by assisting in the supervision of the same group of children and the implementation of activities and services for these children.

[6] Approved training is child-related training provided by an individual or by an organization with expertise in preparation of early childhood professionals. The training should have written goals and objectives, and the facilitator should assess the student's competence, document the student's mastery, and be considered a valid training option by the appropriate regulating entity.

[7] A "Substitute Teacher" is defined as an adult who meets the qualifications of a provider, is designated by the provider and approved by the regulating authority, and who provides care, protection, supervision, and guidance in the family home when the provider is unable or unavailable to provide direct care. A substitute can work no more than 240 hours over 12 months.

Part 2: Ongoing Training/Professional Development[8]						
	Rising Star	**1**	**2**	**3**	**4**	**5**
		★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★★☆	★★★★★
All Staff (Teachers and Assistant Teachers) Professional Development	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	All staff members have: • 20 annual clock hours of approved[4] training[9] • Current CPR & First Aid Certification appropriate for ages of children in care At least one staff member is: • Member of an Early Childhood Professional Association OR • Working with a Mentor	All staff members have: • 24 annual clock hours of approved[4] training[7] • Current CPR & First Aid Certification appropriate for ages of children in care At least one staff member is: • Member of an Early Childhood Professional Association OR • Serving as a Mentor, Trainer or College Instructor OR • Author of an article, narrative or report published in a journal or other scholarly publication	All staff members have: • 28 annual clock hours of approved[4] training[7] • Current CPR & First Aid Certification appropriate for ages of children in care At least one staff member is: • Member of an Early Childhood Professional Association OR • Serving as a Mentor, Trainer or College Instructor OR • Author of an article, narrative or report published in a journal or other scholarly publication	All staff members have: • 32 annual clock hours of approved[4] training[7] • Current CPR & First Aid Certification appropriate for ages of children in care care At least one staff member is: • Member of an Early Childhood Professional Association OR • Serving as a Mentor, Trainer or College Instructor OR • Author of an article, narrative or report published in a journal or other scholarly publication

[8] All staff hired within the last 12 months is not required to submit documentation related to Standard 1, Part 2, with the exception of documentation verifying new staff orientation training. However, documentation to verify the start date of employment for these staff will be required.

[9] Approved training topics include, but are not limited to: child development, behavior management and discipline techniques, child observation, developmentally-appropriate curriculum, inclusive practices, family involvement and communication, health and safety (including medication administration, injury prevention, immunization requirements, daily health observation, and compliance with OSHA blood borne pathogens regulations), recognizing and preventing the spread of communicable diseases, nutrition, and child abuse detection and prevention.

STANDARD 2: ENVIRONMENT AND INTERACTIONS (Assessed by observation)						
	Rising Star	**1**	**2**	**3**	**4**	**5**
	☆☆☆☆☆	★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★★☆	★★★★★
Overall Family Child Care Environment **Rating Scale-Revised** **(FCCERS-R)** Space & Furnishings; Personal Care Routines; Listening & Talking; Activities; Interaction; Program Structure; Parents & Provider	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• Average FCCERS-R score of 3.00-3.49 • No FCCERS-R subscale below a 2	• Average FCCERS-R score of 3.50-3.99 • No FCCERS-R subscale below a 2	• Average FCCERS-R score of 4.00-4.99 • No FCCERS-R subscale below a 3	• Average FCCERS-R score of 5.00 or better • No FCCERS-R subscale below a 3
Classroom Assessment Scoring System (CLASS) Emotional Support; Classroom Organization; Instructional Support	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• Agree to allow a CLASS observation and incorporate the results into a Quality Improvement Plan that is completed after the initial rating (CLASS data will be collected, but not used in the rating process)	• Agree to allow a CLASS observation and incorporate the results into a Quality Improvement Plan that is completed after the initial rating (CLASS data will be collected, but not used in the rating process)	• Agree to allow a CLASS observation and incorporate the results into a Quality Improvement Plan that is completed after the initial rating (CLASS data will be collected, but not used in the rating process)	• Agree to allow a CLASS observation and incorporate the results into a Quality Improvement Plan that is completed after the initial rating (CLASS data will be collected, but not used in the rating process)

STANDARD 3: STRUCTURE (Assessed by observation)						
	Rising Star	**1**	**2**	**3**	**4**	**5**
	☆☆☆☆☆	★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★★☆	★★★★★
Staff to Child Ratio **And Group Size**	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• 1 staff:16 points[10] For each staff member: • No more than 4 children 0-15 months • No more than 5 children 16-23 months • No more than 6 children 2-years-old No more than 8 children 3- and 4-years-old	• 1 staff:14 points[8] For each staff member: • No more than 3 children 0-15 months • No more than 4 children 16-23 months • No more than 6 children 2-years-old • No more than 7 children 3- and 4-years-old	• 1 staff: 12 points[8] For each staff member: • No more than 3 children 0-15 months • No more than 4 children 16-23 months • No more than 5 children 2-years-old • No more than 6 children 3- and 4-years-old	• 1 staff:12 points[8] For each staff member: • No more than 3 children 0-15 months • No more than 4 children 16-23 months • No more than 4 children 2-years-old • No more than 6 children 3- and 4-years-old
STANDARD 4: PROGRAM MANAGEMENT (Assessed by observation and documentation)						
	Rising Star	**1**	**2**	**3**	**4**	**5**

[10] Points are calculated using the following method (if under the age of 8, include the provider's own children and resident children): children birth to 15 months = 4 points; 16 – 23 months = 3 points; 2 – 4-year-olds = 2 points; 5 – 9 year-olds = 1 point; 10-year-olds and older = O points.

	☆☆☆☆☆	★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★★☆	★★★★★
Overall Business Administration Scale (BAS) Qualifications & Professional Development; Income & Benefits; Work Environment; Fiscal Management; Recordkeeping; Risk Management; Provider-Parent Communication; Community Resources; Marketing & Public Relations; Provider as Employer	Working to comply with the requirements of the appropriate regulating authority (e.g., VDSS Licensing, Local Ordinance, Family Child Care System) OR Voluntary Registered Family Day Home	In good standing with requirements of the appropriate regulating authority (e.g., VDSS Licensing Standards, Local Ordinance, Family Child Care System)	• Average BAS score of 3.00-3.49 • No BAS item below a 2	• Average BAS score of 3.50-3.99 • No BAS item below a 2	• Average BAS score of 4.00-4.99 • No BAS item below a 3	• Average BAS score of 5.00 or better • No BAS item below a 3

Rationale for Inclusion of Toddler CLASS in the Virginia Star Quality Rating Family Child Care Home Demonstration Pilot

Research Basis for Including Interactions and Selecting an Optional CLASS Assessment

The specific qualities of interactions are the mechanism through which curriculum and environmental quality are translated into learning results. Because research shows strong correlation between the quality of interactions and child outcomes for academic development, in addition to social, emotional, and motivational development, interactions are recognized by the classroom-based standard and have the greatest weight in determining a program rating in the classroom-based VSQI standard.

Unfortunately, the home-based development team was unable to recommend a particular assessment of provider and child interactions that was appropriate, reliable, and valid for use in family child care settings. The CLASS tools, while appropriate for the ages of children in care in family day homes, have been tested in center-based settings only. In discussions with the CLASS developers at UVA, there is some belief that the instrument could translate into family child care settings, but research would need to be conducted to determine the kinds of revisions needed to adapt the tool for family child care settings. For this reason, the CLASS instrument is encouraged as part of the pilot in family day homes, but the scores from the assessment will neither benefit nor penalize a program's overall Star Rating.

Although CLASS scores themselves are not factored into the FCCH rating, the scale does consider whether or not the provider agreed to have a CLASS assessment conducted. This is considered a demonstration of commitment to the quality improvement process, and the results of the assessment will inform the mentorship process. Because FCCERS-R scores and CLASS participation are averaged across Standard 2, a numerical value must be assigned to signify whether the provider agreed to participate in the CLASS assessment. The following method was selected so that providers who declined the CLASS assessment would not receive credit, and providers who agreed to the assessment would not be penalized in their overall Standard 2 score.

If providers decline to have the CLASS assessment, a score of 1 is entered. If providers agree to the assessment, a score of 2, 3, 4, or 5 is entered:

- If FCCERS score is 1, enter a 2 for Toddler CLASS agreement (this will give a boost to providers whose ERS scores were low)
- If FCCERS score is 2, 3, 4, or 5, enter the same value for Toddler CLASS agreement (this will maintain the ERS score when the values are averaged)

Virginia Early Childhood Foundation (VECF) (2011). *Standards for Family Child Care Homes.* Available at the VECF website, http://www.smartbeginnings.org/Portals/5/PDFs/VSQI/FCC_QRIS_Standards.pdf.

Virginia Star Quality Standards Survey: Expert Panel Responses

N=7		Percent
First, are there any standards or levels of the standards for home-based care that you are confused about or would like additional clarification regarding?		
	Yes	57%
	No	43%
	Not sure	0%
	Total	100%
Are any of the four standards not critical or important to quality in home-based child care, in your view?		
	Yes	0%
	No	100%
	Not sure	0%
	Total	100%
Now we will go through each Star standard for your views on their indicators (strands) and how the levels are structured. The first standard concerns provider and assistant Education, Qualifications and Training, including professional development. Do you agree that each strand of the first standard is necessary or important for indicating quality in family child care businesses?		
	Yes	71%
	No	14%
	Not sure	14%
	Total	100%
Does each Star Quality level for this standard reflect that degree of quality, in your view?		
	Yes	57%
	No	14%
	Not sure	29%
	Total	100%
The second standard is Environment and Interactions. Do you agree that each strand of the second standard is necessary or important?		
	Yes	100%
	No	0%
	Not sure	0%
	Total	100%
Does each Star Quality level for this second standard reflect that degree of quality, in your view?		

	Yes	57%
	No	0%
	Not sure	43%
	Total	100%
The third standard is Structure, which means group size and adult-to-child ratios. Do you agree that this standard is necessary or important?		
	Yes	86%
	No	0%
	Not sure	0%
	No answer	14%
	Total	100%
The fourth standard is Program Management. Do you agree that each strand of the fourth standard is necessary or important?		
	Yes	71%
	No	0%
	Not sure	14%
	No answer	14%
	Total	100%
Does each Star Quality level for the fourth standard reflect that degree of quality, in your view?		
	Yes	57%
	No	0%
	Not sure	43%
	Total	100%
Should any of these four standards count more toward an overall Star level than others?		
	Yes	43%
	No	14%
	Not sure	43%
	Total	100%
Do the standards capture the important aspects of quality for home-based providers - that is, is there anything critical that is missing?		
	Yes	71%
	No	29%
	Not sure	0%
	Total	100%

How satisfied are you with how the standards are measured?		
	Very satisfied	29%
	Satisfied	29%
	Neutral	29%
	Dissatisfied	0%
	Very dissatisfied	0%
	No answer	14%
	Total	100%
Are the standards fair to and reasonable for home-based providers?		
	Yes	14%
	No	0%
	Not sure	86%
	Total	100%
Are the standards informative to parents who use family care?		
	Yes	14%
	No	29%
	Not sure	43%
	No answer	14%
	Total	100%
Do the Star Quality standards, including their measurement, adequately facilitate or lend themselves to mentors or child care coaches developing quality Improvement Plans with home-based providers?		
	Yes	71%
	No	0%
	Not sure	29%
	Total	100%
Do the Star Quality standards, including their measurement, adequately facilitate or lend themselves to family child care providers' being able to progress along the levels at a reasonable pace?		
	Yes	14%
	No	14%
	Not sure	71%
	Total	100%

Virginia Star Standards for Local Coordinators
N=6

		Percent
First, are there any standards or levels of the standards for home-based care that you are confused about or would like additional clarification regarding?		
	Yes	33%
	No	67%
	Not sure	0%
	Total	100%
Are any of the four standards not critical or important to quality in home-based child care, in your view?		
	Yes	17%
	No	83%
	Not sure	0%
	Total	100%
Now we will go through each Star standard for your views on their indicators (strands) and how the levels are structured. The first standard concerns provider and assistant Education, Qualifications and Training, including professional development. Do you agree that each strand of the first standard is necessary or important for indicating quality in family child care businesses?		
	Yes	100%
	No	0%
	Not sure	0%
	Total	100%
Does each Star Quality level for this standard reflect that degree of quality, in your view?		
	Yes	83%
	No	0%
	Not sure	17%
	Total	100%
The second standard is Environment and Interactions. Do you agree that each strand of the second standard is necessary or important?		
	Yes	100%
	No	0%
	Not sure	0%
	Total	100%
Does each Star Quality level for this second standard reflect that degree of quality, in your view?		
	Yes	67%
	No	0%
	Not sure	33%
	Total	100%

The third standard is Structure, which means group size and adult-to-child ratios. Do you agree that this standard is necessary or important?		
	Yes	83%
	No	0%
	Not sure	17%
	Total	100%
The fourth standard is Program Management. Do you agree that each strand of the fourth standard is necessary or important?		
	Yes	50%
	No	17%
	Not sure	33%
	Total	100%
Does each Star Quality level for the fourth standard reflect that degree of quality, in your view		
	Yes	50%
	No	17%
	Not sure	33%
	Total	100%
Should any of these four standards count more toward an overall Star level than others?		
	Yes	83%
	No	0%
	Not sure	17%
	Total	100%
Do the standards capture the important aspects of quality for home-based providers - that is, is there anything critical that is missing?		
	Yes	50%
	No	17%
	Not sure	33%
	Total	100%
How satisfied are you with how the standards are measured?		
	Very satisfied	0%
	Satisfied	50%
	Neutral	50%
	Dissatisfied	0%
	Very dissatisfied	0%
	Total	100%

Are the standards fair to and reasonable for home-based providers?		
	Yes	17%
	No	33%
	Not sure	50%
	Total	100%
Are the standards informative to parents who use family care?		
	Yes	50%
	No	17%
	Not sure	33%
	Total	100%
Do the Star Quality standards, including their measurement, adequately facilitate or lend themselves to mentors or child care coaches developing quality Improvement Plans with home-based providers?		
	Yes	100%
	No	0%
	Not sure	0%
	Total	100%
Do the Star Quality standards, including their measurement, adequately facilitate or lend themselves to family child care providers' being able to progress along the levels at a reasonable pace?		
	Yes	67%
	No	0%
	Not sure	33%
	Total	100%
Assuming funding exists to continue with the family child care portion of VSQI, do you anticipate any barriers to enrolling more providers, when the rating results will be published?		
	Yes	33%
	No	17%
	Not sure	50%
	Total	100%
Assuming funding exists to continue with the family child care portion of VSQI, do you anticipate any barriers to administering it well at the local level?		
	Yes	33%
	No	33%
	Not sure	33%
	Total	100%

To scale up this pilot for the entire state and successfully engage more family child care providers, what needs to be done, in your view? Please check all that apply.		
	Continue as is	0%
	Increase the amount of materials stipend for providers	17%
	Add a self-study component prior to actual rating	67%
	Increase training opportunities other than through mentoring	100%
	Change the rating procedures	50%
	Change the mentoring procedures	0%
	Change training procedures for raters/mentors	0%
	Change the administration procedures	17%
	Other	50%

Description of Survey Results and Focus Group Discussions for the Expert and Local Coordinator Panels

Regarding Virginia's draft Home-Based Star Quality Standards

March, 2011

Expert and local coordinator panels

Seven of nine (78%) experts invited to participate in the panel discussion returned surveys prior to the focus group and their responses framed the discussion. Eight experts participated in the discussion, while the ninth mailed her comments. Survey responses indicated that the experts generally agreed that:

1. The four draft Standards are important and good indicators of quality for family child care;
2. Most levels adequately capture meaningful gradations in quality;
3. Measurement tools were satisfactory;
4. The Standards lend themselves to quality improvement efforts;
5. As written, the Standards may not be informative to families.

Within their general agreement, experts raised important questions or concerns, and disagreed on other questions. This content framed most of the focus group discussion that is summarized below.

Content of the Standards and Star Quality level gradations

The expert panel generally agreed that all four Standards were necessary and/or important components of quality for family child care, as was each strand of the second and fourth Standards (the third Standard, *Structure*, has only one strand). While most felt the strands for the first Standard, *Education, Qualifications and Training*, were satisfactory, a minority wondered whether the education requirements were too high and/or not supported by research. The difference between levels "3" and "4" struck some as a "big jump in expectations" that might not be supportable without significant levels of technical assistance and accessibility of higher education degree-granting programs to home-based providers. Another expert noted that research even with classroom-based child care is currently inconclusive regarding the precise level of education and degree of specialization in early childhood education that predicts higher child care quality and children's outcomes, and that very little evidence exists regarding assistant teacher education and children's outcomes.

Other experts agreed that, since it is often extremely difficult for family child care providers to obtain a four-year college degree and there is little solid research to strongly support requiring a specific type of degree, it might be best to provide alternate pathways – besides a formal higher education pathway - to the highest Star levels for this Standard. On the other hand, the panel agreed that education generally is linked to higher quality and that this is an important message to convey to providers and other stakeholders.

In relation to another indicator of staff qualifications – the education and training of substitutes, the third of three indicators for Standard 1 -- one expert advised eliminating requirements for substitutes, noting that other states do not include them and that they are too difficult to measure accurately.

Interview participants had some difficulty with aspects of measuring strands for the second Standard, *Environment and Interactions*. Some questioned the appropriateness of using score cut-points on the FCCERS-R or BAS to determine Star levels. Concerns were that (1) a one-point difference in scale scores is within the margin of error, yet would yield different Star ratings; (2) research has not clearly determined that there are meaningful differences in child outcomes related to differences in the middle range of FCCERS-R scores (as opposed to the very high and low ends of the scale); and (3) that if Star levels were tied to differential reimbursement rates, the state might open itself to appeals and even legal suits that would be hard to defend.

Virtually all the expert panelists agreed on survey that the third Standard, *Structure*, is necessary or important (86% agreement, with one non-response). Some expressed concern more generally that the Standards are not comprehensible to parents due to their technical description, with this third Standard being an example of difficulty interpreting how points are calculated in relation to ratios and group size. (Virginia uses a point system as part of its licensing standards (Virginia Department of Social Services, 2010)).

Survey results for the full group indicated a split opinion regarding Star gradations for the fourth Standard, *Program Management*, with 5 percent agreeing that each level for the fourth Standard adequately reflects the gradation of quality indicated by Star Quality Standards, and 4 percent not sure about this. This issue was not discussed during the focus group because the difference in viewpoints became apparent only after all the surveys had been returned.

Weighting of Standards

Whether or not to weight any Standard more than others motivated lively discussion. The interview and survey responses indicated mixed views on this issue, with 43 percent in favor of weighting, 43 percent not sure, and 14 percent opposed to weighting. Those favoring weighting selected Standard 2, *Environment and Interactions*, as the Standard to weight. They argued that Standard 2 has the most evidence behind it, and weighing it more heavily would help mitigate potential provider concerns about Standard 1 (*Education, Qualifications and Training*).

On the other hand, concerns were expressed about transparency, communication with providers and families about the meaning of the Stars, and the degree of rater reliability that would become magnified if the *Environment and Interaction* Standard were weighted more heavily. Several panel members commented that the concept of weighting is difficult to communicate to stakeholders and the public and complicates an already complex system. Others felt that, as discussed earlier, weighting Standard 2 would highlight fine-grained differences on the FCCERS-R that the system and the raters probably do not have the precision to support. For example, experts observed that whether a family child care business scored a 3.99 or 4 on the FCCERS would push a provider more toward a Standard 2 Star of "3" or a "4," which could be very hard to explain to providers and to justify given the inherent one-point margin of error built into scale reliability estimates.

The suggestion was made that VSQI developers "wait on weighting" and subject this question to an empirical test once enough data exist to support such an assessment. The issue of weighting was also discussed in relation to an original intent on the part of the VSQI developers to keep the Standards and Star levels as consistent as feasible between classroom- and home-based ratings. Virginia's classroom-based ratings do weight the second Standard more heavily than other Standards; however, in the classroom-based version, the second Standard consists only of an assessment of interactions (i.e., the Classroom Assessment Scoring System, or CLASS) and does not include an assessment of the environment. Environment is one strand of the fourth Standard in the classroom-based version and is therefore not weighted more heavily.

Fairness and facilitation of providers' progression along levels

The panel had many questions regarding how VSQI's infrastructure actively supports quality improvement and whether VSQI's primary goal focused more heavily on quality improvement or on

accountability. While the group felt that the Standards are laudably ambitious, many experts expressed concern that without substantial, stable investment in targeted quality improvement activities, family child care providers were unlikely to meet the higher ends of the quality continuum, calling into question how "fair" they were to providers. Most panelists felt that with an adequate support system in place – including training opportunities, mentoring, and financial incentives for pursuing higher education – home-based providers could make reasonable progress, but if providers did not perceive the availability and benefits of these supports, they would not engage with VSQI.

A general consensus emerged that the higher the Standards, the greater the demand for substantial investment in quality improvement infrastructure, and that a critical question to address is the degree to which the VSQI will be able to meet those demands once the program is scaled up. With adequate quality improvement investment, panelists agreed that family child care providers could progress and reach high levels. One expert noted that his state has empirically defined "reasonable progress" as moving up a level every 24 months, which corresponds to Virginia's classroom-based re-rating schedule.

Some panel members also raised the issue of providers getting "stuck" and noted that Virginia will need to decide how long a provider can remain in the system at the same level. Experts noted that some states invest relatively little at the lower levels in order to focus resources on moving to higher, more personally tailored coaching or training and similarly may set a time limit for how long a child care business can remain at one level.

How the Standards may not be informative to parents and the meaning of a Star level of "3"

The expert group agreed that as written, the Standards are too complex for families to understand. Families would not comprehend the FCCERS-R and providers would have difficulty communicating the meaning of specific Standards. Panelists noted that some states try to "message" the meaning by focusing each level around a particular theme. Indiana, for example, focuses each level on a topic such as accreditation, curriculum, and so on. This is easy for parents to understand and provides a conceptual ladder for providers. The group appreciated that Virginia has written materials for providers to share with parents but thought there might need to be additional or different ways of communicating the meaning of the Stars to the public. In a similar vein, the group was somewhat unclear about what a "3" rating might mean, partly because different states have different metrics. One expert reported that

Maine has a four-level program, and empirical testing of the levels suggests an appreciable difference exists between levels 1 and 2, on the one hand, and 3 and 4 on the other. Some panelists noted that in a five-star ladder system such as the VSQI, parents may consider a rank of "3" mediocre, while it in fact reflects quality two steps above state licensing requirements. More data over time will help answer this question, experts agreed.

Local Coordinators

Four of six surveys (66 %) were returned prior to the focus group and formed the basis for the discussion. (Another two were completed later so that the total survey response rate was 100%). All six local coordinators and a seventh co-coordinator participated in the discussion. The following represents a summary of local coordinators' thoughts and concerns about the draft home-based Standards a little more than halfway through the pilot demonstration project.

Content of the Standards

The coordinators generally agreed that the first three Standards are necessary and/or important components of quality for family child care, as is each strand of the first and second Standards (the third Standard, *Structure*, has only one strand). Views differed regarding whether the fourth Standard, *Program Management,* assessed using the Business Administration Scale (BAS), represented an important aspect of quality care for children. Some felt this Standard was extremely important for sustainability (helping providers feel more professional, more committed, and therefore more likely to stay in business and stay with VSQI). Others felt that the concept was appropriate and important, but that details remained to be worked out to make it equitable and useful. Still others objected to the Standard itself ("Centers don't have this Standard, yet they are businesses even more so than family child care"; "doesn't relate to quality if quality is focused on the child"), while other concerns focused on the BAS or difficulties with accounting for situations in which home-based providers do not themselves manage the business end. Two examples provided were when husbands ran the business portion, and when providers are enrolled in an Infant-Toddler Network, which manages many facets of the family child care business for members. In some situations cultural norms dictate that the head of household, most often the husband or father, handle the business aspects of the home-based child care enterprise. The actual child care provider may have little knowledge of these aspects.

Some participants expressed concerns regarding possible mismatches between some actual home-based child care and professionalization of family child care, and ways the Standard may inadvertently undermine important positive qualities of family child care. For example, for small family child care homes, program management as measured by the BAS may be beyond what providers feel is necessary for the successful operation of these businesses and can be overwhelming to providers. One participant noted that her region lost many interested providers when they learned about the BAS training requirement. Others observed that the BAS may penalize providers for flexible practices, which is a factor often cited by parents as a reason they prefer family child care. On the other hand, one coordinator reported good success with and positive provider feedback using the BAS.

Star level gradations

The majority of coordinators – though not all – believed that most Standard Star levels generally reflected different gradations of quality for family child care. Some coordinators expressed unease about the requirement of a BS in Early Childhood for the top Star for Standard 1, noting that many providers have no access to obtaining such a degree. Others noted that there seemed to be a jump in difficulty between level 3 to 4 that was not present between other Star levels.

However, the second Standard, *Environment and Interactions*, generated the most discussion. Coordinators expressed considerable concern regarding how the FCCERS-R is used to calculate Star levels. One set of observations focused on the requirement that all subscales fall at specified rating thresholds in order to progress along the Star continuum. *Space and Furnishings* and *Personal Care* were two subscales particularly noted as often difficult to score highly on for reasons that may be outside of provider control or for other reasons. For instance, providers who live in apartments may need to use city parks for outdoor play rather than their backyards, which could score lower on the FCCERS-R. According to one coordinator, depending on the season and age of the children in care, the standards set by the American Academy of Pediatrics, which form the basis of the FCCERS-R *Personal Care* subscale, are excessive and can leave single providers with little time or attention to monitor or interact with other children. At least one other coordinator disagreed with this point, but a general consensus developed that requiring threshold subscale ratings may leave many providers "stuck" even though all other aspects of their care and business may warrant moving up the Star ladder. Most coordinators advocated using average FCCERS-R scores and not requiring minimum subscale thresholds.

Weighting some standards more heavily than others

Local coordinators agreed that *Environment and Interactions* should count more in overall Star calculations than other Standards, particularly since much mentoring is geared toward this Standard. The extent of weighting was more difficult to agree upon. Some believed that Standard 2 should be heavily weighted, whereas others felt the weighting should be slight. One coordinator was particularly concerned that Standard 2 not overshadow Standard 3, *Structure*, noting that high quality was not feasible with high child- to-adult ratios.

Home-based Standards and the Star Quality system overall: Fairness and barriers

Coordinators agreed that the home-based provider Star standards were well structured for mentors to help providers develop and use Quality Improvement Plans (QIPs) and to assess progress. With the exception of the BAS and a few details of the FCCERS-R, as noted above, coordinators were generally satisfied with how the Standards were proposed to be measured. However, they expressed strong and unanimous reservations about the plan to publish Star ratings prior to providers being more prepared for ratings. Some LCs advocated that some mentoring occur prior to conducting ratings that would be published.

All coordinators agreed that a pre-rating coaching preparation was essential for VSQI to be sustainable with family child care providers. Coordinators expressed the opinion that the VSQI system was too complex and unfamiliar for home-based providers to take in all at once, and that publishing pre-mentored ratings without some coaching or initial self-assessment at least, was not fair to providers. Some coordinators felt that initial ratings should be considered baseline ratings that would never be published, but that would provide the basis for QIPs, with follow-up ratings then published after some specified period.

Coordinators noted that VSQI terminology, such as “three-week window,” took considerable explaining to providers, particularly for providers whose primary language is not English. They also perceived a major gap in the process to date, namely, the lack of specified support for providers to understand and accept the Summary Reports. Coordinators stated that for family child care providers, who often operate solo and whose “environment” is also their home, the Summary Reports feel more personal than is true for Centers and that providers often feel personally criticized and deflated by them.

Someone suggested that perhaps the mentors could review the Summary Report with the provider rather than having the report mailed to the provider before that relationship had been established. Coordinators believed that, with sufficient mentoring and other support, providers could progress along the Star levels at a reasonable pace, but that, as mentioned earlier, it was considerably harder to move beyond a "3" than to reach a "3." They felt that requiring a BS in a child-related field would also prevent most providers from reaching the top level of Star quality.

Summary of National Experts' and Local Coordinators' Views

In general, both groups concurred that the first three of the four Standards for family child care capture important aspects of quality; that the Standards lend themselves to developing quality improvement plans; and that Standard measurement is generally satisfactory, at least for quality improvement efforts. Experts agreed that the fourth Standard, *Program Management*, is important, but local coordinators were divided about this, with half endorsing it and the other half not sure or not in favor of it. If the Standard is retained, attention will need to be paid to situations in which the care provider herself does not manage business details or other circumstances in which formal business practices may not reflect provider wishes or goals.

Some coordinators stated that requiring a BS in early childhood for the highest Star level of Standard 1 is not realistic for most providers. Some believed the jump was too big between the higher levels (3-5) compared to the earlier levels and might discourage providers from continuing. Members of the expert panel also wondered about the "jump" between level 3 and 4 for the first Standard, particularly regarding the educational hours required at the higher level.

Coordinators agreed that the second Standard, *Environment and Interactions,* should count more toward overall Star ratings than the others, but the expert panel was divided on whether or not to weight Standards at all, with some noting that there is very little research to support specific educational levels or cut-offs for family child care. In general, local coordinators appeared to favor weighting Standard 2, whereas most of the expert panel favored "waiting on weighting" until the issue could be examined empirically.

While most of the requirements for Star level progression along the Standards were satisfactory to both groups, local coordinators mostly agreed that the FCCERS-R subscale threshold minimum for

Standard 2 could leave providers "stuck" at an inappropriately lower overall Star level despite quality improvements in other areas. If Standard 2 is more heavily weighted than others, this potential roadblock becomes particularly salient. Coordinators noted that certain subscales, such as *Space and Furnishings* and *Personal Care Routines*, were especially likely to hold providers back, sometimes in ways they could not control -- an outcome generally seen as unfair to the providers and likely to result in attrition. The majority, but not all, argued for eliminating the subscale requirement.

Experts focused more on whether Virginia could sustain the infrastructure required to measure and mentor so many indicators, and on the need for VSQI developers to decide how to handle providers who make little progress despite supports. At least one state has determined what seems to be a "reasonable amount of time" to progress from one level to the next, with that time period – 24 months – which corresponds to the VSQI classroom-based re-rating window.

The expert panel agreed that more work and better "messaging" could be done to make the standards accessible to parents and the public. One suggestion was to tailor each Star level to a particular focus of quality, such as regulatory compliance, curriculum, and so on. At this point, the expert panel was unclear how the public would interpret the mid-point level 3 and that parents may underestimate the quality provided, since it is not toward the upper end of the Star scale.

Local coordinators were asked additional questions regarding the sustainability of family child care VSQI. Consensus was strong that publishing baseline Star ratings was not fair to providers and would result in lack of program take-up by the home-based provider community. The group strongly advocated providing a pre-rating preparatory phase for family child care providers to orient them to VSQI terminology, procedures, methods of assessment, and expectations. Many also urged that Star levels be published only after some kind of coaching or self-assessment, with time allowed for improvement. Other concerns focused on supporting providers receiving Summary Report results and ensuring, to the extent feasible, that Early Language Learner providers receive language help to understand VSQI.

Appendix C

Pilot Forms and Documents

VIRGINIA STAR QUALITY INITIATIVE
Committed to Quality Early Learning

You are invited

to learn more about a new pilot project:

The Virginia Star Quality Initiative for Family Child Care Homes!

Come to an informational meeting to find out about a new, exciting project available through Smart Beginnings Alexandria/Arlington. A grant is funding a pilot demonstration of Virginia's Quality Rating and Improvement System for Family Child Care.

This 6-month project will help Smart Beginnings develop a quality rating specifically for Family Child Care. You can try it out for free – and be the first in Virginia to help decide how it should work!

This program is already being piloted in child care centers across Virginia. Find out how you can help Virginia learn what works (and doesn't work) in this same process for Family Child Care.

At the informational meeting you will learn:

- What is the Virginia Star Quality Initiative (VSQI) and how does it help Family Child Care homes?
- What can providers do to help develop the VSQI for Family Child Care?
- How can providers get FREE resources to improve quality?

You are welcome to attend any of the meetings to learn more:

Location: Arlington Department of Human Services
2100 Washington Blvd. Arlington VA 22204 (Room ____)
Date: Wednesday, December 22, 2010
Time: 6:30pm – 7:30pm

Location: Alexandria Department of Child and Human Services
2525 Mount Vernon Ave. Alexandria, VA 22201 (Room ____)
Date:
Time:

For more information please call:

SMART BEGINNINGS
Alexandria/Arlington

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VIRGINIA STAR QUALITY INITIATIVE

Application for Family Child Care Homes: 2010-2011

Revised: 11/1/2010

SECTION I

Please check the status of your family child care home (select all that apply):

☐ Licensed Family Child Care Home

Site Name _____

License # _____

☐ Regulated by Local Ordinance

Site Name _____

☐ Approved by a Licensed Family Day System

Site Name _____

☐ Virginia Preschool Initiative

Name of VPI Grantee _____

Site Name _____

☐ Head Start

Name of Head Start Grantee _____

Site Name _____

☐ Military Approved

Site Name _____

Tax ID # _____

**Please send to your local coordinator by mail or email a copy of the most recent documentation verifying that this home is in good standing with applicable regulatory requirements.

SECTION II

Primary Contact _____

Physical Address _____

City _____

State _____ Zip _____ City/County _____

Mailing Address _____

City _____

State _____ Zip _____ Area Code _____ Phone _____

Area Code _____ Fax _____ Email _____

In what year did you open this family child care home? _____

What is your primary language? _____

Educational background: High School ☐ CDA ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate ☐

Please list additional employees:

Name _____

Hours Worked	M	T	W	Th	F

Responsibilities: _____

Name _____

Hours Worked	M	T	W	Th	F

Responsibilities: _____

Do you have someone who comes in as a substitute? ◯ yes ◯ no If yes, name: _____

SECTION III

Days of Operation ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Sat ☐ Sun

Hours of Operation from _____ to _____

Is your child care home open at least 180 days per year? ◯ yes ◯ no

Total Number of Children Enrolled _____ What is the capacity of your family child care? _____

Please complete all applicable categories:

	Infants 0-15 months	Young Toddlers 16-23 months	2-year olds	3-year olds	4-year olds	5-year olds	School Age	Total Enrollment
Can you serve? *(Check if yes.)*	☐	☐	☐	☐	☐	☐	☐	
# Enrolled full-time								0
# Enrolled part-time								0

How many children enrolled speak English as a second language? ____

How many children enrolled receive:

Child care subsidies from Department of Social Services	___	Head Start	___
Special education or early intervention (Parts B and C of IDEA)	___	Virginia Preschool Initiative	___
Other kinds of subsidies or scholarships (private)	___	Military subsidies	___

Do you participate in the USDA Nutrition program? ◯ yes ◯ no

If yes, how many children enrolled are eligible for free or reduced-price meals under USDA nutrition programs? _____

How many children have identified disabilities or special needs? _____

SECTION IV

Fees and Waiting List

What are your fees? (Please leave the areas of the chart blank that do not apply to you.)

	Infants 0-15 months	Young Toddlers 16-23 months	2-year olds	3-year olds	4-year olds	5-year olds	School Age
Full Day							
Half Day							

Are these fees ◯ weekly ◯ monthly ◯ daily?

Do you maintain a waiting list? ◯ yes ◯ no Do you currently have children on the waiting list? ◯ yes ◯ no

	Infants 0-15 months	Young Toddler 16-23 months	2-year olds	3-year olds	4-year olds	5-year olds	School Age	Total on Waiting List
# on Waiting List								0

SECTION V

Is this program currently accredited by the National Association for Family Child Care (NAFCC)? ◯ yes ◯ no

If no, are you currently undergoing the accreditation process? ◯ yes ◯ no

Do you use any recognized child assessment tools, (e.g. PALS, Brigance, etc.)? ◯ yes ◯ no

If yes, please list the assessment tools used:

Date _____

Name and Title _____

Memorandum of Agreement

_____ (Name) would like to participate in the Virginia Star Quality Initiative (VSQI) Family Child Care Home Demonstration. The Virginia Department of Social Services (VDSS) has awarded the Virginia Early Childhood Foundation (VECF) funding to pilot a demonstration of the VSQI Family Child Care Home Standards. VECF and the VDSS through the Office of Early Childhood Development (OECD) co-sponsor the VSQI.

I understand that the process to participate in the Demonstration will involve:

- ★ Completion of all parts of this application.
- ★ Submission of all relevant documents to VECF; all documents that support this application and subsequent rating will be kept and be available for review by VECF, and by the local coordinating agency for the pilot. This includes, but is not limited to, the following:
  - verification of good standing with regulations of the regulating authority;
  - copies of any forms or documents referred to in this application;
  - documentation forms and supporting documents for Standards 1, 3, and 4; and
  - Business Administration Scale, Environment Rating Scale, CLASS, and Star Quality score cards and reports.
- ★ Maintenance of good standing with the requirements of the appropriate regulating authority. A program may be suspended or removed from VSQI when any of the following occurs:
  - numerous, repeated, or serious risk non-compliances with applicable child care regulatory requirements;
  - physical move to a different location;
  - not actively participating in the mentoring process;
  - founded case of abuse or neglect as noted in § 63.2-1508 of the Code of Virginia; or
  - a notice of proposed denial or revocation of licensure or approval is issued.

  Any facility that receives notification of a proposed denial or revocation of child care licensure or approval must verbally notify the local coordinator for the pilot within 5 business days and in writing within 10 business days.
- ★ Participation of the home in an on-site assessment by a randomly-assigned Star Quality Rater including an interview. The Rater will generate a thorough summary report for providers detailing results. Family Child Care Homes will work with a mentor to develop a quality improvement plan.
- ★ I give permission for the Virginia Early Childhood Foundation to release for evaluation and research purposes data gathered during the star rating process. No individual program, employee or child information will be identified in a final report.
- ★ Please note that the rating of family child care homes in this Demonstration will be used for guidance only and will not be publicized.

I, _____ certify that the information provided in this application is true and complete. I agree to notify the local pilot coordinator promptly if any of this information changes. Any of the information provided in this application may be checked by local pilot coordinators, staff at VECF, or an agency approved by VECF to review applications. If the information is found to be false, the program may be withdrawn from the VSQI. If an application is resubmitted with corrected information, it may be reconsidered at the discretion of VECF.

_____ _____

Signature of Owner of the Family Child Care Home *Date*

_____

Print Name

Revised 11/1/10

Waiver for Conflict of Interest: Provider

A conflict of interest is defined as any relationship between a Star Quality Rater and a
interfere or be perceived to interfere with the Rater's ability to exercise objectivity in ti
Raters should recuse themselves from an assignment due to conflict of interest if they
by the program; serve(d) as a mentor, consultant, or evaluator in the program; have a
is/was employed by the program or is/was a mentor, consultant, or evaluator there; a
the program's Board of Directors, or have a relative in that position; have a monetary
the outcome of the program's Star rating; have a close personal relationship with indi
program; or have any relationship that might compromise the objectivity of the ratings

I, _____(Full Name), give my conser

_____ (Rater name) to serve as a Sta

any conflict of interest.

I, _____(Full Name), object to the as

_____ (Rater name) to serve as a Sta

the following conflict of interest:

_____

_____

_____

_____

I certify that the information provided on this form is true and complete.

Signature. _____ Date. _____

Print Name. _____

Waiver for Conflict of Interest: Rater

A conflict of interest is defined as any relationship between a Star Quality Rater and a program which could interfere or be perceived to interfere with the Rater's ability to exercise objectivity in the rating process. Raters should recuse themselves from an assignment due to conflict of interest if they: are/were employed by the program; serve(d) as a mentor, consultant, or evaluator in the program; have a close relative who is/was employed by the program or is/was a mentor, consultant, or evaluator there; are or have served on the program's Board of Directors, or have a relative in that position; have a monetary or personal interest in the outcome of the program's Star rating; have a close personal relationship with individuals involved in the program; or have any relationship that might compromise the objectivity of the ratings process.

I, _____ (Full Name), verify that I am able to serve as a Star Quality Rater for _____ (Family Child Care Provider Name), with no conflict of interest.

I, _____ (Full Name), am unable to serve as a Star Quality Rater for _____ (Family Child Care Provider Name) due to the following conflict of interest.

_____

_____

_____

Confidentiality Agreement

I, _____ (Full Name), agree to hold in trust and confidence any confidential information or documents including child or staff records, disclosed to me, discovered by me, or prepared by me in the course of or as a result of the Star Quality observation at _____ (Family Child Care Provider Name). I agree that any confidential information shall be used only for the purposes of this evaluation and shall not be disclosed to any third party without approval from the participating provider.

I certify that the information provided on this form is true and complete.

Signature: _____ Date: _____

Print Name: _____

CLASS Permission Form for the Family Child Care Demonstrati

The CLASS (Classroom Assessment Scoring System) is an assessment tool develope
Virginia. The CLASS measures interactions between and among children and teache
subscales: emotional support, classroom organization, and instructional support. Al
CLASS developed specifically for Family Child Care Settings because of the strong co
quality teacher-to-child and child-to-child interactions and positive child outcomes ar
using the Toddler CLASS is available to Family Child Care Homes participating in the
Initiative. The Toddler CLASS observation takes 3-4 hours and is conducted by a Sta

I, _____(Full Name), give my consi
Mentor to conduct a 3-4 hour Toddler CLASS Observation and understand that CLAS
but not used in the rating process.

I, _____*(Full Name)*, do not give m
Quality Mentor to conduct a 3-4 hour Toddler CLASS Observation.

I certify that the information provided on this form is true and complete.

Signature: Date:

Print Name:

VIRGINIA STAR QUALITY INITIATIVE
Committed to Quality Early Learning

Summary Report for the Family Child Care Demonstration

RATER NAME: _____
DATE OF VISIT: _____
FAMILY CHILD CARE PROVIDER NAME: _____
ADDRESS: _____
PHONE: _____
LOCAL COALITION: _____

STANDARD 1: EDUCATION, QUALIFICATIONS, & EXPERIENCE
(Assessed by documentation)

Teacher (Family Child Care Provider) Findings:					
Name:	Education:	First Aid	CPR	Approved Training Hours	Professional Development Activities
		☐ Yes ☐ No	☐ Yes ☐ No		☐ Member of an Early Childhood Professional Association ☐ Working with a Mentor ☐ Serving as a Mentor, Trainer or College Instructor ☐ Author of an article, narrative or report published in a journal or other scholarly publication

Assistant Teacher(s) Findings: ☐ N/A					
Name:	Education:	First Aid	CPR	Approved Training Hours	Professional Development Points
		☐ Yes ☐ No	☐ Yes ☐ No		☐ Member of an Early Childhood Professional Association ☐ Working with a Mentor ☐ Serving as a Mentor, Trainer or College Instructor ☐ Author of an article, narrative or report published in a journal or other scholarly publication
		☐ Yes ☐ No	☐ Yes ☐ No		☐ Member of an Early Childhood Professional Association ☐ Working with a Mentor ☐ Serving as a Mentor, Trainer or College Instructor ☐ Author of an article, narrative or report published in a journal or other scholarly publication

Substitute Teacher Findings: ☐ N/A					
Name:	**Education:**	**First Aid**	**CPR**	**Approved Training Hours**	**Professional Development Points**
		☐ Yes ☐ No	☐ Yes ☐ No		☐ Member of an Early Childhood Professional Association ☐ Working with a Mentor ☐ Serving as a Mentor, Trainer or College Instructor ☐ Author of an article, narrative or report published in a journal or other scholarly publication

STANDARD 2: ENVIRONMENT AND INTERACTIONS
(Assessed by observation using the FCCERS-R)

This section includes item scored using the FCCERS-R instrument written by Thelma Harms, Debby Cryer and Richard M. Clifford. Items achieving scores of 5 or above are considered to have been met and will not be commented upon. Items that need to be improved will be commented upon.

Space and Furnishings

1. Indoor space used for child care ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

2. Furniture for routine care, play & learning ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

3. Provision for relaxation and comfort ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

4. Arrangement of indoor space for child care ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

5. Display for children ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

6. Space for privacy ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Personal Care Routines

7. Greeting/departing ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

8. Nap/rest ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

9. Meals/snacks ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

10. Toileting/diapering ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

11. Health practices ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

12. Safety Practices ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Listening and Talking

13. Helping children understand language ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

14. Helping children use language ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

15. Using Books ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Activities

16. Fine Motor ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

17. Art ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

18. Music/movement ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

19. Blocks ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

20. Dramatic Play ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

21. Math/number ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

22. Nature/Science ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

23. Sand and water play ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

24. Promoting acceptance of diversity ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

25. Use of TV, video, and/or computer ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

26. Active physical play ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Interaction

27. Supervision of play and learning ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

28. Provider-child interaction ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

29. Discipline ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

30. Interactions among children ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Program Structure

31. Schedule ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

32. Free play ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

33. Group time ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

34. Provisions for children with disabilities ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Parents and Provider

35. Provisions for parents ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

36. Balancing personal & caregiving responsibilities ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

37. Opportunities for professional growth ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

38. Provisions for professional needs ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Provider agreed to allow a CLASS observation ☐ Yes ☐ No

STANDARD 3: STRUCTURE
(Assessed by observation)

Age of Children Present During Observation	# of children present*	Point value for age group	Point Calculation
Birth -- 15 months		4	0
16 – 23 months		3	0
2 years (24 – 35 months)		2	0
3 – 4 years (36 – 59 months)		2	0
5 – 9 years		1	0
10 - 13 years		0	0
		Total Points	0

*If children are under the age of 8, include the provider's own children and resident children

STANDARD 4: PROGRAM MANAGEMENT
(Assessed by observation using the BAS and documentation)

This section includes item scored using the BAS instrument written by Teri N. Talan and Paula Jorde Bloom. Items achieving scores of 5 or above are considered to have been met and will not be commented upon. Items that need to be improved will be commented upon.

1. Qualifications and Professional Development ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

2. Income and Benefits ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

3. Work Environment ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

4. Fiscal Management ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

5. Recordkeeping ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

6. Risk Management ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

7. Provider-Parent Communication ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

8. Community Resources ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

9. Marketing & Public Relations ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

10. Provider as Employer ☐ N/A ☐ Score of 5 and above ☐ Score of less than 5 (comment below)

Submit by Email

1/2011 8

Family Child Care Demonstration

Rating Checklist

Rater Name:_____ **Family Child Care Name:**_____

Submitted to VECF by Rater:

FCCERS-R and BAS Score Sheets ☒ Yes ☐ No Issues:_____

Excel Score Calculator ☒ Yes ☐ No Issues:_____

FCC Education Qualifications & Training Form ☒ Yes ☐ No Issues:_____

BAS Documents for Review Checklist ☒ Yes ☐ No Issues:_____

Site Evaluation and Time Log ☐ Yes ☒ No Issues:_____

Submitted to VECF by Local Coordinator:

Conflict of Interest Forms (Rater & FCC) ☒ Yes ☐ No Issues:_____

Toddler CLASS Permission Form ☒ Yes ☐ No Issues:_____

Summary Report ☒ Yes ☐ No Issues:_____

Edits to the Summary Report (areas that required editing are checked)			
FCCERS: 1. Indoor space		27. Supervision of play and learning	
2. Furn. for routine care		28. Provider-child interaction	
3. Provisions for relax		29. Discipline	
4. Arrangement of indoor space		30. Interactions among children	
5. Display for children		31. Schedule	
6. Space for Privacy		32. Free play	
7. Greeting/departing		33. Group time	
8. Nap/rest		34. Provisions for children w/ disabilities	
9. Meals/snacks		35. Provisions for parents	
10. Toileting/diapering		36. Balancing personal and caregiving responsibilities	
11. Health practices		37. Opportunities for professional growth	
12. Safety practices		38. Provisions for professional growth	
13. Helping children understand language		*BAS:* 1. Qualifications and Professional Development	
14. Helping children use language		2. Income and Benefits	

15. Using books		3. Work Environment	
16. Fine Motor		4. Fiscal Management	
17. Art		5. Recordkeeping	
18. Music and movement		6. Risk Management	
19. Blocks		7. Provider-Parent Communication	
20. Dramatic play		8. Community Resources	
21. Math/number		9. Marketing and Public Relations	
22. Nature/science		10. Provider as Employer	
23. Sand and water play			
24. Promoting acceptance of diversity			
25. Use of TV, video, computers			
26. Active physical play			

Virginia Star Quality Initiative

Star Quality Mentor – Monthly Contact Summary Form

Star Quality Mentor's Name: Jane Doe Month/Year: May 2011

Name of Program: Stacy's Family Child Care Home

Name of Primary Program Contact: Stacy Owner

Type of Contact	Date(s) of Contact	Duration of Contact	Mileage	Contact Initiated by...
Email	5/17, 5/19	Prep:___ Contact: ___ Follow-Up:___		Mentor: X Program:___
Phone	5/9, 5/12	Prep:___ Contact:0.25 Follow-Up:___		Mentor:___ Program: X
On-site	5/16	Prep:___ Contact:1.5 hrs Follow-Up:___	45	Mentor: X Program: X

Please complete the information. Be thorough and specific. Don't forget to include not only what was accomplished or discussed, but also by whom.

Description of Activities/Assistance Provided:

- I reviewed the BAS Checklist with Stacy.
- Stacy and I reviewed the current setup of the child care area. Suggestions including removing some materials (to use for rotation) and to free up some shelf space.
- We discussed the possibility of Stacy attending the Babies & Tots Conference.

Accomplishments/Goals Completed:

- Stacy had placed artwork (creative expression!) in the display in the child care area. A bulletin board with photographs of the children had been added since the last visit.

Problems Encountered, Issues of Concern:

- Stacy called to reschedule two mentoring visits 30 minutes before the actual visit

Recommendations /Follow Up;

Stacy:

- Remove materials to use for rotation and free up some shelf space

Jane:

- Email Stacy a sample budget

Next visit date: June 12, 2011

Additional Comments:

I certify that the information provided on this form is true and complete.

Mentor's Signature: Date: 6/1/2011

Star Quality Mentor – Monthly Contact Summary Form 1

Virginia Star Quality Initiative
Quality Improvement Plan for Family Child Care Home Demonstration

(to be completed and submitted to the Local Coordinator no more than 1 month after receipt of the observation summary report)

Program Name: _____	**Primary Program Contact: _____**
Mentor Name: _____	**Date of Plan: _____**

Summary of Quality Improvement Goals (by Standard area):

Standard 1: Education, Qualifications, and Training
Goal 1: _____

Goal 2: _____

Standard 2: Environment and Interactions (assessed by FCCERS-R with supplemental Toddler CLASS Observation done by Mentor)
Goal 1: _____

Goal 2: _____

Standard 3: Structure
Goal 1: _____

Goal 2: _____

Standard 4: Program Management (assessed by BAS)
Goal 1: _____

Goal 2: _____

List each Identified goal for each standard

Why will achieving this goal help improve program quality?

How will we achieve this goal? (Resources, materials)

Who is responsible for achieving this goal?

When will it be accomplished?

What evidence will demonstrate the goal has been achieved?

STANDARD/GOALS	**WHY**	**HOW**	**WHO**	**WHEN**	**EVIDENCE**
Standard 1 **Goal 1:** **Goal 2:**					
Standard 2 **Goal 1:** **Goal 2:**					

Standard 3 **Goal 1:** **Goal 2:**					
Standard 4 **Goal 1:** **Goal 2:**					

Rev. 11/22/2010

COALITION NAME:

Provider Name	Email	Phone	Address	Rater Assigned	3-Week Window for Rating	Unavailable Dates	Date of Rater Visit	Date Summary Report Received	Date Summary Rpt Submitted to VECF	Name of Mentor Assigned	Date of Toddler CLASS Observation
ex. Stacy Owner	*stacyowner@gmail.com*	*555-555-1212*	*123 Main St, City, VA 22222*	*Jane Doe*	*1/3/11 - 1/21/11*	*1/3, 1/14, 1/19*	*1/13/2011*	*1/18/2011*	*1/24/2011*	*Sally Mentor*	*1/28/2011*

Local Coordinator Progress Report

Subgrantee: **Contract #:**

Budget Category	VECF Budget Total	Period 1: 11/11/10 - 12/31/10	Period 2: 1/1/11 - 3/31/11	Period 3: 4/1/11 - 6/30/11	Total Funds Expended	VECF Funds Remaining
Local Coordination	$3,786.00	$0.00	$0.00	$0.00	$0.00	$3,786.00
Training on BAS	$180.00	$0.00	$0.00	$0.00	$0.00	$180.00
Ratings	$2,500.00	$0.00	$0.00	$0.00	$0.00	$2,500.00
Mentorship	$10,500.00	$0.00	$0.00	$0.00	$0.00	$10,500.00
Quality Improvement	$10,000.00	$0.00	$0.00	$0.00	$0.00	$10,000.00
TOTAL	$26,966.00	$0.00	$0.00	$0.00	$0.00	$26,966.00

Total Budget(Period 1)-Note: same forms are used throughout duration of Pilot Demonstration

Subgrantee: **Contract #:**

Local Coordination

Date	Recipient	ID Number	Expenditure Justification	Total Amount	VECF Portion	Payment #
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
			Total	$0.00	$0.00	

Training on Business Administration Scale

Date	Recipient	ID Number	Expenditure	Total Amount	VECF Portion	Payment #
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
			Total	$0.00	$0.00	

Ratings

Date	Recipient	ID Number	Expenditure	Total Amount	VECF Portion	Payment #
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	
				$0.00	$0.00	

Expenditures

Virginia Early Childhood Foundation
8001 Franklin Farms Drive, Suite 116
Richmond, VA 23229
804-358-8323 (phone) - 804-358-8353 (fax)
Contract #:

Subgrantee Name:	
Federal ID #	
Grantee Address:	

Date of Invoice:		
	From:	To:
Period Covered:		
Total Grant:		

Fiscal Agent Name:	
Fiscal Agent Address:	

Mail to Grantee or Fiscal Agent:	Grantee

Budget Category	(Budget) Total VECF Award	VECF Expenditures This Period	Total VECF Expenditures to Date	(Balance) VECF Funds Remaining
Local Coordination	$0.00	$0.00	$0.00	$0.00
Training on BAS	$0.00	$0.00	$0.00	$0.00
Ratings	$0.00	$0.00	$0.00	$0.00
Mentorship	$0.00	$0.00	$0.00	$0.00
Quality Improvement	$0.00	$0.00	$0.00	$0.00
TOTAL	$0.00	**$0.00**	$0.00	$0.00

GRANTEE CERTIFICATION

I certify that, to the best of my knowledge, the information above is correct, that no expenditures have been allocated to any other program, that all expenditures have been made in accordance with the contract conditions, that payment is due, and that payment has not been previously requested.

Signature of Subgrantee Authorized Representative	Typed Name	Signature of Fiscal Agent	Typed Name

VECF APPROVAL

Do not use this space. For VECF use only.

Check Release Amount:	
Signature	Date

Invoice

Virginia Star Quality Initiative
Family Child Care Demonstration
Status Report
Contract #:

Subgrantee Name:		**Date of Report:**		
			From:	To:
Submitted By:		**Period Covered:**		

Activities	Outputs	Accomplishments

Comments, Issues, and Concerns

Status Report

Appendix D

Rater and Mentor Survey Responses

	Virginia SQI Family Pilot Rater Introductory Survey N=19 (Note: Twelve of the 19 respondents conducted pilot ratings)	
		Percent
Q1	**What is your experience using ERS?**	
	I have never used any of the ERS instruments	16%
	I have used ERS for self-assessment only	16%
	I have been trained as an ERS rater	53%
	Other	16%
	Total	100%
Q1a	**If you have ERS training, was it for: (check all that apply)**	
	A state quality rating system	58%
	Mentoring	32%
	Research	0%
	Self-assessment	16%
	Staff development of own business/center	16%
	N/A - never trained before as rater	11%
	Other	5%
Q2	**Which ERS instrument have you been trained on? (check all that apply)**	
	ECERS (original)	21%
	ECERS-R (revised)	58%
	ITERS	11%
	ITERS-R	58%
	FDCERS	16%
	FDCERS-R	74%
	SACERS	0%
	Trained on one ERS, not sure which	0%
	N/A - not trained on any	11%
Q3	**How long ago was your last ERS training?**	
	Less than one year ago	58%
	1 to 2 years ago	26%
	3 to 5 years ago	5%
	More than 5 years ago	0%
	Not sure	5%
	No answer	5%
	Total	100%
Q4a	**In prior training, did you train to reliability with a scale author?**	
	Yes	37%
	No	32%
	Not sure	0%

	N/A - no prior training	11%
	Other	21%
	Total	100%
Q4b	**In prior training, did you train to consistency with a master rater?**	
	Yes	32%
	No	37%
	Not sure	0%
	N/A - no prior training	11%
	Other	11%
	No answer	11%
	Total	100%
Q5	**Have you ever been trained in a different observation rating system from ERS?**	
	Yes	63%
	No	32%
	Other	5%
	Total	100%
Q5a	**If yes, which other observation systems?**	
	Classroom Assessment Scoring System (CLASS)	53%
	Child Observation System (COS)	5%
	Arnett Caregiver Interaction Scale	5%
	Play Observation Scale (Rubin et al.)	5%
	Early Language and Literacy Childhood Observation (ELLCO)	11%
	N/A - no training on other observation systems	21%
	Other	11%
Q6	**What is your highest educational degree or attainment?**	
	Less than high school	0%
	High school diploma or GED	0%
	Certificate program (inc. Child Development Associate)	0%
	Associate's degree	16%
	Bachelor's degree	16%
	Master's degree	53%
	Professional or PhD degree	5%
	Other	11%
	Total	100%
Q7	**What field or discipline did you study in college, university, or other higher education institution? (Check all that apply for each major or degree.)**	
	Early Childhood Education	79%
	Child Development	11%
	Psychology or Human Development	32%

	Social Work	5%
	Family Studies	5%
	Education/Teaching K-12	26%
	Public Health	0%
	Not applicable	0%
	Other	32%
Q8	**How long have you worked in child care or early childhood education?**	
	Less than 1 year	0%
	1 to 2 years	5%
	3 to 5 years	5%
	6 to 10 years	16%
	11 to 20 years	21%
	More than 20 years	47%
	N/A - never worked in this field before	0%
	No answer	5%
	Total	100%
Q9	**If you have ever worked in ECE, what positions have you held?(Check all that apply.)**	
	Child care provider	0%
	Child care business owner	0%
	Early childhood educator	16%
	Head Start teacher or other staff	0%
	Preschool or nursery school teacher (private school)	0%
	Prekindergarten teacher (public school program)	5%
	Child care or ECE administrator	11%
	Child Development Associate trainer	5%
	Faculty of college early childhood care/development program	0%
	QRIS rater	5%
	QRIS mentor	0%
	N/A - have not worked in early childhood	0%
	Other	58%
Q10	**What languages do you speak? (Check all that apply.)**	
	English	100%
	Spanish	5%
	Chinese	0%
	Korean	0%
	Arabic	0%
	Other	16%
Q11	**What are your primary interests in participating as a mentor in the Virginia Star Quality Improvement pilot?(Check all that apply.)**	

	Interested/invested in family child care	42%
	Interested/invested in early childcare quality improvement systems	90%
	Have own child care business	0%
	Would like to make mentoring/VSQI a full-time job	37%
	Need extra money	21%
	Like to travel	26%
	Like to learn new things	63%
	Other	5%
12	**How long have you lived in Virginia?**	
	Less than one year	5%
	Between 1 and 2 years	11%
	Between 2 and 5 years	16%
	Between 5 and 10 years	11%
	More than 10 years, but not exclusively	26%
	All my life	32%
	N/A - don't live in Virginia	0%
	Total	100%

	Home-Based Demonstration Rater Field Survey N=16	
		Percent
Q1	**Are you finished with all assigned ratings for the demonstration pilot?**	
	Yes	83%
	No	8%
	Not Sure	8%
	Total	100%
Q2b	**Would you be willing to participate in a short follow-up interview regarding the demonstration project?**	
	Yes	92%
	No	8%
	Other	0%
	Total	100%
	PROCEDURES & REPORTS	
Q3	**On average, how well did you feel rating visits went? (Note: This pertains to visits for which you completed a Summary Report.)**	
	Very smoothly	17%
	Smoothly	58%
	Neutral	8%
	Only slightly smoothly	8%
	Not smoothly at all	8%
	Total	100%
Q4	**On average, how receptive to you were family providers whose businesses you rated?**	
	Very receptive	50%
	Receptive	42%
	Neutral	8%
	Marginally receptive	0%
	Very unreceptive	0%
	Total	100%
Q5	**Did you encounter any challenging circumstances in scheduling or conducting ratings that felt especially challenging?**	
	Yes	50%
	No	50%
	Not sure	0%
	Total	100%
Q6	**How satisfied were you with the process of ASSIGNING you to a provider for rating?**	
	Very satisfied	42%
	Satisfied	42%

	Neutral	8%
	Dissatisfied	8%
	Very dissatisfied	0%
	Total	100%
Q7	**How satisfied were you with the process of SCHEDULING your rater visits?**	
	Very satisfied	42%
	Satisfied	25%
	Neutral	17%
	Dissatisfied	17%
	Very dissatisfied	0%
	Total	100%
Q8	**How helpful did you find the Rater Guidelines document outlining visit procedures?**	
	Very helpful	33%
	Helpful	50%
	Neutral	17%
	Unhelpful	0%
	Very unhelpful	0%
	Not sure what this is	0%
	Total	100%
Q9	**How satisfied were you with the Scoring Calculator?**	
	Very satisfied	83%
	Satisfied	17%
	Neutral	0%
	Dissatisfied	0%
	Very dissatisfied	0%
	Total	100%
Q10	**How satisfied were you with the Summary Report format?**	
	Very satisfied	25%
	Satisfied	42%
	Neutral	17%
	Dissatisfied	8%
	Very dissatisfied	8%
	Total	100%
	TRAINING	
Q11	**How well prepared were you for conducting the FCCERS-R portion of the provider rating visit, once you became reliable or consistent? That is, once you finished your training, how well prepared were you for your first visits?**	

	Very well prepared	75%
	Prepared	17%
	Neutral	8%
	Unprepared	0%
	Very unprepared	0%
	Not sure what this is	0%
	Total	100%
Q12	**How satisfied were you with any Training-to-Consistency visits you made? This refers to visits made in your local area with another rater for the purpose of training (Note: This questions is for both master and field raters.)**	
	Very satisfied	33%
	Satisfied	8%
	Neutral	17%
	Dissatisfied	17%
	Very dissatisfied	0%
	N/A- Did not participate in any consistency visits	25%
	Total	100%
Q13	**How well prepared were you for conducting the BAS portion of the provider rating visit? That is, once you finished your training, how well prepared were you for your first visits on the BAS?**	
	Very well prepared	0%
	Prepared	83%
	Neutral	17%
	Unprepared	0%
	Very unprepared	0%
	Not sure what this is	0%
	Total	100%
Q14	**How well prepared were you for completing the scoring and summary report documentation? That is, once you finished your training, how well prepared were you for your first visits at completing documentation?**	
	Very well prepared	17%
	Prepared	58%
	Neutral	25%
	Unprepared	0%
	Very unprepared	0%
	Not sure what this is	0%
	Total	100%
Q15	**Thinking back, how helpful was the one day author training with Dr. Helms and colleagues from North Carolina to your understanding of the FCCERS-R and how to use it?**	
	Very helpful	17%
	Helpful	50%

	Neutral	17%
	Unhelpful	17%
	Very unhelpful	0%
	Total	100%
	THOUGHTS OF STANDARDS AND PROJECT	
Q16	**How familiar are you with the Star Quality Standards for family child care home providers?**	
	Very familiar	42%
	Familiar	50%
	Neutral	0%
	Unfamiliar	8%
	Very unfamiliar	0%
	Not sure what this is	0%
	Total	100%
Q17	**Given what you know of the Star Quality Standards for family child care home providers, how satisfied are you that they accurately reflect the level of child care and family care business quality?**	
	Very satisfied	0%
	Satisfied	83%
	Neutral	0%
	Dissatisfied	0%
	Very dissatisfied	8%
	Don't know the Standards	8%
	Total	100%
Q18	**Do you want to continue your involvement in Virginia's Star Quality Initiative (VSQI) in the future?**	
	Yes	92%
	No	8%
	Not Sure	0%
	Total	100%
Q18a	**IF YES to the previous question, what would you like to do with Virginia's Star Quality Initiative? Check all that apply.**	
	Rater (center and family child care)	67%
	Rater (center only)	0%
	Rater (family home care only)	17%
	Mentor (center and family home care)	33%
	Mentor (center only)	17%
	Mentor (family child care only)	8%
	Local coordinator	33%
	Trainer	75%
	Other	25%

Q19	Was the rating fee for each home visit ($250) reasonable compensation?	
	Yes	50%
	No	25%
	Not sure	25%
	Total	100%

	Mentor Field Survey N=16	
	TRAINING	
Q1	**How well prepared were you for coaching providers on the BAS?**	
	Very well prepared	6%
	Well prepared	63%
	Neutral	13%
	Somewhat prepared	13%
	Not well prepared	6%
	Do not know what this is	0%
	Total	100%
Q2	**How well prepared were you for coaching providers using the Relationship Model?**	
	Very well prepared	19%
	Well prepared	38%
	Neutral	31%
	Somewhat prepared	0%
	Not well prepared	0%
	Do not know what this is	6%
	No answer	6%
	Total	100%
Q3	**How well prepared were you for rating providers on the Toddler CLASS (before using the tool in your coaching)?**	
	Very well prepared	31%
	Well prepared	19%
	Neutral	19%
	Somewhat prepared	19%
	Not well prepared	6%
	Do not know what this is	6%
	Total	100%
Q4	**How well prepared were you for coaching providers using the Toddler CLASS?**	
	Very well prepared	38%
	Well prepared	19%
	Neutral	38%
	Somewhat prepared	0%
	Not well prepared	6%
	Do not know what this is	0%
	Total	100%
Q5	**How well prepared were you for developing QIPs with family child care providers?**	

	Very well prepared	19%
	Well prepared	44%
	Neutral	0%
	Somewhat prepared	25%
	Not well prepared	13%
	Do not know what this is	0%
	Total	100%
Q6	**How well prepared were you for how to complete paperwork for your coaching visits?**	
	Very well prepared	6%
	Well prepared	25%
	Neutral	25%
	Somewhat prepared	25%
	Not well prepared	6%
	Do not know what this is	6%
	No answer	6%
	Total	100%
Q7	**Overall, how well prepared were you for coaching family child care providers?**	
	Very well prepared	25%
	Well prepared	56%
	Neutral	13%
	Somewhat prepared	6%
	Not well prepared	0%
	Total	100%
Q8	**Q8. I would have liked more training on/in: (Check all that apply)**	
	Business practices	25%
	Relationship coaching model	13%
	Toddler CLASS	44%
	Family Child Care Environmental Rating Scales - revised	13%
	Developing a QIP	38%
	Working with a QIP	19%
	Completing required paperwork	38%
	Establishing rapport with providers	0%
	Scheduling visits	0%
	Coaching providers on challenging behaviors	13%
	Coaching providers on accessing resources	25%
	Coaching providers on parent communication	6%
	Coaching providers on children's development	13%
	Coaching providers on how to refer child for evaluation	0%

	Other	25%
	MENTORING PRACTICE	
Q10	**What time of day or evening and of the week do MOST of your coaching visits occur?**	
	Morning	6%
	Afternoon	44%
	Evening	25%
	During the day but not consistent	50%
	Weekends	25%
Q11	**At this point, about how many total mentoring visits have you completed, across all your provider clients?**	
	One or none	0%
	2 to 5	6%
	6 to 10	50%
	11 to 15	6%
	16 to 20	31%
	More than 20	6%
	Total	100%
Q12	**Do you use any specific mentoring curriculum (besides the Relationship Model) with your providers?**	
	Yes	6%
	No	63%
	Not sure	31%
	Total	100%
Q13	**When you are coaching a provider, do you MOSTLY:**	
	Work directly with her	25%
	Work directly with other assistants/employees in home	6%
	Work equally with provider and assistants	6%
	Work directly with children	0%
	Work directly with parents	0%
	Observe	0%
	Combine observation and direct work with provider	56%
	Combine observation and direct work with children	6%
	Other	0%
	Total	100%
Q14	**How much did you use the Family Child Care Provider Toolkit in your work with providers?**	
	All the time	19%
	Much of the time	0%
	Occasionally	38%
	Never	25%

	Not sure what this is	13%
	No answer	6%
	Total	100%
	QIP DEVELOPMENT	
Q15	**How much were the providers' personal goals for quality improvement consistent with areas of improvement identified in the Summary Report?**	
	Very consistent	31%
	Consistent	50%
	Neutral	13%
	Somewhat inconsistent	0%
	Very inconsistent	6%
	N/A - none listed in report	0%
	Total	100%
Q15a	**How much were the providers' personal goals for quality improvement consistent with areas for improvement identified in your initial CLASS observation?**	
	Very consistent	6%
	Consistent	25%
	Neutral	50%
	Somewhat inconsistent	6%
	Very inconsistent	6%
	N/A - none listed in report	0%
	No answer	6%
	Total	100%
Q15b	**How much of your time with providers is spent addressing goals specific to the QIP?**	
	Most of the time	31%
	Three-fourths of the time	50%
	Half the time	13%
	One-quarter of the time	0%
	Less than one-quarter of the time	6%
	N/A - have not completed QIP	0%
	Total	100%
Q16	**How satisfied were you with the PROCESS of developing the QIPs with your providers?**	
	Very satisfied	19%
	Satisfied	56%
	Neutral	6%
	Dissatisfied	19%
	Very dissatisfied	0%
	Total	100%

Q17	**How satisfied were you with the eventual QIP you developed with your providers?**	
	Very satisfied	31%
	Satisfied	63%
	Neutral	6%
	Dissatisfied	0%
	Very dissatisfied	0%
	Total	100%
Q18	**Was the purchase of suppplies included in the QIP?**	
	Yes	94%
	No	6%
	Not Sure	0%
	Total	100%
Q18a	**Have you had a provider ask for help with something not on the QIP?**	
	Yes, often	19%
	Yes, occasionally	63%
	No	19%
	N/A - no completed QIP	0%
	Total	100%
Q19	**Are all the sections of the QIP - the rationale, the plan itself, the plan for tracking - helpful?**	
	Yes	88%
	No	13%
	Not sure	0%
	Total	100%
Q21	**Overall, my mentoring experiences with family providers so far has been:**	
	Very rewarding	44%
	Rewarding	50%
	Neutral	6%
	Somewhat disappointing	0%
	Very disappointing	0%
	Total	100%
	FAMILY CHILD CARE DEMONSTRATION PROJECT	
Q22	**How well were you satisfied with your local coordinator's matching process? That is, how she matched you with a given provider to mentor. If you have more than one coordinator, complete this for the one you have most contact with.**	
	Very satisfied	56%
	Satisfied	38%
	Neutral	0%

	Somewhat dissatisfied	0%
	Very dissatisfied	6%
	Total	100%
Q23	**How well were you satisfied with your local coordinator's communication with you?**	
	Very satisfied	31%
	Satisfied	38%
	Neutral	13%
	Somewhat dissatisfied	13%
	Very dissatisfied	6%
	Total	100%
Q24	**How well were you satisfied with your local coordinator's supervision?**	
	Very satisfied	31%
	Satisfied	19%
	Neutral	38%
	Somewhat dissatisfied	6%
	Very dissatisfied	6%
	Total	100%
Q25	**How useful was the feedback on the QIP you received from VECF staff and/or your local coordinator?**	
	Very useful	25%
	Useful	25%
	Neutral	6%
	Only slightly useful	6%
	Not useful	13%
	Not sure what this refers to	25%
	Total	100%
Q26	**. How well were you satisfied with the overall FCCP mentoring procedures? (This includes what you were/are expected to do with providers, what you document, and how you communicate your documentation to your LC or to Betty or other VECF staff).**	
	Very satisfied	31%
	Satisfied	56%
	Neutral	6%
	Somewhat dissatisfied	0%
	Very dissatisfied	6%
	Total	100%
Q27	**In your experience, is the BAS a useful tool with which to work with providers to improve their business?**	
	Yes	88%
	No	6%

	Not sure	6%
	Total	100%
Q28	**In your experience, is the Toddler CLASS a useful tool with which to work with providers for quality improvement?**	
	Yes	75%
	No	19%
	Not sure	6%
	Total	100%
Q29	**In your experience, is the mentoring Relationship Model taught during fall training a useful model to use for mentoring providers?**	
	Yes	69%
	No	6%
	Not sure	19%
	No answer	6%
	Total	100%
Q31	**At this point, how confident are you that you will reach your goal stated above by the end of the demonstration?**	
	Very confident	44%
	Confident	50%
	Neutral	6%
	Not confident	0%
	Very unconfident	0%
	Total	100%
Q32	**Would you mentor family providers again?**	
	Definitely	69%
	Probably	25%
	Neutral	0%
	Probably not	0%
	Very unlikely	6%
	Total	100%
Q33	**How many of your family child care providers will want to continue with VSQI once Star Ratings are published, do you think?**	
	100%	31%
	About 75%	25%
	About half	25%
	about 25%	13%
	None	0%
	Don't know	6%
	Total	100%

BACKGROUND AND INTERESTS		
Q34	**What observation systems have you been trained on? Check all that apply.**	
	Environmental Rating Scoring System	63%
	Preschool Classroom Assessment Scoring System (CLASS)	63%
	Child Observation System (COS)	6%
	Arnett Caregiver Interaction Scale	13%
	Play Observation Scale (Rubin et al.)	0%
	Early Language & Literacy Childhood Observation (ELLCO)	19%
	N/A (no training on observations systems other than BAS and Toddler CLASS)	25%
	Other	0%
Q35	**What is your highest educational degree or attainment?**	
	Less than high school	0%
	High school diploma or GED	0%
	Certificate program (including. Child Development Associate)	13%
	Associate's degree	19%
	Bachelor's degree	44%
	Master's degree	25%
	Professional or PhD degree	0%
	Other	0%
	Total	100%
Q36	**What field or discipline did you study in college, University or other higher education institution? (Check all that apply for each major or degree).**	
	Early Childhood Education	75%
	Child Development	31%
	Psychology or Human Development	13%
	Social Work	6%
	Family Studies	0%
	Education/Teaching K-12	19%
	Public Health	0%
	Not applicable	0%
	Other	19%
Q37	**How long have you worked in the field of child care or early childhood education? Check all that apply.**	
	Less than 1 year	0%
	1 to 2 years	0%
	3 to 5 years	13%
	6 to 10 years	0%
	11 to 20 years	25%
	More than 20 years	63%
	N/A - never worked in this field before	0%

	Other	0%
	Total	100%
Q38	**If you have worked in ECE, what positions have you held? (Check all that apply.)**	
	Child care provider	50%
	Child care business owner	44%
	Early childhood educator	63%
	Head Start teacher or other staff	13%
	Preschool or nursery school teacher (private school)	50%
	Prekindergarten teacher (public school program)	13%
	Child care or ECE administrator	69%
	Child Development Associate trainer	6%
	Faculty of college early childhood care/development program	13%
	VSQI rater	19%
	Mentor to early childhood providers (through VSQI or other arrangement)	69%
	N/A - have not worked in early childhood	0%
Q39	**What languages do you speak? (Check all that apply)**	
	English	100%
	Spanish	6%
	Chinese	0%
	Korean	0%
	Arabic	0%
	Other	25%
Q40	**What are your primary interests in participating as a mentor in the Virginia Star Quality Improvement pilot for home-based providers? (Check all that apply)**	
	Interested/invested in family child care	56%
	Interested/invested in early childcare quality improvement systems	75%
	Have own child care business	6%
	Would like to make mentoring/VSQI a full-time job	31%
	Need extra money	25%
	Like to travel	13%
	Like to learn new things	75%
	Other	13%
	STAR QUALITY STANDARDS OVERALL	
Q41	**Given what you know of the Star Quality Standards for family child care home providers, how satisfied are you that they accurately reflect the level of child care and family care business quality?**	
	Very satisfied	25%
	Satisfied	56%
	Neutral	13%

	Dissatisfied	0%
	Very dissatisfied	6%
	Do not know the Standards	0%
	Total	100%
Q42	**Do you want to continue your involvement in Virginia's Star Quality Initiative (VSQI) in the future?**	
	Yes	81%
	No	6%
	Not sure	13%
	Total	100%
Q42a	**IF YES to the previous question, what would you like to do with Virginia's Star Quality Initiative? Check all that apply.**	
	Rater (center and family child care)	13%
	Rater (center only)	6%
	Rater (family home care only)	13%
	Mentor (center and family home care)	69%
	Mentor (center only)	0%
	Mentor (family child care only)	19%
	Local coordinator	13%
	Trainer	25%
	Other	6%
Q42b	**As a new project, we are very interested in the experiences of all participants to help make improvements. Would you be willing to participate in a group interview with other mentors to provide feedback on the demonstration project?**	
	Yes	88%
	No	0%
	Other	6%
	No answer	6%
	Total	100%

Appendix E

Family Child Care Home Provider Interview Responses

Virginia Star Quality Initiative Survey - Provider Survey
N=61 (55 complete and 6 partial)

		Percent
Please tell us the reasons that you decided to participate in the Star Quality Initiative		
Q 7a	**Importance of coaching and mentoring received**	n=56
	Very important	77%
	Somewhat important	20%
	Not very important	2%
	Not at all important	2%
	Don't know/Refused	
	Total	100%
Q 7b	**Importance of provision of materials**	n=56
	Very important	79%
	Somewhat important	16%
	Not very important	0%
	Not at all important	4%
	Don't know/Refused	2%
	Total	100%
Q 7c	**Importance of written feedback in Quality Improvement Plan**	
	Very important	67%
	Somewhat important	31%
	Not very important	0%
	Not at all important	2%
	Don't know/Refused	0%
	Total	100%
Q 7d	**Importance of potential for business increase due to star rating**	n=55
	Very important	82%
	Somewhat important	6%
	Not very important	11%
	Not at all important	2%
	Don't know/Refused	0%
	Total	100%
Q10a	**How satisfied with information provided about program**	n=50
	Very satisfied	68%
	Somewhat satisfied	24%
	Somewhat dissatisfied	8%
	Not at all satisfied	0%
	Don't know/Refused	0%
	Total	100%

Q10b	**How satisfied with application process**	n=50
	Very satisfied	64%
	Somewhat satisfied	28%
	Somewhat dissatisfied	2%
	Not at all satisfied	2%
	Don't know/Refused	4%
	Total	100%
Q10c	**How satisfied with training on the Business Administration Scale**	n=50
	Very satisfied	54%
	Somewhat satisfied	30%
	Somewhat dissatisfied	6%
	Not at all satisfied	4%
	Don't know/Refused	6%
	Total	100%
Q10d	**How satisfied with Star Quality Rater visits**	n=50
	Very satisfied	44%
	Somewhat satisfied	36%
	Somewhat dissatisfied	6%
	Not at all satisfied	12%
	Don't know/Refused	2%
	Total	100%
Q10f	**How satisfied with relationship with mentor**	n=50
	Very satisfied	96%
	Somewhat satisfied	0%
	Somewhat dissatisfied	2%
	Not at all satisfied	0%
	Don't know/Refused	2%
	Total	100%
Q10g	**How satisfied with Star Quality program overall**	n=50
	Very satisfied	78%
	Somewhat satisfied	16%
	Somewhat dissatisfied	6%
	Not at all satisfied	0%
	Don't know/Refused	0%
	Total	100%
Q12	**How useful is the summary report**	n=50
	Very useful	52%
	Somewhat useful	34%
	Not very useful	6%

	Not at all useful	6%
	Don't know/Refused	2%
	Total	100%
Q13	**Were you surprised by what was in the summary report**	n=50
	Yes	72%
	No	20%
	Don't know/Refused	8%
	Total	100%
Q16	**Evaluate length of mentor visits**	n=50
	Too short	2%
	Too long	10%
	About right	86%
	Don't know/Refused	2%
	Total	100%
Q17	**Evaluate frequency of mentor visits**	n=50
	Too often	4%
	Not often enough	6%
	About right	88%
	Don't know/Refused	2%
	Total	100%
Q18	**Evaluate timing for mentor visits**	n=50
	Very convenient	88%
	Somewhat convenient	12%
	Somewhat inconvenient	0%
	Not at all convenient	0%
	Don't know/Refused	0%
	Total	100%
Q19	**Have you and your mentor developed a Quality Improvement Plan**	**n=50**
	Yes	96%
	No	4%
	Don't know/Refused	0%
	Total	100%
Q20	**How satisfied with planning process**	**n=50**
	Very satisfied	90%
	Somewhat satisfied	10%
	Somewhat dissatisfied	0%
	Not at all satisfied	0%
	Don't know/Refused	0%
	Total	100%

Q23	How satisfied with mentorship overall	n=50
	Very satisfied	92%
	Somewhat satisfied	8%
	Somewhat dissatisfied	0%
	Not at all satisfied	0%
	Don't know/Refused	0%
	Total	100%
Q25a	How clear is Education, Qualifications, and Experience of Provider Standard	n=50
	Very clear	68%
	Somewhat clear	28%
	Not very clear	2%
	Not clear at all	2%
	Don't know/Refused	0%
	Total	100%
Q25b	Value of this standard as measure of quality childcare	n=50
	Excellent	28%
	Good	50%
	Fair	16%
	Poor	2%
	Don't know/Refused	4%
	Total	100%
Q25c	How clear is Learning Environment and Interactions Standard	n=50
	Very clear	70%
	Somewhat clear	26%
	Not very clear	2%
	Not clear at all	0%
	Don't know/Refused	2%
	Total	100%
Q25d	Value of this standard as measure of quality childcare	n=50
	Excellent	40%
	Good	44%
	Fair	14%
	Poor	0%
	Don't know/Refused	2%
	Total	100%
Q25e	How clear is Structure of Child to Provider Ration Standard	n=50
	Very clear	80%
	Somewhat clear	16%

	Not very clear	0%
	Not clear at all	0%
	Don't know/Refused	4%
	Total	100%
Q25f	**Value of this standard as measure of quality childcare**	**n=49**
	Excellent	49%
	Good	43%
	Fair	6%
	Poor	0%
	Don't know/Refused	2%
	Total	100%
Q25g	**How clear is Business Administration Scale**	**n=49**
	Very clear	63%
	Somewhat clear	22%
	Not very clear	4%
	Not clear at all	4%
	Don't know/Refused	6%
	Total	100%
Q25h	**Value of this standard as measure of quality childcare**	**n=49**
	Excellent	41%
	Good	39%
	Fair	14%
	Poor	6%
	Don't know/Refused	0%
	Total	100%
Q26	**How likely that you will continue to participate in Star Quality Initiative after pilot**	**n=49**
	Very likely	74%
	Somewhat likely	20%
	Somewhat unlikely	2%
	Not at all likely	4%
	Don't know/Refused	0%
	Total	100%
Q27	**How likely that you will continue to participate if Stars are made available to the public**	**n=49**
	Very likely	74%
	Somewhat likely	20%
	Somewhat unlikely	2%
	Not at all likely	2%

	Don't know/Refused	2%
	Total	100%
Q28	**How likely that you will recommend Star Quality Initiative to other child care providers**	**n=49**
	Very likely	78%
	Somewhat likely	16%
	Somewhat unlikely	2%
	Not at all likely	4%
	Don't know/Refused	0%
	Total	100%
Q30	**To what degree has Star Quality Initiative improved child care services you provide**	**n=49**
	A great deal	57%
	Somewhat	35%
	A little	6%
	Not at all	2%
	Don't know/Refused	0%
	Total	100%
Q32	**How many more years do you think you will provide child care**	**n=55**
	1	2%
	2	2%
	3	2%
	5	11%
	6	2%
	7	4%
	8	2%
	10	16%
	15	11%
	20	18%
	25	4%
	30	6%
	70	2%
	99	20%
	Total	100%
Q33	**Currently provide regular child care for own children/grandchildren**	**n=55**
	Yes	44%
	No	56%
	Don't know/Refused	0%
	Total	100%
Q34	**Currently have assistants/family members helping provide care interested**	**n=55**

	in training through VSQI	
	Yes	42%
	No	58%
	Don't know/Refused	0%
	Total	100%
Q35	**Other than providing childcare, are you employed at another job**	**n=55**
	Yes	4%
	No	96%
	Don't know/Refused	0%
	Total	100%
Q36	**Race/Ethnicity (check all that apply)**	**n=55**
	White	36%
	African American/Black	49%
	Asian	7%
	Hispanic	13%
	Other	4%
	Don't know/Refused	0%
Q37	**Own/Rent residence where care is provided**	**n=55**
	Own	78%
	Rent	20%
	Other	0%
	Don't know/Refused	2%
	Total	100%

Appendix F

Local Coordinator Suggestions for Documentation

Appendix F

Local Coordinator Suggestions Regarding Documentation

- It would take a lot of labor off the LCs to have templates for all documentation
- Time logs were very helpful because I pay [the mentors] based on this and it holds mentors accountable
- Would like a requisition form that would be tied to the QIP so we would know which one of the QIP goals an item addresses; would be nice to have a central list. My suggestion: say we have 3 vendors to use, you can only order from one of them. I usually have email documentation of what the mentors have ordered; I have them save the packing list so I can put it with the invoice.
- The mentor monthly summary is better than center-based form; on site number of hours is important but difficult to put estimate number of hours o phone/email time
- The monthly mentor form fits well with the QIP but not enough time to look at mentor activities. Maybe complete the logs only quarterly.
- Need to create a separate form for rater's comments to mentors that is not necessarily in the public document; create a way for raters to communicate specific information to mentors (details about personal care issues, for example).
- Create drop down menus for reports with a standard list of responses (rationales) so we don't have to cut and paste
- Have a standard response list for each standard, would cut down on need for revision
- Create one form that serves both center and home-based programs.
- Integrate financial forms into one document for both VSQI programs
- Additional forms needed are calculation and tracking sheets to show how much money provider has for QIP purchases and how many mentor hours mentors have left
- Create incentive forms – what provider wants to order and what the goal is.
- Wish there had been a single tracking device or document that includes this information:
    - -- Tracking sheet for mentor visits (rather than having to look through all the monthly reports)
    - -- The resource application form needs an item description as well as the item number (it was very time consuming for the mentors to go back and add the description).
    - -- The Smart Beginnings invoice form would be a good template for tracking purchases
- The monthly progress report needs to be rewritten for family child care –make it better adapted to the home-based project

Appendix G

Demographic and Child Care Patterns Across Pilot Regions

Demographic and Child Care Patterns Across Pilot Regions

The research team had prepared regional demographic profiles to identify major socioeconomic variations between the regions that may in turn result in variations in pilot experiences and outcomes. Considering that the pilot includes six regions, covering 33 counties and cities with diverse characteristics and different histories of supporting family providers, it was critical to contextualize findings by locality, as well as to generalize across pilot sites. Continuation of the VSQI initiative for family home child care providers, facilitated at the regional and local level, should be similarly contextualized for planning and evaluative purposes.

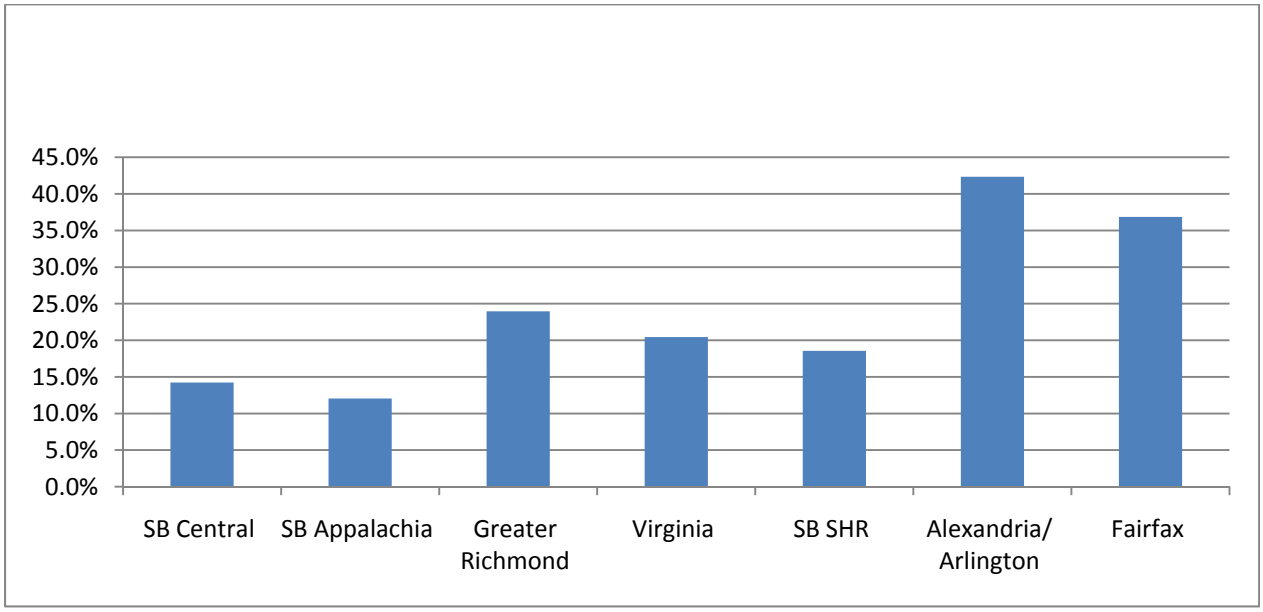
In order to identify contextual variations among regions, the data points were gathered for each local jurisdiction and aggregated by region.[11] Statewide measures were used for comparison purposes. Data were collected over three dimensions: 1) demographic and socio-economic context, 2) child well-being indicators, and 3) child care context. Once compiled, the data were analyzed by region and then compared to state averages in order to identify where the regional context varied significantly from the overall state context. When appropriate, regional aggregation involved weighting the data point based on a proportion of the overall population represented at the jurisdictional level. Data points were contextualized where appropriate for comparison. This process involved converting to ratios either per 10,000 total population or 10,000 children under the age of 10. The data represents three categories of measures: 1) demographics and geography, 2) child care capacity and utilization as based on child care subsidy, and 3) child well-being. These measures are presented in Tables G.4, G.5, and G.6 at the end of this chapter.

The remainder of this chapter highlights the variation from state level averages at both the collective pilot area and regional levels. These highlights are then related both to the findings of the pilot process and to future considerations of the VSQI initiative.

Collective Pilot Area: The pilot areas included 33 of Virginia's 120 jurisdictional localities, an area that covered 49percent of both the state's overall population and the population of children ages 0 -- 4. However, the pilot regions collectively covered only 24 percent of Virginia's geography as measured by land volume, reflecting that four out of the six pilot regions were in areas with high population density. The pilot areas had a slightly lower unemployment rate of 6.2 percent compared with the state rate of

6.6%[12] In terms of educational attainment there was great variation among the regions, with the Northern Virginia pilot regions far exceeding the state average for educational attainment and the Appalachia and Central regions falling below the state average. The educational levels are reflected in Figure G. 1.

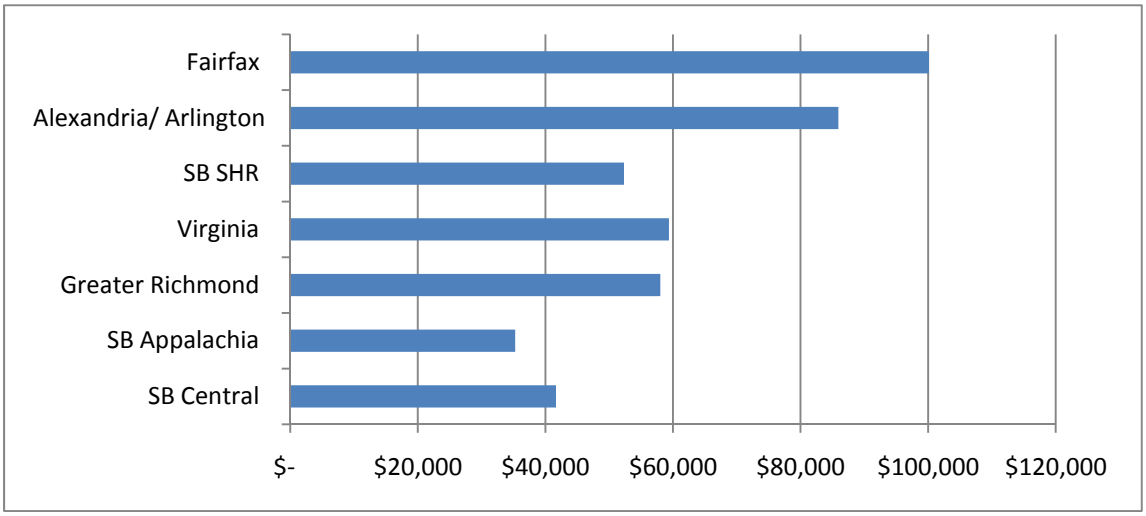
Figure G.1. *Percentage of Population with an Associate's Degree or Higher.*



Overall the pilot regions represented a population with slightly higher levels of education than the overall state, with 26percent of residents holding an associate's or degree or higher compared with 20percent of Virginia residents. The pilot areas also had higher levels of median household income at $67,325 compared with the state overall at $59,372 (see Figure G.2).

[12]Unemployment rate as of February 2011.

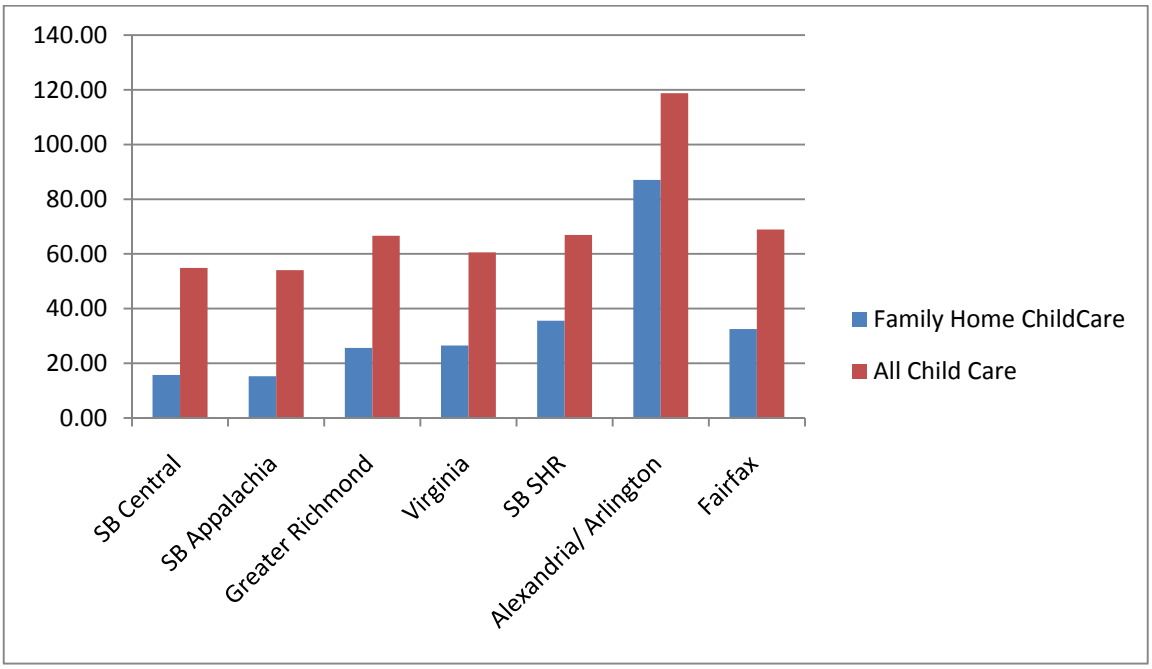
Figure G. 2. *Income Variations by Pilot Regions and State.*



In the area of child well-being and school readiness, the pilot regions were on par with the state as a whole in areas of poverty, on-time graduation, and PAL-K scores. However the pilot regions had a significantly higher rate of uninsured low-income children, —20%, compared to the state, which had 17 percent. Of note, the analysis indicates a consistent relationship between higher levels of aggregate income at the jurisdictional level with higher rates of uninsured low income children.

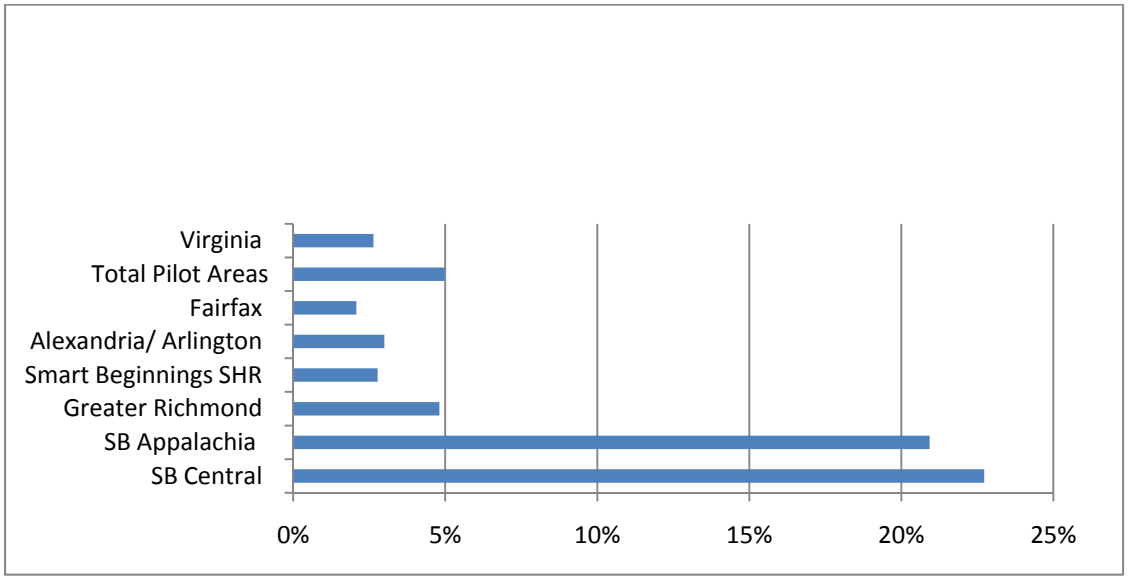
In the dimension of child care, the pilot regions had an estimated 58 percent of the state's registered or licensed family day homes and 56 percent of all child care establishments, with a slightly higher concentration of family day homes than the state overall (see Figure G.3).

Figure G.3. *Child Care Establishments: Virginia and Pilot Regions*



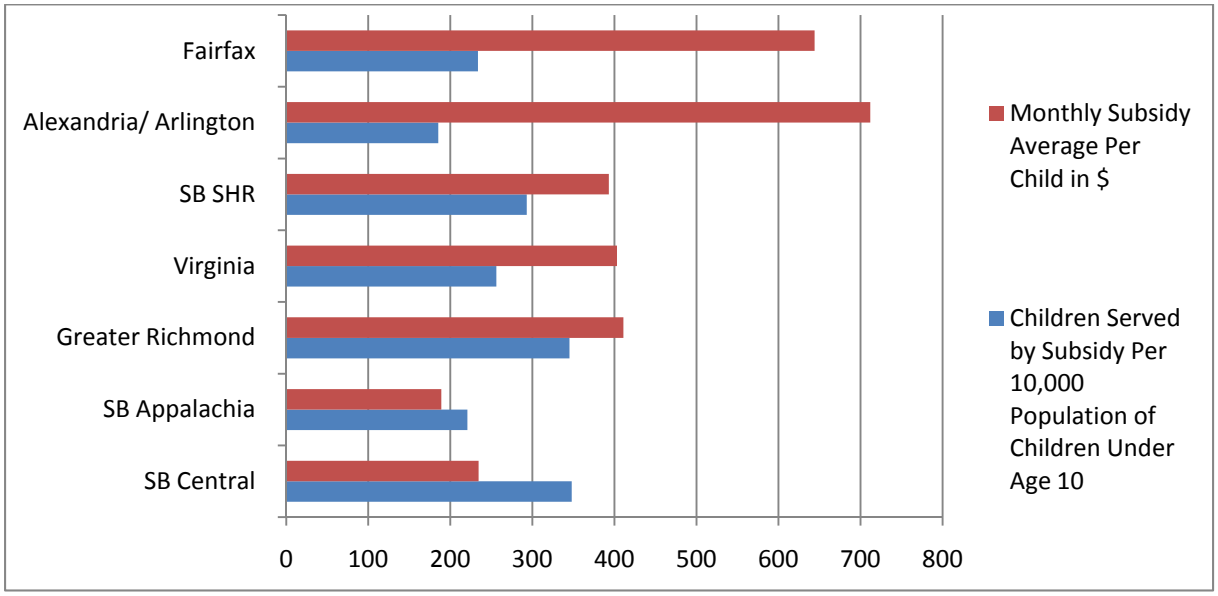
The number of child care establishments per region was relevant to the VSQI process given that regions with lower proportions would have more difficulty recruiting providers from a small pool. There was a wide variation in recruitment of providers in relationship to the number of qualified providers. For the collective regions, 6 percent of qualified providers were involved in the pilot project, while Appalachia and Central Virginia had over 20 percent of qualified providers engaged in the pilot (see Figure G. 4).

Figure G. 4. *Pilot Family Home Child Care Establishments as a Percentage of Total Qualifying Home Child Care Establishment*



The pilot regions represented 61percent of Virginia's child care subsidy expenditures, reflecting the higher subsidy payment rates in Fairfax, Arlington, and Alexandria. Contextualized to units per 10,000 populations of children under the age of 10, the pilots collectively had a higher utilization of child care subsidy than did the state as a whole. The relationship of subsidy utilization per 10,000 people and subsidy rate per region compared to the state is represented in Figure G. 5. While this comparison does not have direct significance to the process evaluation of the VSQI pilot, it does raise possible implications for any ongoing evaluation of the VSQI.

Figure G. 5. *Subsidy Utilization per 10,000 Population of Children under Age 10 and Subsidy Rate in Dollars.*



Alexandria/Arlington: In the demographic and socioeconomic context, Alexandria and Arlington had a significantly higher rate of children under the age of five compared with the other regions and the state as a whole. Alexandria in particular contributed to this higher rate with children under age five comprising 8.4percent of the population compared with 6.8percent of the pilot regions collectively and 6.7percent of the state. In Contrast, the region had a lower ratio of children ages 5 to 9 as compared to the other regions and the state. The Alexandria/Arlington region also had the highest population density of all the regions with a density of 8,300 per square mile compared with 203 per square mile for the state. The region had the lowest unemployment rate of all regions at 1.6percent and the second highest median household income at $85,931. The region also had the highest education level with 42percent of the population with an associate's degree or higher. The Alexandria/Arlington area had

the highest rate of net in commuters of all pilot regions at 1,398 residents per 10,000.[13] This compares to the state net out commute of 108 per 10,000.

In terms of child well-being, the region had a low poverty rate of 7.6 percent but a comparatively high level, 27 percent, of uninsured low income children. While PAL-K scores were above the state average, on-time graduation was the second lowest among the region.

In the context of child care, the region had the highest ratio of home-based child care providers of all the regions at 87.07 per 10,000 children under the age of 10 compared with 34.04 for all of the pilot regions and 26.52 for the state.[14] The region also had the lowest rate of children served through child care subsidy. The region also had the highest rate of all child care providers and the highest rate of average per child monthly subsidy expense at $712. These dynamics are likely explained by the high income/low poverty levels resulting in lower ratios of families qualifying for child care subsidy.

Relevance to Pilot Evaluation: As represented in LV Figure 4 Arlington/Alexandria recruited 3percent of all qualified family home child care providers to participate in the pilot, while recruitment in Alexandria was quite efficient and successful much more effort was required in Arlington. One explanation for this was that local licensing requirements but additional paper work and structure on FCCH providers already and that participation in the demonstration pilot was perceived as an additional encumbrance that the providers were not able to take on at the time.

Relevance to sustainability: With the highest proportion of children in the age population for child care participation, Arlington/Alexandria had a complimentary high proportion of family home child care providers compared with the other pilot regions the state. The rich body of FCCH providers in the region provides a strong environment for expanded efforts in a densely populated area with high levels of cultural diversity.

Fairfax: Fairfax County and Fairfax City data were included in the regional data summary. This region had the third highest ratio of the pilot regions for the under age 5 population at

[13] Commuting patterns were analyzed to determine the number of people who commute into a locality for employment and those who commute out for employment. Localities with "net in" commutes had more workers coming in for employment than residents commuting out. Localities with "net out" commuters had more residents leaving the jurisdiction for employment than workers commuting in.

[14] It should be noted that data used to characterize Arlington and Alexandria's child care establishment came from a different source than the other pilot localities, a variance that reflects unique licensing and permitting structures for FCCH providers in these localities.

6.9percent; however, the region also had the highest total under age 5 population, at 73,505 children. The population density for the region was also significantly higher than the state average at 2,688 per square mile. Socio-economically the region had the highest median household income at $100,122, a lower unemployment rate at 4.6 percent and the second highest educational level with 37 percent of the population having an associate's degree or higher. The Fairfax area had the second highest rate of net out commute of all pilot regions at 192 residents per 10,000.

In the area of child well-being, Fairfax ties with Arlington and Alexandria, with an uninsured rate of 27 percent among low income children, contrasting with 56 percent, the lowest poverty rate of all regions. School readiness and success indicators were mixed with the highest level of PALS-K scores, which were below school readiness at 17 percent, juxtaposed with the highest on-time graduation rate of 91.2 percent

In the area of child care, the region had the third highest ratio of home-based child care and the highest ratio of all child care establishments. However, the total number served per 10,000 was below the state ratio. These variations are likely explained by the higher levels of income that resulted in a lower proportion of the population qualifying for subsidy and the additional child care capacity being utilized by residents of other localities with commuting patterns that enabled access to child care in Fairfax.

Relevance to Pilot Evaluation: The data indicate that Fairfax had a robust population of family home providers who likely serve families from outside of the immediate Fairfax area. While Fairfax reported some challenges in initially engaging providers, they eventually were able to recruit twelve and retain 10 providers through the targeted recruitment process.

Relevance to sustainability: With 482 registered family child care providers and their ongoing commitment to and use of family child care providers for multiple early childhood education programs, Fairfax should have the ability to successfully recruit a broader range of providers to participate in the program. As demonstrated in Figure G. 4, only 2 percent

of Fairfax providers participated in the pilot. As noted throughout the report, in the future, additional attention should be given to the effects and implications of cultural and language- related diversity.

Greater Richmond: For this demonstration pilot, the Greater Richmond region included Richmond, Petersburg, Chesterfield, Goochland, Hanover, Henrico, and Powhatan.[15] This region had a significantly higher population density, at 656 per square mile, compared with the state average of 203. The region had the second highest net in commute of all regions at 388 per 10,000. Great Richmond's median household income was just below the state median rate at $58,007 and the unemployment was slightly higher at 7.3 percent. The education level exceeded the state average at 24 percent of the population having an associate's degree or higher.

Child well-being indicators were comparable to state measures as well as the aggregate of the pilot regions, with the poverty rate being slightly higher than the state average. Child care capacity included a ratio of home based providers that was on par with the state ratio, and all child care establishments were at a higher rate than the state ratio. The region had the highest rate of utilization of child care subsidy with 345 per 10,000 children under age 10, compared with a state ratio of 256.

Relevance to Pilot Evaluation: Greater Richmond most closely approximated the state averages across most indicators, with the exception of higher levels of income. While this may indicate that family home child care providers were better positioned to meet the educational components of the VSQI Standards, additional data specific to family home providers need to be gathered.

Relevance to sustainability: This region had many of the components in place that would indicate a successful environment for a full implementation of the VSQI for family home providers, including a robust population of family providers, experience providing quality

[15] Two of the 15 providers from Greater Richmond were located in Dinwiddie, which is not normally covered by Smart Beginnings Greater Richmond

improvement service to providers, and a complimentary initiative in place to prepare providers for rating and quality improvement processes.

Smart Beginnings Appalachia: For this demonstration pilot, the area covered by Smart Beginnings Appalachia included the localities of Lee, Scott, Wise, Tazewell, Smyth, Washington, Russell, Norton, and Bristol.[16] This region had the lowest population density of all pilot regions with 79 residents per square mile. This region also had the lowest ratio of children under the age of five, at 5.3 percent of the total population compared with 6.7 percent for the state. The region had a net out commute of 98 per 10,000 and the second highest unemployment rate of all regions at 8.1 percent. Median household income ($35,260) and education level was the lowest of all the regions and far below the state average with only 12 percent of the population having attained an associate's degree or higher.

In the area of child well-being, the region had the highest poverty rate of 18 percent compared with the overall state rate of 10.6 percent. On-time graduation rates were the lowest of all regions at 78 percent and PALS-K scores below readiness was the second highest of the regions at 16.3 percent. In contrast, the ratio of low income uninsured children was the lowest of all regions and significantly below the state level at 5.1 percent.

In the context of child care the region had the second lowest ratio of both home-based (15.26) and all child care establishments (54.03) and ratios that were significantly below the state ratios of 27 for home based and 61 for total child care providers per 10,000 population. Given the low population density and lack of proximate higher density areas, this low ratio likely had a greater impact here than in the higher density area of Alexandria/Arlington. The region also had the second lowest ratio of subsidy utilization among the population of children under age 10. It should be noted that while Alexandria/Arlington had the lowest utilization rate, the poverty rate in the Appalachian region was 2.4 times higher. The Appalachian region also had the lowest subsidy monthly average rate per child, $189, compared with $403 for the state and $465 for the other pilot regions.

[16] Tazewell and Smyth Counties are usually covered by Smart Beginnings Smyth/Tazewell. Russell and Washington Counties and Bristol city are usually covered by Smart Beginnings Virginia Highlands.

Relevance to Pilot Evaluation: The low population density and ratio of family care providers in the region explains the difficulty in recruiting providers for the pilot that was experienced by the primary local coordinator for this region. In addition, the low density and education levels help explain the difficulty this area has recruiting and retaining qualified raters and mentors.

Relevance to Sustainability : The relatively low number of family home child care providers in the Appalachia area may have support a high level of possible impact on the quality of child care. As noted in the Engagement and Mentors chapters, while more preparatory work is needed to enable providers to be prepared for rating and quality improvement, the indicators of child well-being provide opportunity for significant impact for early childhood interventions.

Smart Beginnings Central Virginia: For this demonstration pilot, the area covered by Smart Beginnings Central Virginia region was comprised of the jurisdictions of Amherst, Appomattox, Bedford City, Bedford County, Campbell, Lynchburg, Pittsylvania, and Danville.[17] This region had the second lowest population density with 112 people per square mile. Of all the pilot regions, Central Virginia had the second lowest ratio of children under the age of five. It also had the highest unemployment rate at 8.4 percent, and the second lowest median household income at $41,654. Fourteen perfect only of the population had an associate's degree or higher.

In the child well-being dimension, the region had the second highest poverty rate of 15.6 percent, an on-time graduation rate of 83 percent, which was slightly lower than the state average, and PALS-K scores below readiness but above the state average at 16.3 percent.

In the area of child care capacity, the region had lower ratios than the state of both home-based (15.74) and all child care (54.86). However, the region had the highest rate of subsidy utilization of all pilot regions and a rate of 348 per 10,000 children under the age of 10,

[17] Smart Beginnings Danville Pittsylvania was not in place when the demonstration pilot was initiated, but will be covering Pittsylvania County and Danville City in the future.

a figure that is significantly higher than the state rate of 256. The Central Virginia region had the second lowest subsidy monthly average rate per child of $235 compared with $403 for the state and $465 as an average for the other pilot regions.

Relevance to Pilot Evaluation: As demonstrated in Figure G. 4, the Central Virginia region engaged 23 percent of providers in the pilot effort with ostensibly the most efficient engagement strategy, which used a targeted approach and had a strong network and complementary initiatives already in place.

Relevance to sustainability: The region had a strong network and backdrop of initiatives to support the VSQI for family home child care providers. Considering that 23 percent of the regional providers had already been engaged in the pilot and other corresponding initiatives, this region is well positioned to continue and expand the VSQI for family home child care providers.

Smart Beginnings South Hampton Roads: The Smart Beginnings South Hampton Roads region was comprised of Norfolk, Portsmouth, Suffolk, Chesapeake, and Virginia Beach. This region had the highest ratio and population of children, with 151,762 children under age 10. The region also had a high rate of population density at 951 people per square mile. Median household income was lower than the state average at $52,324 as was the education level with 18.6 percent having attained an associate's degree or higher.

The region's unemployment (7%) and poverty (10.9%) rates were on par with the state averages. School readiness and success indicators were slightly better than the state averages, with PALS-K scores being below school readiness at 11.3 percent, compared to 14.1 percent for the whole state and on-time graduation rate of 86 percent, slightly higher than the state average of 85.5 percent.

Home-based child care as a ratio of total child care establishments was the highest among all the regions at 35 percent and higher than the state average of 31 percent. The region also had the highest ratio of home-based child care per 10,000 children under the age of 10 of all the pilot regions (35.58) and a significantly higher ratio than the state average of 26.52 per

10,000 children. The ratio of children served monthly through subsidy, 293 per 10,000 children, was also significantly higher than the state average of 256.

Relevance to Pilot Evaluation: As noted, the region had the highest ratio of home child care providers and a relatively low proportion participating in the pilot at 3 percent. The process evaluation indicates that the targeted engagement approach, in the same time frame as state level licensing changes, complicated the recruitment process even with a large number of providers.

Relevance to sustainability: A large population of 540 licensed or registered providers and complementary initiatives positions the region well to engage a much larger and more diverse range of family home child care providers in ongoing quality improvement efforts.

Summary

Regional variation across indicators of demographic, economic, and early child well-being give insight into the results of the VSQI for family home child care providers' pilot and pave the way for future expansion and evaluation. The considerable variations that exist among Virginia's distinct regions need to inform how resources are allocated and how programs are evaluated.

Table G1. Pilot Region and Virginia Comparisons – Demographics and Geography

Region	Percent of State Pop	Pop 2010 Estimate	Percent under 5	Percent 5 – 9	Size of Region (Square Miles)	Pop Density	Net Out Commute Per 10,000	Unemployed Rate (Feb '11)	Median Household Income	Education Level (Associate's Degree +)
Smart Beginnings Central Virginia Region	4.4%	351,070	6.0%	5.9%	3,141	112	(280.20)	8.4%	$41,654	14.2%
Smart Beginnings Appalachia Region	3.4%	269,221	5.3%	5.1%	3,409	79	(97.99)	8.1%	$35,260	12.1%
Greater Richmond Region	11.0%	879,293	6.6%	7.3%	1,341	656	388.21	7.3%	$ 58,007	24.0%
Smart Beginnings SHR Region	12.8%	1,023,086	7.2%	7.7%	1,076	951	99.56	7.0%	$52,324	18.6%
Alexandria/ Arlington Region	4.3%	341,971	7.5%	5.2%	41	8,300	1,397.75	1.6%	$85,931	42.3%
Fairfax	13.3%	1,061,781	6.9%	7.0%	395	2,688	(192.22)	4.6%	$100,122	36.8%
Total Pilot Areas	49.0%	3,926,422	6.8%	6.9%	9,404	1,860	150.86	6.2%	$67,325	26.0%
Virginia		8,010,340	6.7%	6.5%	39,492	203	(107.80)	6.6%	$59,372	20.4%

Table G2. Pilot Region and Virginia Comparisons – Child Care Context

Region	Registered or Licensed Family Day Care Providers	Home-Based Child Care Establishments Per 10,000 Children	All Registered Day Care Providers	All Child Care Establishments Per 10,000 Children	Home based as Ratio of Total	Families Served Monthly Average '11	Children Served Monthly Average '11	Children Served Monthly Average '11 Per 10,000 Children	County Monthly Average Subsidy	Average Per Child Monthly Exp
Smart Beginnings Central Virginia Region	66	15.74	230	54.86	22.3%	855	1,459	347.96	336,715	235
Smart Beginnings Appalachia Region	43	15.29	152	54.03	22.1%	363	621	220.75	126,497	189
Greater Richmond Region	312	25.64	811	66.65	27.8%	2,433	4,202	345.33	1,682,077	411
Smart Beginnings SHR Region	540	35.58	1,016	66.95	34.7%	2,624	4,450	293.22	1,664,981	393
Alexandria/ Arlington Region	379	87.07	517	118.78	42.3%	585	807	185.41	564,738	712
Fairfax	482	32.51	1,022.00	68.94	32.0%	2,091	3,464	233.65	2,280,180	644
Total Pilot Areas	1,822	34.04	3,748	70.02	32.7%	8,951	15,003	280	6,655,187	465
Virginia	3,141	29.70	6,738	63.71	31.8%	15,912	27,088	256	10,918,329	403

Table G 3. Pilot Region and Virginia Comparisons – Child Welfare Indicators

Region	Low Income Uninsured Children	Poverty Level – 2009	On-time Graduation	PALS-K Scores Below Readiness (09 – 10)
Smart Beginnings Central Virginia Region	12.5%	15.6%	83.0%	15.6%
Smart Beginnings Appalachia Region	5.1%	18.0%	77.7%	16.3%
Greater Richmond Region	18.2%	11.6%	83.8%	14.0%
Smart Beginnings SHR Region	19.3%	10.9%	86.0%	11.3%
Alexandria/ Arlington Region	27.0%	7.6%	81.9%	12.8%
Fairfax	27.0%	5.6%	91.2%	17.0%
Total Pilot Areas	20.2%	10.2%	85.7%	14.3%
Virginia	17.4%	10.6%	85.5%	14.1%

Table G.4. Data Sources for Local Variation

Type of Data	Data Point	Source
Demographic and Socio - Economic Context	Population	Virginia Employment Commission Community Profiles Database http://www.vawc.virginia.gov/gsipub/index.asp?docid=342 Retrieved between April and May, 2011
	Population Ages 0 - 5	
	Population Ages 6 - 12	
	Unemployment rate	
	Education Level	
	Commuting Patterns	
	Size of Region (Square Miles of total land area)	National Association of Countieshttp://www.naco.org/Counties/Pages/FindACounty.aspx. Retrieved between April and May, 2011
	Population Density	Population/ Size of Region
	Median Family Income	The Annie E. Casey Foundation Kids Count Data Center http://datacenter.kidscount.org Retrieved between April and June, 2011
Child Well-Being	Uninsured children	
	Poverty Level	
	On time Graduation	
	PALS-K Scores Below Readiness	
Child Care Context	Subsidy Utilization	Virginia Department of Social Services Child Care Assistance Reports http://www.dss.virginia.gov/geninfo/reports/children/child_care.cgi May, 2011
	Registered or Licensed Day Care Providers	All Localities: Virginia Department of Social Services Child Day Care Registry http://www.dss.virginia.gov/facility/search/cc.cgi April – June, 2011 Arlington and Alexandria: http://www.dss.virginia.gov/family/cc/arlington_familybased.pdf http://alexandriava.gov/humanservices/info/default.aspx?id=9588 July, 2011