



RESEARCH REPORT

Child Care Providers' Reflections on Quality Improvement

District of Columbia Child Care Policy Research Partnership Study

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Glossary

Capital Quality: Capital Quality is the District of Columbia's enhanced Quality Rating and Improvement System (QRIS). It was launched in 2016, fully implemented in 2018, and began publicly posting ratings in 2019. Capital Quality replaces Going for the Gold, DC's original QRIS, with a system that measures program quality and focuses on continuous quality improvement. It employs a common measure of quality across child development programs offered in public charter schools, DC Public Schools, and community-based organizations. Providers' ratings are posted on My Child Care DC, DC's consumer education website, which allows parents to search for, review, and compare the quality of various child development facilities throughout DC and make informed decisions when deciding where to enroll their child.

Child Care and Development Block Grant (CCDBG) and Child Care and Development Fund (CCDF): The CCDBG is a federal law that authorizes CCDF spending of federal and state matching funds on child care, including child care subsidies, quality improvement, consumer education, and research.

Classroom Assessment Scoring System™ (CLASS™): The Classroom Assessment Scoring System™ (CLASS™) is an observational instrument designed to assess classroom quality in PK–12 classrooms. It describes multiple dimensions of teaching that are linked to student achievement and development. It measures the quality of early educator–child interactions captured in emotional support, classroom organization, and instructional support domains. DC uses the CLASS™ to reliably assess classroom quality and help new and experienced teachers become more effective. It is used in child care facilities that participate in Capital Quality and serve preschool-age children (ages 3 to 5). CLASS observations were not completed in 2019–20. CLASS observations were voluntary in 2020–21 and are being conducted in 2021–22. The data will not be used for high stakes purposes (such as for determining ratings or Capital Quality designations) but will be used for the annual pre-K report and for professional development purposes.

Consumer education: Efforts to provide families with the information they need to search for and select child care, including public ratings generated through quality rating and improvement systems like Capital Quality.

Continuous Quality Improvement Plan (CQIP): An ongoing documented plan developed by providers to improve processes, operations, and the quality of services. Providers develop and annually revise their CQIP with the support of their quality facilitator, who may tailor technical assistance based on the

CQIP, observation assessment results, and the provider's goals. The CQIP is developed in the Quick Base application, a secure, online database.

Environment Rating Scales (ERS): A measurement tool used to assess child care quality based on observational ratings of the physical environment, basic care routines, curriculum, adult-child interactions, schedule and program structure, and provisions for parents and staff. ERS are used to assess licensed child care facilities that participate in Capital Quality and serve infants and toddlers (with the Infant/Toddler Environment Rating Scale, or ITERS) or are based in homes (with the Family Child Care Environment Rating Scale, or FCCERS). ERS observations were not completed in 2019–20 and have since been on pause because of the COVID-19 pandemic.

Going for the Gold: The child care quality rating and improvement system that preceded Capital Quality in DC.

Nontraditional-hour facilities: Licensed child care facilities that offer care beyond standard hours (7:00 a.m. to 6:00 p.m. from Monday to Friday), including those offering 24-hour care. Nontraditional-hour child care includes care provided during the early morning, evenings, overnight, weekends, and holidays.

Quality facilitators: Capital Quality employs coaches called quality facilitators who meet with child care providers to support quality improvement efforts including preparing for observations, creating continuous quality improvement plans (CQIPs), identifying quality improvement activities, and linking providers to resources. Quality facilitators also provide technical assistance and professional development.

Quality rating and improvement system (QRIS): An accountability tool typically implemented at the state or county level for child care programs that rates program quality and supports providers in improving program quality, implemented (at least in part) with CCDF funding.

Executive Summary

As of 2017, 49 states and the District of Columbia were devoting public resources to implement quality rating and improvement systems (QRISs) designed to support early care and education (ECE) quality and families' selection of ECE programs. The idea is that supporting ECE quality and publicly posting ratings will lead to improved quality and help parents find quality care.

In 2018, DC launched a new QRIS, Capital Quality. Licensed child development facilities in the District with a signed agreement with the Office of the State Superintendent of Education (OSSE) for subsidized child care were automatically enrolled in Capital Quality over a two-year period. Other licensed child development facilities have been encouraged to participate as volunteers. Capital Quality

- provides direct coaching to center directors and lead caregivers in licensed homes to support them in their work to improve the quality of their ECE services;
- offers professional development for child care providers and select staff;
- gives providers access to funding for materials and infrastructure improvements;
- incentivizes providers with tiered subsidy reimbursement rates, so providers at higher quality levels receive higher rates;
- provides third-party independent observers, not affiliated with Capital Quality implementation, who produce valid and reliable ratings using standard observation measures; and
- posts information on facility quality on a publicly available child care search website maintained by OSSE (My Child Care DC)—as well as inside participating child care facilities—with the goal for families to use the information as they search for and select ECE providers.

Based on interviews with 36 child care providers participating in Capital Quality, we found that the new QRIS is helping providers work toward their quality improvement goals. Key findings include the following:

- Participating providers reported favorable experiences with most components of Capital Quality. In particular, they appreciated the support of their quality facilitators and belonging to a community of practice with other local providers.
- Most study participants reported benefits from participating in Capital Quality, including improvements in the physical learning environment, enhanced instruction and adult-child

interactions, a greater sense of professionalism and personal growth, and improvements in staff motivation and content knowledge.

- Some providers reported challenges with the amount of time required for quality improvement activities. Several felt discouraged when the level of professional development offered did not meet their needs, when their quality facilitators had inadequate training or experience, or when they believed their facilities' ratings did not accurately represent their program's quality.
- Study participants offered a range of recommendations that included tailoring professional development to meet providers' needs, expanding coaching to classroom staff, ensuring metrics are adjusted to reflect providers' voices, and reconsidering how subsidy rates are linked to quality more equitably to better support all providers working to improve quality.

New federal investments in child care and early education provide DC with an opportunity to address the challenges with Capital Quality and build on its strengths. Future research with local early educators and parents as part of the larger District of Columbia Child Care Policy Research Partnership Study will strengthen the evidence base about Capital Quality's role. This report lays the foundation for potential system changes to help DC achieve its aim of improving access to quality child care throughout the District.

Child Care Providers' Reflections on Quality Improvement

Introduction

Child care quality matters both for children and parents. Research shows that quality ECE has a positive impact on young children's growth and development (Bassok et al. 2016; Yoshikawa et al. 2013) and that parents who use higher-quality child care have fewer absences from work and demonstrate greater productivity (Shellenback 2004). Moreover, parents who receive child care subsidies are more likely to be employed, report higher earnings, and retain employment over time (Blau 2002; Danziger, Ananat, and Browning, 2004; Forry and Hofferth 2011). Increasing access to high-quality and affordable child care can yield benefits for parents and children—especially those in families with low incomes.

Yet even before the COVID-19 pandemic, many families—especially those with low incomes—faced challenges accessing quality child care (Guzman et al. 2009; Jessen-Howard et al. 2018; Sandstrom et al. 2018; Schilder and Sandstrom 2021). Families with infants and toddlers and those working nontraditional hours have been facing even greater challenges given limited care supply that meets their needs (Henly and Adams 2018; Sandstrom et al. 2019). Since the COVID-19 pandemic, the overall supply of child care in the United States has declined and challenges accessing quality care have increased (Adams, Ewen, and Luetmer 2021).

To address this problem, federal policies put in place in the past decade have focused on building care supply and improving the quality of existing supply. The 2014 reauthorization of the Child Care and Development Block Grant and associated regulations included several provisions emphasizing the importance of quality.¹ Some of these provisions call for states to design and implement systems—called quality rating and improvement systems (QRIS)—to rate the quality of child care and support quality improvements through coaching, professional development, and technical assistance.² And as of 2017, 49 states had piloted or implemented a QRIS.³

DC—like many states—launched a revised QRIS in 2018 based on new evidence about the types of supports that yield desired improvements. This QRIS—called Capital Quality—provides research-based supports to enhance the quality of existing child care available to DC families. Licensed child care facilities with a child care subsidy agreement are required to participate in Capital Quality, and other

licensed providers have been encouraged to participate voluntarily. They are assigned one of four quality designations: *developing*, *progressing*, *quality*, or *high-quality*. Newly enrolled facilities are designated *preliminary*. Unique features of Capital Quality are the following:

- **A common definition of quality and associated standards across care settings.** Capital Quality provides a common, consistent definition of quality across child care centers and family child care homes (referred to as child development centers and child development homes in DC). The standards account for the quality of the physical environment, interactions between adults and children, implementation of curriculum, and family engagement.
- **Targeted quality improvement supports.** Capital Quality assigns a one-on-one coach (called a quality facilitator) to each child care facility who meets regularly with the director or family child care owner. The quality facilitator helps identify areas of strength and opportunities for improvement, and they work with the director to develop and implement a continuous quality improvement plan (CQIP). Program directors also participate in a community of practice with other providers to support peer sharing and learning and overall professional development. Participating facilities also receive curriculum materials and resources. Capital Quality offers enhanced supports to facilities with lower-quality ratings—referred to locally as quality designations—and tailored supports to facilities with higher ratings.
- **Independent observers who rate facility quality using validated tools.** Trained and reliable observers conduct independent observations using valid and reliable measures. These measures are a central feature of Capital Quality. OSSE contracts with independent vendors to conduct the observations annually. Each contractor follows certification procedures established by the tool developers and conducts ongoing reliability checks. Because of the COVID-19 pandemic, observations scheduled to occur in spring and fall 2020 and 2021 were cancelled. Because of the postponed observations, facilities that began participating in Capital Quality in 2019 have maintained their initial quality ratings and associated subsidy reimbursement rate and have not yet had their quality reassessed.
- **Incentives in the form of tiered subsidy reimbursement rates.** Each participating provider's subsidy reimbursement rate is determined by their quality rating, or designation. Facilities with higher ratings receive higher reimbursement. For example, centers given a *high-quality* designation have a reimbursement rate for full-time infant care more than 40 percent higher than the rate for facilities with a *developing* designation. The difference for child development homes is 35 percent. The theory behind tiered reimbursement is that the higher rate will serve as an incentive for facilities to work toward improved quality. The subsidy rates are based on a

cost of quality model designed to provide payments based on the actual cost of providing quality child care.

- **Public ratings.** Capital Quality developers intended for families to easily access and review information on program quality and compare the quality of various programs to make more informed decisions when deciding where to enroll their children. As of 2019, OSSE publicly posted each facility's profile and quality designation on DC's child care search website, My Child Care DC.⁴ This website allows parents to search for care based on the quality rating. Because of delays in observations during the COVID-19 pandemic, current ratings are based on observations that occurred before 2020.

We designed our research study to address questions about whether the quality improvement efforts offered through Capital Quality have been meeting the needs of child care providers, their staff, and local families. This report presents findings from our interviews with 36 directors of child development centers and child development homes and expanded homes⁵ in DC about their experiences with and perspectives on Capital Quality. The interviews occurred between July and November 2020 during the early months of the COVID-19 pandemic. During the data collection period, some facilities were temporarily closed, and others continued serving families or were in the process of reopening. In that context, we asked directors about the benefits of Capital Quality and how it has affected their program, their relationship with their quality facilitator (the coach who works with them to set program goals for reaching higher quality), challenges with participation, and recommendations for changes. We also expanded the original study design to explore how the pandemic affected child care providers broadly, including their quality improvement efforts.

BOX 1

Context Affecting Capital Quality Implementation

Capital Quality is the largest quality improvement initiative in DC, but it is one of many factors affecting child care quality in the District. At the time that Capital Quality was being implemented, child development centers and homes were also eligible to receive infant and toddler grants, were informed of new child care licensing requirements, experienced changes in minimum wage law, and were affected by the COVID-19 pandemic. Each factor is described briefly below.

- **Initiatives to support infant and toddler care.** DC has taken steps to address the unmet need of families with infants and toddlers, estimated to be as high as 28,000 slots (Reinvestment Fund 2018). At the time of our study, nearly \$3 million in *Access to Quality Child Care Expansion Grants* fund improvements in facilities and create new quality infant and toddler slots. In addition, since 2015, DC has supported a system improvement strategy called the Quality Improvement

Network (QIN). DC has used a federal Early Head Start—Child Care Partnership grant and other public and private funding to support networks of centers and homes to meet Early Head Start standards.

- **Pre-K expansion.** In 2008, DC passed legislation known as the Pre-K Enhancement and Expansion Act. This law requires facilities to be accredited by a national accrediting body approved by OSSE to receive a Pre-K Enhancement and Expansion Program (PKEEP) grant for pre-K services.^a
- **New minimum education requirements.** In efforts to improve child care quality, DC raised minimum education requirements for child care program directors and teaching staff. Final regulations were published in December 2016. By December 2023, lead teachers and expanded home caregivers must have completed an associate degree, and center assistant teachers, home caregivers, and associate home caregivers must earn a Child Development Associate (CDA) credential. By December 2022, center directors must hold a bachelor's degree in early childhood education or a related field, or hold a bachelor's degree in any field with at least 15 semester credit hours.
- **Changes in wages.** DC raised its minimum wage to \$14.50 an hour, effective January 2019, and again increased the minimum wage to \$15.20 in July 2021. The increase occurred because of policy action that ties DC's minimum wage to the Consumer Price Index. In July 2022, the minimum wage will increase again to \$16.10 an hour.^b
- **COVID-19 pandemic.** At the time Urban researchers were collecting data and DC was phasing in Capital Quality, the pandemic led to child care facility closures. During this time, DC chose to continue supporting child care providers by issuing child care subsidy payments to those who had been providing subsidized care before the pandemic and by continuing to support quality improvement activities. Policies have continued to change throughout the pandemic and the federal government has provided stimulus funding to offset some of the challenges experienced by child care providers as a result of the pandemic.
- **Increased awareness of structural racism.** In the aftermath of the George Floyd murder, the nation experienced an increased awareness of structural racism (Nguyen et al., 2021). In DC, the majority of the child care and early education workforce is composed of Black and Latina women who have faced barriers to opportunities as a result of structural racism. The research team accounted for this context when analyzing the key themes that emerged from our qualitative analysis.

^a Pre-K Enhancement and Expansion Amendment Act of 2008, D.C. L. No. 17-202 (July 18, 2008), <https://code.dccouncil.us/us/dc/council/laws/docs/17-202.pdf>.

^b "Office of Wage Hour Compliance: Minimum Wage," District of Columbia Department of Employment Assistance, accessed June 15, 2022, <https://does.dc.gov/service/office-wage-hour-compliance-0>.

Methods

We designed a mixed-methods study to understand child care providers' experiences with Capital Quality. We recruited directors of child development centers and owners or directors of child development homes and expanded homes to participate in the study. Study recruitment and data collection occurred from late July to November 2020. We collected the data during the early phase of the COVID-19 pandemic and analyzed the data over the next year. In this section, we briefly describe data collection procedures, characteristics of study participants, and how we analyzed the data. See appendix A for details on our methods.

Data Collection Procedures

We used two measures to collect data from participants. We designed these instruments to capture providers' perspectives about key aspects of Capital Quality design and implementation during the early days of the COVID-19 pandemic. We designed the questions to focus on the aspects of Capital Quality that would endure beyond the pandemic but included several questions to capture providers' perspectives of the pandemic as well. The instruments included a 24-question web survey and a semistructured interview protocol.

- **Web survey.** We emailed participants a voluntary web survey that asked about the characteristics of children attending the program, the main reasons providers were participating in Capital Quality, the benefits of Capital Quality participations, and challenges with it. A total of 31 of the 36 participants completed the survey before the phone interview.
- **Semistructured phone interviews.** We used a semistructured interview protocol to learn about
 - » quality improvement supports, including the director's relationship with their quality facilitator, development and use of a quality improvement plan, and progress toward goals;
 - » experiences with scheduled observations of the care environment;
 - » perspectives on the Capital Quality rating process and perceived fairness of ratings;
 - » benefits of Capital Quality;
 - » challenges with Capital Quality;
 - » beliefs about how parents use Capital Quality ratings and whether the rating has influenced demand for their program; and
 - » other factors that might have affected their ability to offer quality care, including COVID-19, the recent increase in the minimum wage, and new licensing requirements that

mandate minimum education levels for child care directors and teaching staff members in centers and homes.

Study Participants

A total of 31 program directors completed the web-based survey and 36 participated in the interviews. Of the 36 interview participants, 27 were center directors, 5 were caregivers in child development homes, and 4 were lead caregivers in expanded child development homes. Table 1 displays characteristics of these participants, their programs, and enrolled children.

Nearly all participants reported accepting children receiving a subsidy, which was expected because Capital Quality participation is a requirement for providers with a signed agreement with OSSE to provide subsidized child care. One participant did not serve subsidized children and opted into Capital Quality voluntarily. Six were licensed for nontraditional-hour child care and 11 were accredited. Of the 36 participating facilities, nearly all (35) served both infants and toddlers, 21 also served preschool-age children, and 6 also served school-age children. Across all children enrolled in the represented facilities, nearly half were toddlers (1 or 2 years old) and most were Black (67 percent). Thirty percent of the children enrolled in these facilities spoke a language other than English as their primary home language.

The sample had a mix of Capital Quality designations: 7 were high-quality, 15 were quality, 6 were progressing, 3 were developing, and 5 had recently enrolled and had preliminary ratings. The sample also included providers who began participating in Capital Quality for different time frames. Some had been in the system for several years while others had been participating for only 18 months or so.

Sample characteristics were similar to the characteristics of all Capital Quality participants, with a few exceptions: a larger percentage of providers that we interviewed were rated quality and a smaller percentage were rated progressing compared with facilities in Capital Quality overall. Also, a larger percentage of interview participants participated in the Child and Adult Care Food Program (CACFP) and a smaller share were accredited or held a nontraditional-hour child care license.

Data Analysis

We tabulated the survey data to identify characteristics of participating facilities and providers. To analyze the interview data, we used a detailed coding scheme that reflected the main interview topics, such as the benefits of Capital Quality. We used NVivo software to code the interview transcripts. The

research team performed the quantitative and qualitative analysis. For the qualitative analysis, the team trained data coders and implemented routine coding checks to ensure the coding scheme was followed consistently. The team met weekly to discuss progress on analysis, emerging themes, and the report structure. See appendix A for more details on data coding and analysis.

TABLE 1

Interview Sample Characteristics

Characteristics of participating facilities compared with all licensed child care facilities in Capital Quality

Characteristic	Share of participating facilities with at least one child with characteristic	Share of all enrolled children across participating facilities with characteristic	Share of all child care facilities in capital quality with characteristic
Care type			
Child development center	75%	n/a	77%
Child development home ^a	14%	n/a	15%
Expanded child development home	11%	n/a	8%
Capital Quality designation			
High-quality	19%	n/a	13%
Quality	42%	n/a	30%
Progressing	17%	n/a	37%
Developing	8%	n/a	4%
Preliminary	14%	n/a	17%
Sources of funding			
Accepts child care subsidies	97%	77%	94%
Paid with tuition or private pay	65%	13%	—
Received Pre-K Enhancement and Expansion Program (PKEEP) Funding	16%	16%	10%
Age groups enrolled			
Infants (younger than 12 months)	81%	15%	82%
Toddlers (1–2 years)	97%	49%	95%
Preschool (3–4 years)	72%	29%	78%
School-age (5 and older)	25%	7%	22%
Nontraditional-hour child care license	17%	n/a	46%
Accredited	31%	n/a	46%
Child race/ethnicity			
Asian	13%	<1%	—
Black	94%	67%	—
Latinx	41%	17%	—
White	38%	11%	—

Characteristic	Share of participating facilities with at least one child with characteristic	Share of all enrolled children across participating facilities with characteristic	Share of all child care facilities in capital quality with characteristic
Mixed race or another race	34%	6%	—
Other child characteristics			
Primary home language is not English	66%	30%	—
Has a disability	63%	7%	—

Source: Data on characteristics of children served and sources of funding come from the web survey completed by child care center directors and home providers before participating in qualitative phone interviews (N = 31). This information is not known for all facilities in DC, so table cells for that column are left blank (—). Data on nontraditional-hour child care, quality ratings, and Capital Quality cohort come from 2019 child care licensing data used for study sampling.

^aA child development home is a small, licensed family child care program serving up to 6 children. An expanded child development home is a large, licensed family child care program serving 6 to 12 children.

Findings

Capital Quality consists of multiple complementary components—coaching, Community of Practice, links to resources, and more—designed to improve child care quality. Most participants reported positive perceptions of these components, but perceptions varied. Study participants reported that their experiences were based in part on their roles and responsibilities. In this section, we summarize findings from our survey and interviews related to motivations for participating in Capital Quality, participants’ perceptions of each component of Capital Quality, and reported benefits and challenges with participation. We quote interview participants to illustrate key points they shared. We conclude with a set of recommended changes based on participants’ feedback.

Roles, Responsibilities, and Reasons for Participating

Providers who participated in our study included center directors, center administrators, and family child care providers. Across these roles, participants described their responsibilities as “wearing many hats.” Study participants reported being responsible for leading or participating in accounting and administrative tasks; managing, supervising, and teaching staff; organizing staff professional development and sharing resources with staff; overseeing all classrooms or learning spaces; developing program and quality improvement goals; continually assessing progress on goals; making sure staff have the qualifications necessary to deliver quality care and all staff credentials are up to date; ensuring the program meets licensing criteria; engaging families; and supporting staff well-being. Overall, most study

participants reported that their personal role was to ensure that quality care was provided for the children and families they serve.

MOST PROVIDERS PARTICIPATED IN CAPITAL QUALITY TO IMPROVE QUALITY

Although participation in Capital Quality is required for facilities caring for subsidized children, most providers (74 percent; $n = 23$) reported on the web survey that they wanted to participate in Capital Quality to help improve program quality (figure 1). Among the list of possible reasons we provided on the survey, about half reported they wanted to be a part of a District-wide early childhood initiative and nearly half wanted access to support from a quality facilitator. Fewer joined to attract families to their programs (13 percent; $n = 4$).

FIGURE 1

Reasons for Participating in Capital Quality



Source: Web survey completed by center directors and home caregivers before participating in phone interview ($N = 31$).

Notes: Includes responses selected by at least 10 percent of survey respondents. Respondents could select all reasons that apply.

Providers' Experiences with and Perceptions of Capital Quality

We analyzed interview data to assess providers' perceptions of each component of Capital Quality and its benefits. Below, we summarize several key themes across interviews. Participants described how Capital Quality sets the bar to motivate change in behavior. It offers a combination of direct support from a trained quality facilitator, an opportunity to create a CQIP that helps them prioritize access to

resources, professional development supports, and connections to a peer community. Providers appreciated that the system recognizes them as professionals. All these factors help them work on their goals to improve program quality.

CAPITAL QUALITY CREATES A COMMON DEFINITION AND BAR FOR QUALITY ACROSS SETTINGS

Most study participants reported that Capital Quality establishes quality standards and creates a common definition of quality across family child care homes and child care centers. Several reported that the standard observation instruments and independent observations provide a common metric across programs for both defining and improving quality.

Additionally, multiple study participants reported that Capital Quality “set a bar” for all child care facilities. Some reported that the bar is a high standard, whereas others felt the standards are not particularly high and that all child care facilities could reach them with some support. Moreover, several reported that this common definition and metric help them prioritize actions to improve quality.

I think that without Capital Quality, we wouldn't be able to really determine what help we need. And with their guidance, it really helps us prioritize what we are supposed to be focusing on.

—DC child care provider

PROVIDERS RECEIVE ONGOING SUPPORT FROM QUALITY FACILITATORS

Quality facilitators provide regular coaching supports to the leaders of participating child care facilities. Many study participants reported benefiting from the time spent with quality facilitators, though they reported some variability in their level of engagement. Most providers reported that they met with their quality facilitator every two weeks for about 90 minutes. Some interacted on a weekly basis, having informal phone calls in between scheduled sessions, while others engaged less frequently. This variability exists mostly because developing and progressing facilities typically receive more intensive coaching than quality and high-quality facilities. Even when facilities closed during the pandemic, many study participants continued engaging in regular meetings virtually that focused on issues of health and safety, how to follow CDC guidelines, and supporting families and staff experiencing trauma and stress.

Study participants reported multiple benefits of their work with their quality facilitator. Most described the benefit of having an ongoing relationship with a trusted advisor who is knowledgeable, responsive, and always there to help. They received timely information on available trainings, upcoming observations, changes in child care regulations, and COVID-19 developments. Several reported receiving responsive feedback on a regular basis and calling their quality facilitator whenever they had a question.

The most positive experience I had with Capital Quality was actually meeting my quality facilitator. She is absolutely excellent. We have forged this great relationship. She allows for a level of transparency that allows me to be vulnerable; therefore, I can get the help I really need...I can tell her straight up, "This is where we need help. This is our concern." She is very valuable in helping us to address those needs.

—DC child care provider

Another benefit reported was tailored and hands-on support. Quality facilitators helped point to areas needing improvement to prepare for observations, and post-observations helped providers interpret ratings and observation scores. They walked providers through the process of developing a continuous quality improvement plan (CQIP; box 2). Several providers said they benefited from having a knowledgeable coach to be able to “bounce ideas off of” about how to best improve quality. Several noted the hands-on support and guidance brought a fresh perspective.

BOX 2

Continuous Quality Improvement Plan

The continuous quality improvement plan (CQIP) is an ongoing documented plan developed by providers to improve processes, operations, and the quality of services. Providers develop and annually revise their CQIP with the support of their quality facilitator, who may tailor technical assistance based on the CQIP, observation assessment results, and provider’s goals. The CQIP is developed in the Quick Base application, a secure, online database.

The CQIP requires programs to address the following domains: (1) curriculum and instruction are aligned to DC Common Core Early Learning Standards; (2) formal and informal assessments are aligned to curriculum; (3) formal and informal assessments are implemented; (4) data are used to inform

instructional and professional practices (formal assessments are CLASS™ Pre-K and/or ITERS-R and/or FCCERS-R); (5) culturally and linguistically responsive practices are implemented; (6) inclusion practices are implemented; (7) developmental screenings are implemented; (8) early care and education professionals meaningfully engage in professional development; (9) family engagement promotes positive and goal-oriented relationships; and (10) mission statements reflect both the program and families served. In fall 2020, attendance was also included but is not a current indicator.

CAPITAL QUALITY PROVIDES INDEPENDENT OBSERVATIONS OF CARE QUALITY

Capital Quality ratings are based on independent observational assessments of the care environment. Trained observers complete the assessments using one of three observation tools: (1) the Infant/Toddler Environment Rating Scale-Revised (ITERS-R), designed to assess the quality of infant and toddler classrooms in centers; (2) the Family Child Care Environment Rating Scale-Revised (FCCERS-R),⁶ designed to assess quality of family child care homes; and (3) the Classroom Assessment Scoring System (CLASS)—Pre-K, designed to assess preschool classrooms. The ITERS and FCCERS-R measure the degree to which the child care facility and adult caregivers at the facility promote children’s health and safety, stimulate learning through language and activities, and provide warm, supportive interactions. The CLASS-Pre-K® assesses preschool teachers’ interactions with children, including the emotional climate of the classroom, classroom organization, and instructional supports.

Interview participants described the process of scheduling these observations and being observed and what they learned from them. Overall, they reported that scheduling the observation was simple, but they had mixed feelings about the observation process. Many reported that they are used to being monitored and observed and knew what to expect, but some shared concerns about how observations are done (described later in the section “Challenges with Capital Quality”).

After an observation takes place, providers receive a program-level report showing the score on the specific observation measure. Providers generally commented that the report is useful, as it highlights strengths and weaknesses and points to areas to target improvement efforts. Several reported that specific observation tools (such as the ITERS) helped them develop a better, more tangible understanding of what quality care looks like. Providers reported using the report in a few different ways. Some noted that they reviewed it with their quality facilitator and used it as a guide to develop professional development plans and trainings, while others reported reviewing it with teachers and staff to facilitate a conversation around quality at the program level. In 2020, after data collection concluded for this study component, OSSE began paying for classroom-level reports that were deidentified for 2020–21 voluntary CLASS observations.

If we're doing something really good, then we keep doing what we're doing. But if something needs an improvement, then we take the feedback from the observation and...that's our focus now for our trainings.

—DC child care provider

MOST STUDY PARTICIPANTS PERCEIVE INDIVIDUAL RATINGS AS FAIR

Although several interview participants shared concerns about the fairness of how ratings are determined and felt their quality was higher than their current rating, most felt the system is fair. Several who were rated as quality or high-quality said they agreed with their rating because it was high and reflected their efforts. They described working hard to achieve their designation level. Others who were rated progressing understood why and knew what they needed to do to get to quality, but they first had to overcome certain barriers and improve on certain practices.

I was very proud of [our rating]. I thought it was a wonderful thing. I shared it with my families, and they were even proud. They [were] like, "Well, we didn't need that [rating] to know [you were high-quality]," but I just wanted to let them know that I'm rated by a governing body that's saying I'm a high-quality program. You know, that's a lot to be proud of...I'm saying, because I worked really hard.

—DC child care provider

CONTINUOUS QUALITY IMPROVEMENT PLAN HELPS PROVIDERS PRIORITIZE AREAS TO IMPROVE

At the time of our interviews, nearly all providers had created a CQIP or were in the process of creating one. They reported that developing a CQIP helped them identify their programs' strengths and areas in which they could improve. Most described how having the plan made them more proactive and strategic with planning staff professional development. They tended to use the plan to create goals to improve in specific areas. Setting specific and attainable goals helped make them more accountable. Some participants also reported that the process of reflecting on their program quality and developing

the plan alongside their quality facilitator was helpful for their own learning and professional development.

[The CQIP is] helping me with the goals for our center, the goals for our teachers. Even creating the policies and lesson plans, schedules in our classrooms...Even to the point of displays on the wall, how to get the parents involved in the child's learning.

—DC child care provider

Several participants also referenced the complementary value of their quality facilitator and the CQIP in identifying areas for growth and creating a plan to achieve specific goals. Many believed this more concrete understanding of quality and how to achieve it translated into improvements in adult-child interactions, family engagement, and the physical classroom environment.

Sometimes, when you look at yourself as an overall center, you see a million things that you could improve on. Capital Quality has helped me really organize my thought process about that...Even though it's a lot of work, it has also made my life less overwhelming.

—DC child care provider

CAPITAL QUALITY OFFERS PROFESSIONAL DEVELOPMENT AND PEER LEARNING OPPORTUNITIES

Capital Quality offers a range of professional development opportunities to child care providers with the aim of supporting quality improvement. Providers told us the format of the professional development ranged from in-person to virtual and from formal instruction to informal peer sharing. Several study participants reported that Capital Quality led to connections with other child care providers in DC. Most peer interactions occurred during monthly Community of Practice meetings, where providers were able to get to know each other personally and hear perspectives from others outside their own programs. Several participants noted the benefit of these meetings and learning new

strategies. They were able to use the information that other providers shared about what worked for them to enhance their own program.

We get to ask questions and compare what goes on within our facility with other providers, which is great, because a lot of the time you think you're the only one going through something, and then you find out it's not just you.

—DC child care provider

Overall, participants reported gaining new knowledge from Capital Quality professional development opportunities. Specifically, during semistructured interviews, study participants told us they learned how to

- develop goals that are specific, measurable, achievable, relevant and timebound (SMART) to guide quality improvement (more recently, after interview data were collected, Capital Quality expanded this focus to supporting SMARTIE goals to ensure goals also account for inclusion and equity);
- better engage families and community members, including using multiple methods to share information, such as sharing in person, in writing, and online;
- implement curriculum and develop tailored lesson plans;
- communicate effectively with teaching staff to support their growth; and
- in some cases, administer early childhood screenings.

Some also reported that they shared relevant information from Capital Quality professional development trainings directly with parents, such as information on local community resources.

MOST PROVIDERS POST RATINGS AND SOME BELIEVE PARENTS USE THE RATINGS

Many providers participating in Capital Quality reported posting an official Certificate of Participation in Capital Quality in their facility, which lists their quality rating—a designation of preliminary, developing, progressing, quality, or high-quality. Though posting the designation is not required, some providers may have thought it was a requirement they needed to comply with for ongoing participation

based on their response to our questions about it. Even though most posted the certification, few said they made a point to tell parents or visitors what it means.

We asked them whether parents ever ask about Capital Quality or may be basing their care decisions around Capital Quality ratings. Several directors described their programs' positive reputation in the community and competition among families to get into their programs; they did not feel a need to advertise their quality designation to attract families. Though several providers believed that some parents use the ratings when searching for child care. Four providers (two center-based and two home-based) said they believed families who pay entirely out of pocket, those new to the area, and parents who are educators seem more likely to ask about the ratings. From what they saw, parents take the ratings into account when researching programs, but quality ratings are not the deciding factor in their final choice. They also noted based on past experience that families who access child care subsidies are not as likely to ask about Capital Quality ratings but did not elaborate on the reasons they think this is the case.

In contrast, a small number of providers thought the public ratings played a significant role in parents' child care decisions: "Just like they look for centers that are accredited. This is just, to me, another criteria of what is quality...[Parents say,] 'Yeah, I would like to put my child in the highest quality facility available for me.'" Another provider explained that if families are not seeing improvements over time, they may choose to leave the program.

At the time of data collection, only a few providers reported seeing that the ratings had an impact on demand, with two providers reporting a slight increase in demand after receiving their (positive) ratings. Nonetheless, three providers mentioned that they include their rating in materials for recruitment and fundraising. Additionally, many respondents reported that they regularly inform parents of their quality improvement efforts.

The pandemic affected the observations and timing of determining designations. Specifically, OSSE temporarily cancelled all observations in 2020, which are necessary to calculate ratings. Thus, for some providers we interviewed in 2020, posted ratings did not reflect what they believed their actual program quality might be if observations had occurred.⁷ However, several providers said that before the pandemic they informed families of changes in quality designation, when they occurred.

HIGHER-QUALITY PROGRAMS LIKE LINKING SUBSIDY PAYMENTS TO RATINGS

When asked about basing subsidy reimbursement rates on Capital Quality designations, one-third of providers—10 of whom received ratings in the top two tiers—said they liked the policy of linking subsidy

payments to ratings or were okay with it. These providers thought higher-quality programs deserved increased funding because of the financial investment and hard work required to achieve and maintain quality. In particular, they noted the cost of hiring and retaining qualified staff, without which they could not maintain a high-quality rating. In contrast, other interview participants felt discouraged by this policy, saying facilities with lower-quality ratings need more money from subsidy reimbursement to cover the costs necessary to improve quality. This issue is discussed later in the section on challenges.

I think it's fair. I think that if a program is giving high-quality or quality education to children, then their reimbursement rate should be higher. Because it would make sense that you're spending more to get these...results, right? If you're not spending a lot, then your results aren't going to be the same, because a lot of it has to do with the kind of items that are in the classroom and what you're making sure your children have access to. And so if you're not spending the money to do that, then you're shortchanging children.

—DC child care provider

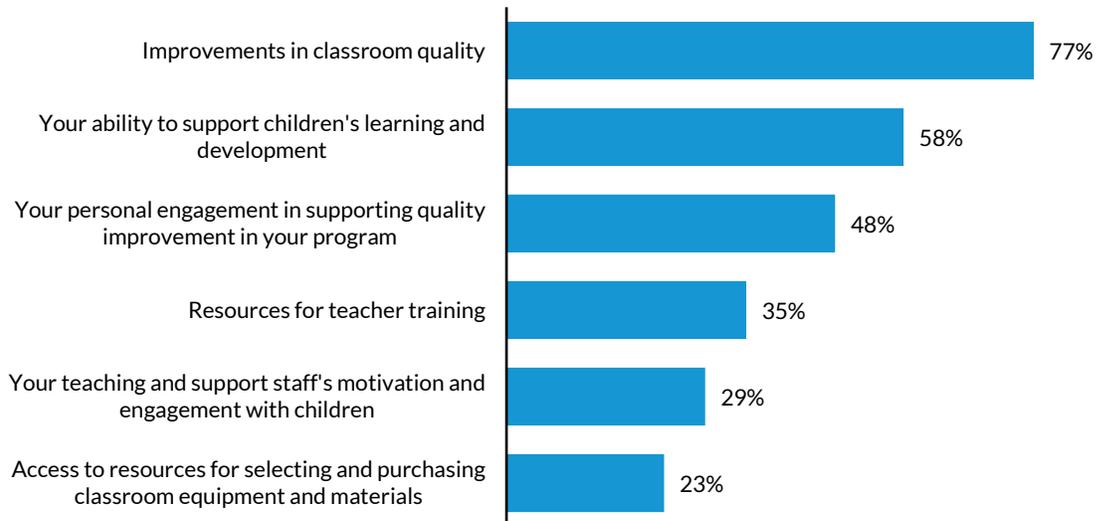
Providers' Reflections on How Capital Quality Benefits Child Development Facilities and Staff

Providers were generally positive about their experiences with Capital Quality and reported that participating had improved their program's quality. Providers at all quality levels noted reaping benefits from Capital Quality. Nonetheless, some providers designated as quality or high-quality were somewhat more critical of Capital Quality, noting that the professional development and coaching were often not tailored to higher-quality facilities' needs. A few mentioned they needed support in areas in which their quality facilitators lacked expertise. In contrast, others were overwhelmingly grateful for their quality facilitator and access to professional development and resources. Figure 2 displays the top benefits survey respondents identified, which align with the observed benefits providers discussed during interviews. They described improvements in the quality of the care environment, improvements in adult-child interactions, increased staff motivation and desire to learn, and a greater sense of professionalism.

FIGURE 2

Observed Benefits of Participating in Capital Quality

Percentage of respondents selecting response option to question, “What are the top three benefits you have seen in your program?”



Source: Web survey completed by center directors and home caregivers before participating in phone interview (N = 31).

Notes: Respondents were asked to select the top three choices. Frequencies show the number of respondents that selected the benefit as one of the top three choices.

Providers Report Observing Improvements in the Physical Learning Environment

Although only 23 percent of survey respondents listed access to resources as one of the top three benefits of participating in Capital Quality, in interviews many providers noted access to free and subsidized classroom resources as a major benefit of Capital Quality. Providers mentioned using funds accessible to them as a Capital Quality participant to purchase items for their facilities, such as new toys, books, computers, furniture, and other classroom supplies. Without Capital Quality, providers reported that many necessary items are not affordable. A few providers also noted that feedback from formal observations, advice from their quality facilitator, and general learning about Environment Rating Scales and areas where they could improve helped them make beneficial changes to the learning environment, such as room arrangement and diapering practices.

The biggest thing that we really improved on was our materials in the classroom...Certain things that [we] were so used to in our routine; that a different set of eyes really helped us realize what the children's needs are and what needs to be in the classroom.

—DC child care provider

PROVIDERS REPORT OBSERVING IMPROVEMENTS IN ADULT-CHILD INTERACTIONS

Providers felt that various Capital Quality components—most notably the trainings, the quality facilitator, and curriculum supports—translated into higher-quality education for children. Trainings provided staff with hands-on examples and best practices for teaching, classroom management, and child and family engagement that they could implement. Program directors noted receiving valuable input on the curriculum and teaching strategies from their quality facilitators, which they passed on to teachers. A few providers noted having highly involved quality facilitators who led hands-on trainings with teachers in the classroom. And several providers saw immense value in using an evidence-based curriculum because it helped structure teaching and effectively engage children.

Every day, I thought in terms of, "What am I going to do with these children?" As a result of having planned lessons with objectivity, with materials, with steps, I think my teaching became quality.

—DC child care provider

PROVIDERS REPORT INCREASES IN STAFF MOTIVATION AND CONTENT KNOWLEDGE

Program directors felt that Capital Quality increased their own and their teaching staff's desire for self-improvement. Several commented specifically on their quality facilitator's positive impact on staff motivation. Others felt they had successfully translated the knowledge they gained through Capital Quality into program improvements. Seeing the outcome of their efforts strengthened their roles as leaders and professionals. Similarly, several program directors noted that the knowledge teachers gained through Capital Quality trainings and the improvements they observed in their teaching had motivated teachers to continue learning and to strive for more. Program directors observed this increase in teacher engagement and how it was improving communication with children and families.

I immediately saw improvement in...the way we were engaging our students, the way our classroom looked, the quality of instruction, the patience the teacher exhibited. I saw improvements in communication...I saw this increase in interest in professional development. It was no longer about, "Oh, let me just rush through these trainings and get these [continuing education units]." It was more about, "Let me find out how I can do my job better."

—DC child care provider

PROVIDERS REPORT FEELING A GREATER SENSE OF PROFESSIONALISM AND LEADERSHIP

Nearly half of the providers we interviewed described how participating in Capital Quality gave them a better understanding of what it means to offer high-quality early care and education. It has shaped their own professional development and role as leaders. Specifically, these providers reported that Capital Quality gave them the following:

- **An increased sense of professionalism.** Some noted that after joining Capital Quality, they had an enhanced sense that they are “professionals”—skilled in what they do. Some noted that being a part of a larger system made them feel more valued, and felt that through Capital Quality, others would also view child care providers as professionals. Relationships with quality facilitators solidified that feeling because they helped providers understand “how important we really are...and they want us to be able to do our job to the best of our ability.”

Capital Quality is putting us at the forefront...We were never given the same opportunities as teachers that are in elementary and secondary education. Capital Quality is giving us a chance to be the professionals that we always thought that we were, we always knew that we were. We are not babysitters.

—DC child care provider

- **A greater understanding of their role as leaders.** Some providers reported that participation supported them in achieving their goals and also in helping them see themselves as leaders

within their programs who can motivate change. They realized how their efforts impact everyone within their programs.

- **A helpful reminder of the important work they do.** Several providers across care settings described how Capital Quality validated them as educators and highlighted the importance of early care and education. It underscored that they do more than simply provide babysitting.

Though not all providers felt strongly that Capital Quality enhanced their identity as professionals and leaders, others noted that participation supported them professionally. It enhanced their vision for their program, helped them think about quality in a new way, and motivated them to stay abreast of new information. Some said participation provided them with the tools to make a better place for children, families, and staff.

Challenges with Capital Quality

Although providers' experiences with Capital Quality were generally positive, they reported several challenges. These include (in order of prevalence) the following:

- the time required for participation is burdensome
- quality metrics and the observation process do not fairly or accurately capture quality
- program-level feedback from observations was not sufficient for quality improvement efforts
- the subsidy reimbursement system tied to quality designations is reported by some as counterproductive to quality improvement
- the focus on program directors without sufficient attention to staff is too narrow
- the system of Capital Quality is not as inclusive of provider voices as some wish
- expectations are not consistent between Capital Quality and other programs and initiatives such as the expectations of the National Association for the Education of Young children, the QIN, and Head Start
- Capital Quality consumer education could be improved, but more information is needed about parents' child care decisions.

We discuss each of these challenges in more detail below.

TIME REQUIRED IS OFTEN BURDENSOME

The amount of time required to participate in recurring meetings, trainings, and quality improvement activities creates challenges for many providers. Directors of smaller centers and home caregivers, who had fewer staff to delegate responsibilities to, most described feeling time constraints.

- **Completing the CQIP can be time consuming.** Despite favorable assessments provided by some study participants, others found the amount of information that needed to be gathered for the CQIP was tedious and burdensome. A number reported that the QuickBase interface for uploading the CQIP was not user-friendly and found the interface frustrating. (Though since our interviews, system improvements have been made to help address this challenge.)
- **Required activities may be too frequent for some providers.** Several study participants reported that the time commitment required to participate in biweekly meetings with quality facilitators was particularly hard. Others mentioned working with their quality facilitators to reduce the frequency or duration of meetings to accommodate their schedules.
- **Balancing time devoted to in-person training with meeting staffing requirements can be difficult.** A number of study participants reported that it was difficult to attend training while leaving their programs understaffed. Several reported that remote professional development opportunities offered during the pandemic allowed them to attend training at their facilities. However, some mentioned that when children are in attendance and providers are attending virtual training, their attention is focused on the training and not the children in their care.
- **Time devoted to trainings can take away from family life and responsibilities.** Study participants noted that attending trainings in the evenings and on the weekends makes it harder to spend time with their own families and get adequate rest. While online trainings reduced transit time, several study participants reported it was still difficult to find time to participate in trainings given other responsibilities.

I think it's super important to remember and understand that a child care and early education center is like a machine that never stops, and there is always something happening. The frequency of which we're required to meet, it's not doable. It's not possible. There is always something going on in this place...Once a week or a couple of times a month...I can't always do that...It isn't the work itself. It's just making time to do it.

—DC child care provider

SOME PROVIDERS BELIEVE OBSERVATIONS DO NOT ACCURATELY CAPTURE QUALITY

Some participants discussed their concerns about how observations are conducted. They felt a one-day observation could not provide an accurate picture of quality, and for something as “high-stakes” as quality ratings, which are publicly posted and determine subsidy reimbursement, the process should involve repeated observations. Some pointed out that something abnormal could happen that day that is out of their control and having visitors can make teachers nervous or make children harder to engage.

Besides repeated observations, other suggestions included having quality facilitators join observations to note issues to talk through with the provider. Because quality facilitators visit facilities regularly and are familiar with the regular program operations and children’s typical behavior, their insights are useful for providing a valid assessment. Another provider commented that teacher interviews should be included to help clarify what observers saw in the classroom.

Several providers expressed concerns about the assessment itself. They noted that the uniform approach to evaluating programs created unrealistic expectations, particularly for smaller centers and homes that often do not have the space and furnishings to meet certain requirements for a high-quality designation. For example, a lack of windows in basement-level programs will keep them from scoring high on the ITERS-R. A few noted that providers with fewer resources or that rely solely on subsidy payments are held accountable to the same expectations as well-resourced providers with private or multiple sources of funding. They believed having more resources makes it easier to meet the higher expectations, so the situation does not feel equitable.

A few participants also noted some inconsistencies between what they were taught in trainings and how they were scored during observations. “It’s like you’re teaching us to do one thing, and then when we do it, we’re in trouble for doing it.” They attributed this inconsistency to individual observers’ differing interpretations of quality metrics or to their lack of experience in child care provision.

FEEDBACK FROM OBSERVATIONS MAY BE INSUFFICIENT FOR QUALITY IMPROVEMENT EFFORTS

Participants commonly expressed frustration with the lack of specificity that the program-level observation report provided. Many noted that the report was unhelpful for improvement because it did not identify specific teachers—a strategy implemented to protect teacher privacy. “I think teachers are more relieved [that they are not identified], but it’s very, very difficult because then you cannot differentiate the professional development.” They mentioned the lack of detailed feedback post-observation makes it hard to implement the necessary intentional changes or modifications. A few providers also said it was difficult to understand how scores were calculated.

Obviously, we do go over our scores, and we try our best to guess and say, “Oh, maybe it was because of this. Maybe it was because of that.” It’s always a maybe, because you just don’t know.

—DC child care provider

PROCESS USED TO ASSIGN QUALITY DESIGNATIONS CREATES CHALLENGES FOR SOME PROVIDERS

Several study participants reported experiencing challenges with the formula that Capital Quality uses to calculate quality ratings and assign a quality designation. These include issues with the one-size-fits-all approach, concerns about equity, and challenges shifting from the old to the new system.

- **One-size-fits-all approach feels unfair.** Several providers reported they did not think the one-size-fits-all approach to the designation process is fair, when providers vary widely in terms of size, finances, neighborhood, and population served. “It’s hard for me to look at a scale and apply it to every classroom and every situation.”
- **The formula used to calculate ratings is complicated.** Several providers critiqued the designation formula, most noting that it is difficult to understand, even for experienced and highly educated providers. The ways the ITERS-R and CLASS factor into the rating felt unfair, as some providers are evaluated using both scales if they serve multiple age groups, giving them multiple scores to factor into the formula. A few providers were unclear whether and how child attendance factored in.

- **Changing to a new rating system and new formula created some confusion and concerns for some.** Two providers reported that they were confused about the transition from the old QRIS called Going for Gold and the new system, Capital Quality. The old system used accreditation as one criterion for determining quality, and accredited providers were rated gold—the top quality tier. These two providers reported frustration that accreditation is no longer considered, and gold providers were reclassified as quality under Capital Quality designations until evidence was met that they were high-quality.

ALTHOUGH SOME PARENTS USE CAPITAL QUALITY RATINGS, MANY DO NOT

About a third of study participants believe some parents use the ratings to inform their child care decisions, but a majority said parents do not appear to use the ratings as they look for and select a provider. Most providers reported that parents never or rarely asked about their program’s ratings. Word-of-mouth recommendations and community reputation were mentioned as key sources of information parents use, and other factors, such as location, often determine the program parents choose.

Several providers mentioned that families more often ask about accreditation than Capital Quality designations, as they may be more familiar with the accreditation system. Or less than half of licensed child care facilities in DC participate in Capital Quality (about 44 percent at the time of data collection), so parents comparing facilities participating and not participating in Capital Quality do not have a common quality measure for comparison other than accreditation.

Very few providers commented on changes in demand related to their quality designation. Thus, our interviews revealed limited evidence to support the theory that posting public ratings would increase demand for higher-rated facilities and decrease demand for lower-rated facilities. However, Capital Quality was relatively new at the time of data collection, and the pandemic disrupted child care services throughout DC. So this topic will be important to explore in future research.

LINKING QUALITY RATINGS TO SUBSIDY RATES VIEWED AS INEQUITABLE BY MANY PROVIDERS

When asked about tiered subsidy reimbursement based on Capital Quality designations, about half of responding providers thought this practice was unfair. The rest mostly agreed with the practice, except two providers who were not aware that reimbursement was tied to their ratings and another who saw both positive and negative aspects to this practice. Challenges with linking reimbursement rates with ratings included the following:

- **Perceptions of inequity.** Of the 17 interview participants (44 percent) who reported they disagreed with linking subsidy reimbursement rates to quality ratings, most reported they believe reimbursing higher-quality providers at higher rates is inequitable because it limits funding to the providers that need it most. They believe this lack of funding makes it harder for providers to improve quality and in turn limits access to high-quality care in the community. Several home-based providers also expressed frustration with homes receiving lower reimbursement rates than centers. Another home-based provider critiqued the drop in reimbursement as children get older, because older children still have educational needs and require individual attention and access to developmentally appropriate materials.

If a center is doing well and thriving, they probably don't need an increased amount of subsidy. If I knew a center was struggling to do what they need to do, I don't think cutting their funding would help. That actually seems rather counterproductive.

—DC child care provider

- **Feeling trapped in a vicious cycle.** Some providers who found themselves in this position of a lower-quality designation reported feeling trapped in a vicious cycle of lower investment and an inability to improve their quality. Several providers at higher designation levels agreed lower-rated facilities need more support to improve their quality, which requires significant financial investment and not rate reductions.

How do you have the money to move up if they give you less money? If my facility gets worse and my funding drops, I'll have to lay off teachers and provide less quality care. It's a cycle...You can't effectively run a business that way.

—DC child care provider

- **Amount of work is the same for lower- and higher-rated facilities.** Several providers reported that all Capital Quality providers have the same amount of work and are held to the same

expectations regardless of quality designation and, therefore, they believed all providers should be reimbursed equally.

- **Reimbursement rates already too low.** Several providers reported concerns that reimbursement rates are too low to simultaneously cover existing costs and pay for required enhancements to achieve higher quality. When asked about the link between subsidy rates and quality ratings, several said current subsidy rates make it hard to pay staff enough to retain them. “[Child care providers] need to be just as competitive as everybody else...We should be able to get paid enough so that we can make sure people are gainfully employed.”
- **Lack of predictable income.** A few providers noted that subsidy reimbursement rates could change if the quality designation changed, potentially to a lower designation. This happened to at least one provider we interviewed who experienced a reduction in payments from one year to the next. They expressed concern with the lack of predictable subsidy payments in a tiered system. This variability can make it made hard to budget for the next year.

SEVERAL PROVIDERS SHARED CONCERNS OVER LOW RATINGS HURTING STAFF MORALE

A program’s quality designation can be a source of pride when scores are high or show improvement over time. Five providers mentioned their belief that teachers feel motivated by their rating to keep working to improve their quality. However, several providers commented on how their less-than-desirable quality designation had disappointed staff and weakened their morale. Quality improvement efforts can be taxing for staff, and when they fail to see improvements in ratings, they can feel they did something wrong or question the system’s validity.

[Capital Quality is] based on these scores that may be good if you have a good day but may be bad if you have a bad day. A bad day is not a reflection of low quality.

—DC child care provider

ALTHOUGH HELPFUL TO PROGRAM DIRECTORS, CAPITAL QUALITY IS NOT FOCUSED ON SUPPORTS FOR PROGRAM STAFF

By design, Capital Quality supports child care program directors who in turn support their staff. Several providers suggested that to make significant improvements direct supports should be expanded to

teaching staff. A couple mentioned how they tried to pass on the knowledge they gained to their staff, but ultimately, they lacked sufficient time to communicate it in its full depth. Providers noted that this created challenges with getting staff to recognize the importance of Capital Quality and be motivated to meet required standards. “I feel like I’m buying into [Capital Quality], but I’m not sure that everybody else has that same buy-in, because they’re not going to the Community of Practice and completing the [CQIP] like I am.” Because the system of coaching is not designed for teaching staff, they may know less about Capital Quality.⁸

A FEW PROVIDERS FEEL CAPITAL QUALITY COULD BE MORE INCLUSIVE OF PROVIDER VOICES

Several providers made comments that they feel they are not in a position of power and indicated they do not feel their voices are heard. They expressed frustration that providers’ feedback is not taken seriously and that they were not included in higher-level decisionmaking about Capital Quality, such as the formula for determining ratings. One provider said, “Nobody was brought to the table to share, ‘Okay, this is how we’re looking at this formula. What are your reservations? What are your ideas?’ It was so top to bottom.” Providers also expressed a desire for more say in the topics covered in trainings and in meetings with their quality facilitators.

Creating an effective QRIS that meets providers’ needs requires that providers have a real voice in decisionmaking and agenda-setting. We should not only be recipients of all this wisdom, but also architects of all these processes. If you give us some capacity in that process, I think we’re going to deliver.

—DC child care provider

Several providers who shared some concerns about their lack of voice provided follow-up comments indicating it was to be expected. Although the protocols did not probe directly on issues of structural racism, a few providers hinted at challenges that they felt were associated with race and location. For example, several noted that they work in predominantly Black wards as they provided comments about lack of provider voices. One provider stated she believes the money spent on Capital Quality would be better spent if given directly to providers, especially small providers who serve primarily disadvantaged children.

EXPECTATIONS BETWEEN CAPITAL QUALITY AND OTHER PROGRAMS ARE NOT WELL ALIGNED

Several providers expressed frustration at the lack of alignment between the standards set forth by Capital Quality, child care licensing requirements, and other quality improvement initiatives, such as National Association for the Education of Young Children (NAEYC) accreditation and DC's Early Learning Quality Improvement Network (QIN)—a collaborative supporting the quality of infant-toddler care using an Early Head Start–Child Care Partnership model. The QIN currently provides training and technical assistance to 14 child development centers and 18 child development homes in DC. Several providers across child development centers and homes reported feeling challenged following multiple programs' standards simultaneously, and even more difficult when the standards were contradictory. For example, several providers described how some Capital Quality training sessions are scheduled during their facility operating hours, and if credentialed teachers attended, the facility would not comply with licensing requirements regarding credentialed teachers on site.

A few participants noted the duplicative nature of trainings required by Capital Quality and the QIN. Moreover, many Capital Quality participants are NAEYC accredited, because DC's former QRIS Going for the Gold required NAEYC accreditation at the gold level. Plus, the Pre-K Enhancement and Expansion Act of 2008 states that facilities must be accredited by a national accrediting body approved by OSSE to receive a Pre-K Enhancement and Expansion Program (PKEEP) grant for pre-K services.⁹ Several providers felt burdened maintaining their accreditation and following NAEYC standards while also completing all requirements for Capital Quality. They hoped for more alignment and less duplicative documentation.

I have a small concern of OSSE changing the rating from Going for the Gold to this Capital Quality, when it was mandated that you had to have NAEYC credentials before and now it's irrelevant, if you will, at this point. I do have a major problem with that. The thing is that... you have to have NAEYC accreditation to even get the Pre-K [PKEEP] grant, even though it really doesn't matter as far as your designation goes. Yeah, I do have a major, major problem with that.

—DC child care provider

BOX 3

The COVID-19 Pandemic and Difficulties Hiring Staff and Making Quality Improvements^a

We interviewed child care program directors during the first year of the pandemic when health and safety concerns were high, vaccines were not yet available, and many child care facilities in DC remained temporarily closed or were in the process of reopening. We asked program directors how the pandemic affected their participation in Capital Quality and progress toward their goals. Most reported that when facilities were closed, they continued working. They were able to participate in virtual professional development opportunities and continue working with their quality facilitators on their CQIP during scheduled virtual meetings.

But some providers noted that the closures in spring 2020 and the 2020–21 academic school year affected their ability to implement planned changes and make progress on quality improvement efforts. Importantly, study participants reported they had been losing staff—many of whom had school-age children still in remote learning arrangements or young children without access to child care at the time. Also, programs were struggling at the time with maintaining staff and required adult-child ratios because of reduced enrollment and lower capacity. During the pandemic, child care facilities generally operated at a lower capacity, meaning having fewer children and adults present at any given time, to follow social distancing requirements. It was not until summer 2021 that providers were allowed to return to ratios in licensing regulations.

In the first place, I've been closed. Whatever I might've planned to do within those months, I am not able to do it. I would say it's a delay in some of the plans that I have. I have new classroom materials that I would like to rearrange and stuff and put things in order. I have plans to enroll new children, and I have plans to bring in other age-appropriate materials. Everything has been in a standstill. I cannot move forward with all of my plans.

—provider in summer 2020

^a See companion fact sheet: Catherine Kuhns, "Reflections on Capital Quality During the COVID-19 Pandemic" (Washington, DC: Urban Institute, 2022), <https://www.urban.org/research/publication/reflections-capital-quality-during-covid-19-pandemic-insights-child-care>.

Providers' Recommended Changes to Capital Quality

We analyzed the recommendations providers made during their interviews to identify key themes. Our analysis revealed several important changes to Capital Quality that providers believed could make the system more effective, including the following:

- **Provide tailored trainings and resources to support advances in program management, teaching, and caregiving practices.** Participants reported some benefits of existing training opportunities but recommended tailoring the training to meet providers' knowledge and

experience and the needs of their facility. For example, several reported that they needed more professional development aimed at those who are experienced, whereas others reported that the entry-level courses were often filled before they could sign up. Centers reported a need for more opportunities for teachers to further their professional development and motivate their commitment to Capital Quality efforts. In addition, several felt it would be helpful to match the quality facilitator's expertise to the program director's needs. In a few cases, providers mentioned needing help in areas in which their quality facilitator was not as knowledgeable.

- **Make it easier to attend trainings.** Offering trainings during the evenings and online could make attending less burdensome for some providers. Streamlining Capital Quality and QIN trainings to make them less duplicative for providers participating in both would make more efficient use of their time. Conversely, ensuring providers who participate in related trainings can receive credit from Capital Quality could address study participants' concerns about the amount of required training.
- **Consider compensating providers for time spent on professional development and related quality improvement activities.** Study participants reported that they were stressed by balancing work, family responsibilities, and professional development but valued the professional development. Compensating providers for time devoted to professional development and related quality improvement activities would reflect the value of these important components of Capital Quality. Alternatively, pay could go to the providers to cover staffing needs while they attend trainings to avoid being out of compliance with adult-child ratio requirements.
- **Adjust the Capital Quality metrics to go beyond one day of observation.** Providers felt an assessment of their program quality could be made fairer and more holistic by conducting multiple observations throughout the year, speaking to quality facilitators and teachers during observations, and conducting other forms of qualitative data collection that account for factors that cannot be captured during an observation. Also, several providers recommended eliminating attendance as a rating criterion for programs serving preschool-age children. Attendance is not formally considered in the formula for Capital Quality designations or considered a quality indicator anymore, but providers' concerns about this issue point to possible communication challenges and the need for clarification.
- **Provide more detailed feedback to providers to inform quality improvements.** Study participants recommended providing more detailed feedback from observations that they can use to improve their scores. For example, several center directors said they would benefit from

receiving scores for each classroom rather than an average facility-level score. More detailed reports could help them better support individual teachers and tailor staff trainings. With this, however, providers recommended that observation reports and data shift from assessments linked with reimbursement rates “to a focus on identifying opportunities for continuous quality improvement.” OSSE is currently providing deidentified classroom-level CLASS reports, but for small programs, it might be possible for owners and directors to identify the lead teachers. The Urban research team notes that using the independent observation data to determine subsidy reimbursement rates while at the same time providing specific classroom data could lead to undesired consequences such as employee dismissals or other penalties.

- **Reduce administrative burden.** At the time of data collection, providers recommended aligning standards and processes to reduce administrative burden. Several noted that they were required to complete different administrative reports for Capital Quality, the QIN (which is governed by the Head Start Program Performance Standards), child care licensing, and PKEEP. Several recommended further aligning the requirements and processes to reduce the administrative burden on child care providers. Since we collected data for this report, OSSE has made several changes to relieve providers from some administrative requirements so they can devote more time to caring for children.
- **Adjust scoring metrics based on resources and assets available to facilities.** Several study participants recommended making adjustments so the quality rating process is more equitable. To them, more equitable means facilities will not have an inherent advantage or disadvantage based on their size, income, funding sources, or building. They believed scoring metrics should take into account these factors, knowing what it takes to achieve a high-quality designation.
- **Ensure subsidy reimbursement structure supports quality improvement and addresses equity.** A majority of study participants recommended changing the reimbursement structure so lower-rated providers are not penalized and do not receive lower subsidy rates. However, a sizable number of participants eligible for a higher reimbursement rate believed linking rates to quality is fair. Tiered reimbursement is designed to incentivize providers to achieve higher quality, but facilities with a lower-quality designation felt they needed more resources to address quality concerns, hire and maintain qualified staff, and break a “vicious cycle.” Facilities with developing and progressing designations currently receive more intensive support from their quality facilitators (i.e., more frequent engagements), and these providers appreciated this hands-on support and felt it was making a difference; however, low subsidy rates was a constant barrier. To address this issue, DC could consider how to restructure subsidy

reimbursement rates and other quality improvement grants and resources so that all providers have the resources they need to improve and sustain their care quality. Providers who have achieved a quality or high-quality designation would continue to receive a higher rate as an incentive to continue their good work and as a resource for sustainable efforts.

Conclusion

Capital Quality was designed with the aim that all licensed child development facilities in DC that receive public funding participate in quality improvement activities (OSSE 2021). Since 2016–18 when Capital Quality rolled out, the implementation context has changed. COVID-19 swept the nation and disrupted child care services, leaving many providers struggling to resume business as usual. Moreover, the nation has become more aware of structural racism and the importance of addressing structural barriers that exacerbate racial inequities. At the same time, federal relief funding and flexibilities offered at the height of the pandemic have offered opportunities to strengthen equitable access to quality child care.

Despite the challenges child care providers experienced because of the COVID-19 pandemic, we found that most child care providers who participated in our study provided favorable evaluations of Capital Quality. As OSSE considers how to best increase access to quality, equitable child care, it is important to consider how to best build on the components providers view most favorably.

Providers recommended several important changes to how observations are conducted, how quality designations are determined, and how resources are distributed that could promote more transparency, equity, and achievement of quality goals. Since the time that the Urban research team conducted the study, OSSE implemented several important changes. These included expanding SMART goals to include equity and inclusion, providing classroom-level CLASS observation reports to participating providers serving preschool-age children, and making changes to QuickBase to make the process of completing the CQIP process less time consuming. In addition, child attendance is no longer considered a quality indicator and plays no role in quality ratings.

Fine-tuning Capital Quality to enhance providers' voices is a recommendation made by providers that is consistent with findings from past studies of QRIS conducted in other states (Dichter 2021). If OSSE decides to tweak components of Capital Quality, it will be important to account for providers' diversity, perspectives, and voices. Consistent with this recommendation, a 2021 report that explored quality improvement in Philadelphia reported that the definition of quality needs to be reformed to

reflect provider voices and noted that work remains to ensure all quality improvement efforts actively address issues of race, ethnicity, and culture (Dichter 2021). We recommend that OSSE consider how to best engage providers to inform future adjustments to Capital Quality implementation. Further, we recommend that OSSE consider engaging providers to share the underlying theory of change, refine the theory of change if it is not consistent with providers' perspectives and needs, and account for the range of funding streams providers in DC are accessing.

For Capital Quality to continue achieving its potential as a consumer education tool to help families looking for child care, more data are needed on the sources of information parents use and trust. As child care providers have reopened and are actively participating in Capital Quality, we recommend that OSSE revisit earlier campaign plans to publicly disseminate information on Capital Quality to help reach DC parents. Research is underway as part of the larger District of Columbia Child Care Policy Research Partnership Study to gather parents' perspectives. This information can strengthen the evidence base about Capital Quality's strengths and areas where it could improve to achieve its aim of increasing access to equitable, quality child care throughout DC.

Appendix. Study Design

We designed a mixed-methods study to understand child care providers' experiences with Capital Quality. Our study targeted directors of child development centers and owners or directors of child development homes and expanded homes. Study recruitment and data collection occurred from late July 2020 to November 2020. In this section, we describe how we selected and recruited participants and collected and analyzed the data.

Sampling Approach

We drew a random sample of 50 licensed child care facilities in DC that were participating in Capital Quality as of November 2019. At that time, 234 licensed facilities were participating, including 179 centers, 36 homes, and 19 expanded homes, which ranged in their geographic location and program characteristics. We stratified the sample based on three characteristics: (1) facility type, so we would have a proportional number of centers, homes, and expanded homes; (2) geographic location, so we could gather perspectives from child care providers from different wards; and (3) size, for centers only, so the final sample would have some small centers with fewer than 50 slots and some larger centers with 50 or more slots.

Study Recruitment

We began recruitment by inviting the 50 sampled facilities to participate in a one-hour telephone interview and complete a brief online questionnaire. Within one week of emailing, trained research staff called each provider and followed a written script to explain the study's purpose, the study requirements and benefits, and possible risks of participation, which were minimal. If a provider agreed to participate, the caller scheduled the interview at a later date and sent a follow-up email with a reminder of the interview date and time.

Because recruitment occurred during the COVID-19 pandemic, many child care facilities were closed or in the process of reopening. In most cases, center directors were still actively working, either remotely or still in the care facility, and were responsive to emails and phone calls. In other cases, our calls were left unanswered. We expected providers in child development homes or expanded homes to be home during the pandemic, either still caring for children or not, depending on their circumstances,

though we found they were most challenging to reach by telephone. Research staff called each selected provider six times before considering the provider hard to reach. They compiled a list of hard-to-reach providers and asked quality facilitators who closely worked with those providers if they had an alternative phone number or any information that could help with recruitment. In a few cases, quality facilitators texted providers letting them know about the study. After implementing these efforts, we considered a case a hard refusal and replaced it with another in the same stratum (i.e., same facility type, ward cluster, and center size).

We stopped recruitment once we reached 36 completed interviews, including 27 centers and 9 homes. At that time, our team came to a consensus that we had reached a saturation point in our data, where consistent themes emerged, and each additional interview added little new information. Over the course of data collection, we replaced 33 hard-to-reach providers, 20 of which were closed during our recruitment period. Additionally, we replaced 17 providers that declined participation. The primary reason for refusals was lack of time; facilities had either recently reopened or were planning to, and providers were busy getting ready to reopen or filling in for staff who had not yet returned to work. Another five facilities remained on the hard-to-reach list and were not replaced. We ultimately contacted 91 providers to get to the 36 completed interviews. Table A.1 shows the distribution of facilities by their operational status at the beginning of the recruitment period.

TABLE A.1
Distribution of Recruited Facilities by Operational Status

	Open at beginning of recruitment effort	Closed at beginning of recruitment effort	Total
Hard-to-reach replacements	13	20	33
Refusals	14	3	17
Recruited	26	10	36

Source: Authors' analyses.

We performed nonresponse analyses to determine if the respondents differed from nonrespondents in terms of location, ages served, and Capital Quality designation. We found that those who responded were similar to nonrespondents in terms of their distribution across DC wards and the ages they served. The final sample included some providers at each quality designation level, but facilities with a designation of progressing were slightly underrepresented and facilities with a *quality* designation were somewhat overrepresented.

Data Collection Procedures

We designed two measures to collect data from participants: a 24-question web survey and a semistructured interview protocol. The questionnaire asked about the characteristics of children attending the program, the main reasons providers were participating in Capital Quality, the challenges of Capital Quality, and its benefits. The survey was programmed into Qualtrics software and administered in English and Spanish, based on the respondent's preference. We asked participants to complete the survey before the interview so interviewers would have some basic information about the participant in advance. A total of 31 providers completed the survey.

The interview protocol covered the following main topics:

- quality improvement supports including the provider's relationship with their quality facilitator, development and use of a quality improvement plan, and progress toward goals
- experiences with scheduled observations of the environment
- perspectives on the Capital Quality rating process and perceived fairness of ratings
- benefits of Capital Quality
- challenges with Capital Quality
- beliefs about how parents use Capital Quality ratings and whether the rating has influenced demand for their program
- other factors that might have affected their ability to offer quality care, including COVID-19, the recent increase in the minimum wage, and new licensing requirements that mandate minimum education levels for child care directors and teaching staff in centers and homes

A native, bilingual Spanish-speaking research analyst translated the protocol into Spanish, and a second analyst with equal translation skills reviewed the translation to identify and resolve errors and inconsistencies. Only one participant requested the interview in Spanish. We offered providers who completed the survey and interview a \$20 e-gift card as a token of appreciation for their time participating in the study.

Six trained data collectors conducted the interviews, which were audio recorded and fully transcribed by an external transcription service. After each interview, the interviewer created a summary memo that described the provider's characteristics, general comments about the interview process (e.g., "We had to reschedule twice because of the provider's busy schedule"), key themes regarding Capital Quality participation including benefits and challenges, key themes regarding quality

improvement activities, effects of COVID-19, and unexpected comments. We held weekly team meetings during the course of data collection to share interview highlights and strategize next steps.

Analysis

Once data collection ended, we tabulated the survey data to identify characteristics of participating facilities and providers. To analyze the interview data, we developed a detailed coding scheme with *a priori* codes that reflected the main interview topics (e.g., benefits of Capital Quality). We used NVivo software to code the interview transcripts. NVivo allows users to code chunks of text to “nodes” or topical codes and run various queries on the data. Researchers can assign “attributes” to the data files to support analysis. Attributes we used included Capital Quality ratings (referred to by OSSE as “designations”), facility type, ages served, accepts subsidies, accredited, nontraditional-hour child care, and Capital Quality cohort number. Assigning these attributes to each transcript file allowed us to investigate certain concepts by each of these key characteristics.

A senior researcher trained two research analysts on the coding scheme. They conducted three test coding sessions by each coding the same interview, checking inter-rater reliability, and discussing points of disagreement or misalignment. Across all codes, the percent agreement was high, above 92 percent for all but one code, which was 89 percent. This process resulted in additional recommended revisions to the coding scheme to clarify points of confusion. Then, the two analysts split the 36 interviews and coded them. To check for reliability and adherence to the coding scheme over time, they double coded every fifth interview on the list and performed reliability checks in NVivo. A research associate managing the data collection checked their work periodically for quality control.

A group of four researchers, including the project’s principal investigator, analyzed the coded data in NVivo, running comparison queries on key provider features including facility type and Capital Quality ratings. Each person on the analysis team was responsible for analyzing data related to a particular set of topics and outlining the key themes with supporting quotes. The analysis team met weekly to discuss progress on analysis, emerging themes, the report structure, and next steps.

Notes

- ¹ “Overview of 2016 Child Care and Development Fund Final Rule,” Office of Child Care (OCC), September 23, 2016, https://www.acf.hhs.gov/sites/default/files/documents/occ/ccdf_final_rule_fact_sheet.pdf.
- ² “Overview of 2016 Child Care and Development Fund Final Rule,” OCC.
- ³ Simon Workman, “QRIS 101: Fact Sheet,” Center for American Progress, May 11, 2017, <https://www.americanprogress.org/issues/early-childhood/reports/2017/05/11/432149/qr-101-fact-sheet/>.
- ⁴ “Welcome to My Child Care DC,” DC Office of the State Superintendent of Education, accessed May 27, 2022, <https://childcareconnections.osse.dc.gov/>.
- ⁵ In DC, child care facilities fall into one of three licensing categories: child development centers, child development homes that can care for up to 6 children in the provider’s home, and expanded child development homes that can care for between 6 and 12 children. “Home caregiver” or “lead home caregiver” is the title used for the main care provider in a home or expanded home whereas an “associate home caregiver” is used for support staff employed in a home or expanded home.
- ⁶ Once observations for ERS resume postpandemic, Capital Quality will use the ITERS-3 and FCCERS-3.
- ⁷ Although CLASS® observations were later offered on a voluntary basis in spring 2021 and for providers offering pre-K in winter or spring 2022, these observations were not used to determine quality ratings. As a result, most facilities maintained the same designations for a period of time after the pandemic began. Providers who had one year of valid observations were given an initial designation in fall 2021.
- ⁸ See the research brief by Willenborg and colleagues (2022), which shows evidence that only about half of early educators in Capital Quality-participating facilities are familiar with Capital Quality by name.
- ⁹ Pre-K Enhancement and Expansion Amendment Act of 2008, D.C. L. No. 17-202 (July 18, 2008), <https://code.dccouncil.us/us/dc/council/laws/docs/17-202.pdf>.

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