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Summary Report of Unlicensed Provider Focus Groups in Michigan

Held October 4-6, 2010

Karen W. Ponder

On October 4-5, 2010 focus groups were held with unlicensed child care providers who serve children that receive subsidies for their child care. Held in five regions of Michigan (Southwest Detroit; Pontiac; Gaylord, with Upper Peninsula via phone; Mt. Pleasant; and Grand Rapids), the focus groups also included a few parents. The Early Childhood Investment Corporation (ECIC) and Michigan's Office of Early Education and Care wanted to learn from the providers about the benefits received from and concerns about the state's recently implemented orientation and training requirement. They also sought feedback about a proposed voluntary Quality Development Continuum. The Quality Development Continuum is being designed to build on the required orientation and training already in place and expand to a tiered plan with the goal of attaining higher levels of quality for the children who are cared for and educated by family, friend and neighbor providers, a significant population of vulnerable children in Michigan. A PowerPoint was developed by the steering committee to provide a visual for the focus groups and questions were created with input from ECIC and the Office of Early Education and Care. The specific responses of the providers were documented by region.

The responses from all regions were overwhelmingly positive concerning the orientation and training that are already required and in place. While there were variances in different regions about the availability of training opportunities, in general providers felt that they were taking advantage of the training opportunities that are available and called for more required training in all regions. The participants were eager to share their experiences and ideas, and appeared to be pleased that they were invited to participate.

Following are the major findings:

- 1. "Quality Development Continuum" elicits a positive response and is generally understood to be about increasing the knowledge of providers in an on-going way.**

The title, "Quality Development Continuum," generally elicited positive reaction, with a few comments about the word 'continuum' being perceived as confusing and a couple of comments that it should say "It's for children". Participants thought that the title clearly articulated a process in which providers were increasing their knowledge in an ongoing manner and believe that parents will understand what it means.

2. Providers believe that the Quality Development Continuum will matter to most parents and that it will help parents know that their providers are increasing their skills; the providers also believe parents need training opportunities similar to their own.

In response to a question about how parents will learn about the Quality Development Continuum and how they can best find out about it, most providers focused more on how important it would be to parents to know that their providers are increasing their skills. Participants in most groups believed that this matters to most parents. In several groups, the providers advocated for more training for parents, expressing that their adult children have noticed their new skills and want to come to classes themselves and learn how to be better parents.

3. Parents and providers support the mandated Great Start to Quality Orientation Training, believe it is very beneficial to children and providers and the majority of participants wanted to see increases in the training requirements.

There was overwhelming support from both providers and parents about the mandated Great Start to Quality Orientation Training. It was seen as very beneficial in providing benefits to children with safer environments and more learning activities, and giving providers a stronger professional image. All groups included discussions about licensure and the providers described benefits they saw in applying and utilizing the information found in the licensing application to improve their quality, even if they don't become licensed. None of the providers thought that the mandated training requirement was too much, and most suggested that it should be increased.

4. Topics offered in required orientation and training were viewed as very beneficial and most providers want more options for training available, and value their relationships with the people who coordinate training as well as the trainers themselves.

Providers generally find the topics now offered in the training requirement to be very beneficial, with several participants asking if they could already access the additional 2 hours of suggested training. Several people commented about their initial negative reactions to mandated training that were dispelled after attending Great Start to Quality Orientation. The providers had very positive comments about the people who coordinate training as well as the trainers themselves, with a slight difference across regions, and clearly value the relationships they have with their coordinators and trainers. The participants offered some ideas for additional training and expressed some challenges with I-billing.

5. A majority of participants from all groups believe financial incentives are important to help them stay in business and value the opportunities to learn along with their peers as more valuable to them than the financial benefits.

In regards to what motivates and incentivizes them to participate, participants from all groups were consistent in the message that the opportunities to learn, socialize, and improve their skills are much greater incentives than the financial incentives. The financial incentives seem to be important to most of them in terms of helping them be able to do this work over time or to “stay in the business”. Opportunities to get together with others through peer to peer meetings and child centered field trips were favorite options for incentives. There was consistency in all 5 groups about the fact that building a peer network was very beneficial and a great incentive for them to be involved in training and quality improvements.

6. Participants embraced the idea of more training hours and encouraged that more be made available, providing particular topic needs and ideas.

In regards to a possible requirement of 20 hours to achieve a higher level on the continuum, the overwhelming response from all groups was that 20 hours is easily attained, and that the interest would be strong for more than 20 as long as there were enough options available in each county. The providers see direct results from their training in terms of better behavior and learning, and most participants agreed that the better educated and trained the provider, the more children will learn. One provider commented, “You can’t teach what you don’t know!”

7. Mentors are generally seen in a positive light, based on the providers’ experiences with the Hubs and their trainers.

There was positive reaction to working with mentors and many participants equated their experiences working with recent staff at the Hubs and with their trainers as examples of positive mentoring experiences. They spoke of mentors as an efficient way to get answers and receive support from people who have “already been there”.

8. In general, the unlicensed providers understand school readiness as a broad range of skills and abilities and feel some pressure about more academic areas, based on their understanding of what is required of kindergarten students.

There was broad awareness among the providers that school readiness is more than academics, and their responses to “What does school readiness mean?” included all areas of readiness as defined by the National Goals Panel: physical, cognitive, social/emotional, language/speech, and approaches to learning. Some expressed a sense of urgency that their children learn how to write, count and read because of what they have to know when they get to kindergarten.

The work that is being done in Michigan to improve the quality of unlicensed child care providers is cutting edge work and by all observations is working and improving quality for many vulnerable young children in the state. The providers who are involved in the required training and orientation show enthusiasm for what they are learning and seem eager to learn more. The success of this required training is demonstrated in the providers' own reports of "learning better ways to help children behave" and "getting new ideas to do with my children." Their positive reaction was best captured at the regional forums by a provider in Southeast Detroit who responded, "When I first got the letter telling me that I had to take training, my response was 'You have got to be kidding—I am sixty-six years old and have raised five children'. Now I miss a training and I am upset—I cannot believe how much I am learning and using it with my grandchildren and teaching my children about being the best parents that they can be." Many other providers reacted similarly.

While the reactions of the providers were overwhelmingly positive in terms of their current training and the proposed Continuum, an area of concern expressed by a few people in all groups was billing and the difficulty of reporting if there were no computer available and it had to be done via telephone. Even though they expressed frustration, they also appeared to have an understanding that it had to be done and a sense that they are finding ways to deal with it. In some regions there was frustration about their inability to complete the registration process to receive payments and some dissatisfaction in getting answers or returned calls from their local office in one region of the state.

While my questions didn't focus on the coordination at the regional level, it is important to note that the relationships between the coordinators, trainers and the providers seem to be very important and may play a significant role in the effectiveness and acceptance of the orientation training requirement as well as a tiered continuum. Providers spoke about their coordinators and trainers in very positive terms and see them as colleagues. When I asked questions about working with mentors, they referred to the coordinators as their mentors, saying they help them figure things out, solve programs and get what they need. They also talked about the value of completing a high school degree in terms of improving their professional image, and believe that learning will be achieved in going through the process to become licensed.

Based on the interviews with providers, I believe they are ready to embrace a Quality Development Continuum and will eagerly participate in it. The state leaders in Michigan's Early Childhood Investment Corporation and Office of Early Education and Care, as well as the regional coordinators and trainers, are to be highly commended on the success of this innovative and excellent initiative.

Early Childhood Policy Research

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To: Joan Blough, Early Childhood investment Corporation

From: Anne Mitchell and Christine Johnson-Staub

We have reviewed all elements of the proposed Michigan Quality Rating and Improvement system as laid out in the April 2007 report ***A Great Start for Kids: Recommendations for a Michigan Child Care Quality Rating and Improvement System***. To make the review easier to digest, we created a chart that lists the features and recommendations, describes other states' experience with each, and offers our comments.

To do this review, we relied on published resources and our experience with states. Anne has worked with Alaska, Arizona, Colorado, Connecticut, Delaware, Florida, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New York, Ohio, Pennsylvania, Rhode Island, Vermont, and Washington. Christine has worked extensively with Massachusetts and developed a familiarity with QRIS in other states through that process. The main publications we used are: NCCIC's ***QRIS Resource Guide*** at <http://nccic.acf.hhs.gov/poptopics/qrisc/resources.html> and the newly released (April 2010) ***Compendium of Quality Rating Systems and Evaluations*** from the federally funded multi-year Quality Rating Systems (QRS) Assessment Project. http://www.acf.hhs.gov/programs/opre/cc/childcare_quality/index.html#reports)

We have several overall comments/recommendations that are more easily communicated here than in the chart.

- 1) While it is true that all QRIS build on the foundation of regulation, a QRIS should not repeat licensing rules. Usually a QRIS includes elements from licensing that can be improved upon, e.g., group size, or infant ratios. One way to streamline MQRIS is to

remove any criteria that are in licensing rules. Another would be to grant licensed programs a Level One status, and ensure that all point criteria represent higher quality than licensing.

- 2) If there are licensing elements you believe should remain in MQRIS, be certain that the steps are a gradual progression from Michigan regulations to national accreditation requirements. Licensing rules are usually yes/no criteria; QRIS by design are progressive.
- 3) Another way to streamline MQRIS is to focus on criteria that genuinely impact the quality of a child's experience, child outcomes. Most researchers would say an onsite-assessment is the best way to measure what really matters.
- 4) The re-application process of MQRIS can be simplified by identifying criteria that do not have to be reported or verified unless they change. An example is staff qualifications. These only need to be reported for new staff or those who advanced their qualifications, ideally via an automated report from the Registry.
- 5) Finally, only about half the currently operating states piloted their QRIS and many of the others phased in gradually. Implementation of MQRIS could be done regionally as Virginia is now doing and New York is considering (www.gsny.org). Michigan's 10 Great Start regions would work well for regional phased implementation.

We are looking forward to discussing our review with you during the week of June 14. We should set that date soon.

Review of Michigan Quality Rating and Improvement System

This chart first addresses the standards and criteria for MQRIS and then the implementation features and proposals.

Child Care Centers

Structural Quality Characteristics – Levels 1-3

Section/Characteristic	Points	Other States Experiences	Comments/Recommendations
Director Qualifications			
60 Semester hrs with 1920 hrs of experience including a minimum of 18 hrs in Early Childhood Education / Child Development	1	<p>Measuring Experience: Massachusetts and Ohio have experience as a criterion by year (not hours).</p> <p>Other models for Director’s Qualifications: VT uses overall percentage of staff with credentials (does not break out specific director requirements); DC requires one 3-credit hour course in administration for Gold level. No degree requirements. Levels are based on hours of in-service training and percentage of staff at CDA level. IN has no separate Director qualifications. ME and several other states reference levels on a state approved career lattice.</p>	How are <i>hours of experience</i> documented and verified under licensing? Is this included in professional development registry? Consider measuring by months or years, not hour.
CDA or Montessori credential with 960 hrs of experience including a minimum of 18 hrs in Early Childhood Education / Child Development	2	<p>Credentials: Ohio uses accredited Montessori certificate; CDA for Director used in OH in combination with 2 yrs of college or 2 yrs experience; IA uses National Administrator credential; KY and PA use a state developed director credential at highest levels. MS requires state director’s credential at Step 3.</p> <p>This is roughly equivalent to TN’s highest level (Level 3)</p>	

Associate’s degree in Early Childhood Education / Child Development with 480 hrs of experience including a minimum of 18 hrs in Early Childhood Education / Child Development	3	Used in combination with % of lead teachers with AA for higher levels in OH. This (MI) is roughly equivalent to the highest point level for director qualifications in LA. MS requires AA for Step 4.	
Bachelor’s degree or higher in child related field including a minimum of 18 hrs in Early Childhood Education / Child Development	4	MS requires BA/BS for Step 5 (highest level).	
Bachelor’s degree or higher in Early Childhood Education / Child Development OR child related field including a minimum of 18 hrs in Early Childhood and 3 credits in administration	5	CO has highest point level of Masters degree or Ph.D. in ECE OR Masters degree or Ph.D. with at least 24 ECE credits for 3 points. DE requires Bachelor’s or higher in ECE plus state’s Director certificate for highest level (Level 5). KY requires state Director’s Credential at highest level (4). As of 7/10, OH requires director to have BA or equivalent (Career Pathways) for Step 3. At its highest level, VA requires that 75% (of directors? In agency? In geographic area?) have Master’s in a relevant field.	There are sufficient states that require a Bachelor’s degree for their highest levels that it seems like a reasonably high expectation for 5 points. Consider an additional state director certification.

Note on MI Director’s qualifications: These essentially line up with the equivalencies detailed in center regulations.

Section/Characteristic	Points	Other States Experiences	Comments/Recommendations
Lead Caregiver/Teacher Qualifications			
100% of classrooms of have teachers with credit	1	<p>The structure for this category is similar to PA which requires increasingly higher % of group supervisors at higher levels of career lattice to reach higher levels.</p> <p>VT uses overall percentage of staff with credentials (does not break out specific lead caregiver/teacher requirements)</p> <p>ME references levels on the state approved career lattice.</p> <p>DC levels are based on hours of in-service training and percentage of staff at CDA or AA level.</p> <p>Other states (e.g. KY) focus teacher and director standards around professional development hours.</p>	This is the minimum under regs – having one qualified lead caregiver/classroom.
25% of classrooms have teachers with credit plus	2	MS requires 25% of all staff have CDA or higher at highest step.	The rest of this category is structured around the % of classrooms whose lead caregivers are qualified in different ways (with higher credentials); If this is documented consistently through licensing it seems like straightforward criteria.
50% of classrooms have teachers with credit plus	3	This is similar to IN's Level 3, but also requires 50% of staff including director complete 20 hours of training annually.	
100% of classrooms have teachers with credit plus	4	OH requires 100% of classrooms to have lead teacher with AA or equivalent (Career Pathways) for Step 3.	

25% of classrooms have teachers with degree	5		
50% of classrooms have teachers with degree	6		
100% of classrooms have teachers with degree	7		
25% of classrooms have teachers with degree plus	8		
50% of classrooms have teachers with degree plus	9	DE has a similar standard, but adds that the other 50% of staff must meet minimum requirements (9 early childhood credits)	Consider how to handle programs with gaps (e.g. 25% of classrooms have degree plus, but the remainder don't have credit plus). Is this a problem? Be clear about whether each point level assumes achievement of previous level.
100% of classrooms have teachers with degree plus	10	CO has points tied to teacher qualifications, with the highest being Bachelors or Masters or Ph.D. degree in ECE OR Bachelors or Masters or Ph.D. in non-ECE field with 24 ECE credits for 7 points. At highest level, VA requires 75% of teachers (not specified lead teachers) hold BA/BS in related field.	This appears to be a reasonably high expectation for the highest level.

Section/Characteristic	Points	Other States Experiences	Comments/Recommendations
Professional Practices			
Program has policies and resources in place to assure that licensing ratios and group sizes are met or exceeded	1	Generally included in licensing. CO, IA, LA, NC have increasing points tied to lower ratios (beyond licensing requirements)	It's easier to measure whether the program meets licensing ratios and group sizes (and presumably that's checked by licensing) than whether they have policies and resources in place.

		OH, KY, TN, VA and NM have lower ratios required at higher levels.	<p>If MI wants a standard related to ratios, consider having increased points for having better ratios, increasing toward accreditation levels. This is more similar to other states.</p> <p>There is a bigger question of whether you want to give points for meeting licensing requirements, or just say that a licensed program is level one, and give points for going beyond licensing standards.</p> <p>Throughout this category, measurement relies on written procedures and policies; Consider developing standard templates or formats that programs are required to use to better define and document standard.</p>
Program has procedure(s) in place for continual maintenance and updating of administrative records	1	<p>Generally included in licensing.</p> <p>DE requires system for maintaining financial records at Level 2. PA requires financial record maintenance system at Star 2.</p>	<p>Required by regs to update some records annually, so checked by licensor? If this is checked annually per regs, it seems duplicative to check annually whether there is a process in place. If this indicator is specifically about financial records, then should be more specific.</p>
<p>Program has written personnel policies and procedures, which improve and lead to staff retention</p> <ul style="list-style-type: none"> • Procedure(s) in place for staff evaluation (1 point) • Procedure(s) for individual or collaborative professional development plan for staff members (1 point) • A documented, graduated salary scale for staff that takes into account education and experience (1 point) • Health benefit plan for staff (1 point) • Paid leave time including: holiday, vacation, and sick time (1 point) 	5	<p>Several states require written personal policies that include the following provisions:</p> <p>Staff evaluation: IA provides points for director and staff self-assessment, and for annual written staff evaluation. KY requires annual staff evaluations at Level 2. ME annual evaluations at Step 2. MD requires “regular” staff evaluation. Required annually at Step 4 in MS and NM. NH also requires annual staff evaluation. PA requires annual performance evaluation at Star 3.</p> <p>Professional Development Plans: Required for all staff at all step levels in OH and OK, and earns 1 point in VT.</p> <p>KY requires annual PD plans at Level 1. IA</p>	<p>Is it possible to get partial points on this standard?</p> <p>Career ladders and professional development plans can be viewed as a high level of sophistication compared, for example to having health benefits. States vary in the weight they give them, and so the weight you give them probably depends on how common a practice it is in MI.</p> <p>Consider weighting the subcategories in this to reflect difficulty and how commonly they are achieved in MI.</p> <p>State standards related to benefits are more complex than the MI standard, but all include health benefits and paid time off. The MI standard is much simpler, and will be easier to document and score.</p> <p>OH uses PAS to measure some of these indicators.</p>

	<p>provides a point for PD plans in place at Levels 3-5. TN requires at Level 3. Required at Step 4 in MS and NM. Required for lead teachers in MN. NH requires a PD plan in place for directors, assistants and lead teachers as one option under the “licensed plus” category.</p> <p>Salary Scale: NH has this as an optional indicator. LA provides one quality point for pay scale. OH requires at level one. MD requires at Level 2. OK requires at 2-3 Stars. PA and DE require at Star 3. VT requires for 3 points. DC requires bonuses or salary increases linked to education levels at the Silver and Gold levels. ME requires <i>plan</i> to implement scale at Step 4.</p> <p>IL uses the Great Start scale for both staff qualifications and salary scales. NM requires an incremental compensation plan that increases at each level.</p> <p>Benefits: Some benefits required at Step 1 in Ohio. DE programs must choose two (4 Stars) or three (5 Stars) of a longer list of potential benefits. Comprehensive benefit package for staff at level 4 (of 5) in MA. NC programs must choose four from a list of potential benefits to earn an optional quality point. LA and NM receive increasing points for choosing from comprehensive list. KY has paid leave at Level 3 and health insurance at Level 4. ME requires two benefits from list at Step 3. MD requires undefined benefits package at Level 4. In PA, programs required to give employees at least three benefits at the Star 3 level. TN requires increasing numbers of benefits at each level, from a list of options. VT requires benefits</p>	
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		<p>package of at least two benefits (2 points).</p>	
<p>Program has written policies and procedures to promote parent involvement</p> <ul style="list-style-type: none"> • Parent participation in governance (1 point) • Parent education opportunities (1 point) • Ongoing opportunities for informal communication with parents and some opportunity for formal communication (i.e. parent/teacher conferences, home visits) to inform parents of children’s developmental progress (1 point) 	<p>4</p>	<p>In NC, optional quality point can be earned for having an “infrastructure of parent involvement” which must include three provisions from a list of communication, engagement, and governance strategies. OK provides a comprehensive list of parent engagement strategies that must be employed at all levels.</p> <p>Governance: Encouraged parent volunteerism (DC); LA points for parent advisory council; ME and TN parent advisory group at Level/Step 3; Parents serving on Board is one option for meeting part of the family partnership requirements at each level in OK. MA has parent participation on Advisory Board at Level 4. At Star 4 level, PA programs demonstrate parent involvement in planning and decision-making.</p> <p>Parent Education: Parent resource center, information available, Parent meetings and trainings (DC, increased frequency at higher levels); CO and PA require programs to provide parents with specific types of information (e.g. child development, community resources and activities, curricular information); LA point for one parent education opportunity/year; MS requires annual parent education training for Step 3; TN requires one educational opportunity per year at Level 3.</p> <p>Communication: Bulletin board (DC, MS, TN); Open-door policy (DC, NM); Newsletter (MS,</p>	<p>It may be challenging to measure/define parent participation in governance. E.g. is it a point if there’s one parent on the Board? Three? A parent advisory board? In states that have this defined, it is generally at a higher level (level 3 or 4), so MI may want to allocate more points.</p> <p>Consider using some of the specific criteria used in other states.</p> <p>How will “ongoing” be defined? Consider specifying frequency of communication, as well as the number of parent education opportunities within a specific time frame. Other states tend to increase points/step for this criteria according to frequency.</p> <p>May want to consider using elements from the PAS (IL uses this) or the Strengthening Families assessment tool (used in NH) to measure these areas.</p> <p>Many states have a parent survey as part of their family engagement and program improvement strategies. Consider adding this either in addition to or in place of governance.</p>

		<p>monthly for Step 5); Conferences/meetings (DE, annual, 3 Stars; DE offers 2x/year for 4 Stars; IA and TN annual; LA, NH offer annually; ME 2x/year at Step 3; MS annually at Step 2, 2x/year for Step 5, PA annual at Star2, 2x/year at Star 3,); Parent handbook (e.g. KY, NH, CO, ME, PA) or other written communication of policies (NH); Systems for daily communication (DE, 2 Stars; IN Level 1; ME, Step 3; NM at 3 Star, PA Star 2); CO and NH require regular communication with parents. Annual conference call with family (IN, Level 1); ME requires 2x/year conferences offered at Step 3. In MN, programs earn increasing points depending on the number of communication strategies employed.</p> <p>Parent/Family Survey: MN gives one point for having a plan for collecting family feedback. CO and NH require parent satisfaction surveys. OK parents surveyed every two years at all Star levels. DC specifies parent involvement in Accreditation process. VT gives 1 pt for annual parent survey. IN requires annual program evaluation by families and staff at Level 2 (of 3). KY requires a documented family feedback process at Level 3. Delaware requires parent involvement in program improvement plan for 5 Stars.</p>	
<p>Program has written policies and procedures to promote community involvement</p> <ul style="list-style-type: none"> • Participation in community associations/collaborative (1 point) • An updated community resource and referral list available to parents (1 point) • Community participation in 	<p>3</p>	<p>Community Collaborations: MA requires documentation of collaboration (letters documenting collaborative relationships, MOU's, etc.); VT provides points for participating in a community "team" for a minimum of 24 hours/year, or for providing "leadership" within the ECE professional community.</p>	<p>How will programs document participation in community associations and collaborative? Specify MOU or letter from convener, for example.</p> <p>How will community participation in governance be defined? No other states require this in their standards. Consider dropping this piece.</p>

<p>governance (1 point)</p>		<p>Community Resource List: MA QRIS includes updated community resource list at Level 2; At 2 Stars, in DE information is shared with staff; At 3 Stars, program provides information to parents about state resources; At 4 Stars, program develops and implements a written plan for referring families to appropriate community services, including the plan in a policy manual. LA requires parents receive resource list at 2 Stars, offers points for offering annually. OK programs maintain current list of resources at 2-3 star levels. TN provides list of resources to parents at Level 3.</p> <p>Community Participation in governance:</p>	
<p>Program engages in annual program improvement measures</p>	<p>1</p>	<p>A program improvement plan is an optional indicator in NH. VT gives 1 pt for written improvement plan based on ERS. MA requires program self assessment at level 2. KY requires a program improvement plan at Level 2 for programs with certain ERS scores. OK programs required to establish and update goals every two years at 2-3 Star levels. IN requires that a strategic plan be in place with annual and long range goals (Level 3). ME requires self assessment and a written improvement plan at Step 3. IA provides points in Levels 3-5 for having an improvement plan in place. At Step 3 in OH, program is required to complete program improvement plan based on PAS self-assessment. Continuous quality improvement plan required at PA Star 3. At 4 Stars in DE, program develops and implements a continuous quality improvement plan.</p>	<p>Make the requirement more specific to make it easier to document, for example requiring that program has a written program improvement plan in place. If it requires documented program improvement plan, this may be worth more than one point. In most other states it is at levels 2-3. Some states tie this to a requirement for use of ERS so that may work at higher levels for MI.</p>

Group and Family Home Providers

Structural Quality Characteristics – Levels 1-3

Section/Characteristic	Points	Other States Experiences	Comments/Recommendations
Provider Qualifications			
Provider has High School Diploma or GED plus 10 hours of professional development in the past 12 months	2	Required in regulations in MI; IL uses Great START levels for qualification standards; MN uses state career lattice.	This is required in regulations, so consider allotting one point; Can be verified through licensing. Throughout this category does type or topic of PD hours matter?
Provider has a high school diploma or GED plus 20 hours of professional development within the past 12 months	4	IA has a similar progression through levels with Bachelor’s degree being highest (4 points). CO has Bachelor’s or Master’s in ECE or in other area +24 credits in ECE as highest level (10 points). Other states typically have CDA plus some college credits (PA) or an AA (OH) at highest level.	This requires annual documentation of PD hours. Will programs be required to submit for rating annually, and if they don’t will they lose these points? Can it be done through registry without requiring re-submitting for rating?
Provider has high school diploma or GED plus 30 hours of professional development in the past 12 months	6		Clock hours?
Provider has an Associate’s Degree in Early Childhood Education or a related field or a CDA or Montessori Credential with 3 CEUs or 30 clock hours of professional development in the past 18 months	8	<p>CDA or equivalent (Career Pathways) required at Step 1 in OH. This is similar to IN Level 2 requirements.</p> <p>CDA meets 2-3 Star requirements in OH. ME has CDA at Step 3 (of 4).</p> <p>CDA meets Star 4 requirements in PA.</p> <p>This is similar to DC’s and TN’s highest levels; In DC, Gold level is CDA plus 30 clock hours of in-service training. KY requires state Director’s Credential and CDA at Level 4 (highest level).</p>	

Provider has an Associate’s Degree in Early Childhood Education or a related field plus 6 CEUs or 3 college credits in child related field within the past 36 months	10	This is similar to OH’s highest level. In NC highest points (7) are given to providers with combination of AA or BA and years of experience.	
Provider has a bachelor’s degree or higher in Early Childhood Education or related field plus 10 hours of professional development in the past 12 months	12	This is similar to IA’s highest level. CO’s highest level is Bachelor’s or Master’s in ECE or in other area +24 credits in ECE as highest level (10 points)	Only two states have provider qualifications this high in their QRIS, but you allocate a high number of points for it, so that makes sense and may serve as a good incentive for attaining degrees.

Section/Characteristic	Points	Other States Experiences	Comments/Recommendations
Professional Practices			
Provider has policies and resources in place to assure that licensing ratios are met or exceeded	1	Generally in regulations. CO and NC give higher points for lower ratios (beyond licensing requirements) KY and NM require lower ratios at higher levels. In OH, lower ratios are optional indicators at each level (which can also be met through accreditation or achieving specific FDCERS scores).	It’s easier to measure whether the provider meets licensing ratios than whether they have policies and resources in place. Consider tying standard to lower ratios, or eliminating standard.
Provider has procedure in place for maintenance and continuous updating of staff and child administrative records	1	KY, TN and PA require plan for management of financial records at second level.	The maintenance of these records is in regulation, although it doesn’t seem to specify continuous updating. How will procedure(s) be documented or demonstrated? Standard procedure form/template? Continuous updating is difficult to document. Can it be evaluated

			annually at licensing visit, or is it enough to have the procedure in place in writing?
Provider belongs to a relevant professional association	2	IA provides points for this at Levels 3-5. This is required for a <i>center</i> administrator or curriculum director in a center in DE, and for <i>center</i> directors in IN. VT awards 2 points for this.	<p>Relevant will need to be defined. Consider whether simply being a member contributes to quality. This standard is more typically included in center standards.</p> <p>Some states give points/credit for a professional development plan for family child care providers. Consider whether this would be more constructive.</p>
<p>Provider provides a basic contract for services rendered (1 point)</p> <p>Contract should also include:</p> <ul style="list-style-type: none"> • Description of payment schedule (1 point) • Description of provider or child vacation (1 point) • Description of sick leaves for child (1 point) • Description of alternate care options (1 point) • Description of provider’s termination policy (1 point) 	6	<p>Contract: KY requires written parent/provider agreements. OK requires signed contract with parents at all star levels. TN provides personalized contracts at Level 1. VT provides one point for a parent contract. In DC contract is at the Silver level in the Parent Involvement provisions, and it is at Level 2 in Indiana.</p> <p>Other models for similar information: KY, NH require caregiver to provide parent handbook. ME specifies only that parents receive written policies (for Step 2).</p>	<p>Can providers get partial credit in this standard, or are all subsections required?</p> <p>If all pieces are required and 6 points are earned, this is considerably more than the value given by other states (typically required at level 2 or even at all levels).</p> <p>Consider giving one or two points for having a contract (as in other states), or giving partial points if not all information is included.</p>
Provider has business liability/accident insurance	2	In PA standards. VT awards 3 points for this.	<p>Can be documented with certificate of insurance.</p> <p>This standard is not very common. Consider whether it’s needed in MQRIS or could be in child care regulations.</p>

<p>Provider has activities or procedures in place that promote parent/child/provider relationships</p> <ul style="list-style-type: none"> • Promoting communication (1 point) • Promoting activities (1 point) • Using parents as resources (1 point) 	<p>3</p>	<p>In NC, optional quality point can be earned for having an “infrastructure of parent involvement” which must include two provisions from a list of communication, engagement, and governance strategies.</p> <p>Communication: NH, PA, ME, TN require offering annual parent/teacher conference; IA, IN, NH (optional) require annual conference with parents. OK, CO and NH require regular communication with parents. DC requires weekly child progress reports to parents at Gold level. KY and ME require written daily report for children under 2 years old. MN provides increasing numbers of points according to the number of communication strategies employed. NM and TN require increasing numbers of family engagement activities, including different forms of communication, at higher levels.</p> <p>Providing Written information: KY, NH, CO requires caregiver to provide parent handbook or written information upon entering program. CO requires programs to provide parents with specific types of information (e.g. child development, community resources and activities, curricular information); ME requires giving parents written policies at Step 2.</p> <p>Parents as Resources: DC requires parent involvement policy at Bronze level. At Gold level, DC requires parents volunteer 3x/year. ME requires procedures for encouraging parent volunteerism (Step 4).</p> <p>Parent Surveys: CO and NH programs required to ask families to complete program evaluation survey</p>	<p>This is very difficult to define and measure. Instead may hone in on two to three best practices that can be easily documented, e.g. annual conference (most common) volunteer hours of parents as resources, a specific number of parent/child activities at program, a specific frequency of written communication, a handbook, etc.</p> <p>Consider using Strengthening Families (used as an optional indicator in NH) self-assessment or Business Administration Scale (BAS), used in IL, as a tool for measuring these elements.</p> <p>Consider awarding a point for an annual parent survey, as many states require, either in this standard or as part of the program improvement standard.</p>
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<p>Provider makes an effort to promote good nutrition</p> <ul style="list-style-type: none"> • Provider follows USDA Child and Adult Food Program Guidelines 	2	<p>MA requires documenting nutritional needs of each child in records (level 2) and training on meeting special dietary needs (level 3). (Note, MA QRIS is in pilot phase.) IA provides points in Level 2 for participating in CACFP.</p>	<p>How is “effort” documented? Is there documentation through food program?</p> <p>This is not a commonly used standard. Consider whether it’s needed. Participating in CACFP may be sufficient and is easier to document.</p>
<p>Program engages in annual program improvement measures.</p>	1	<p>Program Improvement Plans: IA provides points for having a plan in place, based on ERS scores. MN and NH give point for provider having an individual professional development plan. Kentucky requires improvement plan based on ERS for Levels 1 and 2. ME requires a written improvement plan at Step 3, based on self-assessment. 3 Star programs in NM must have a plan for using evaluation results for program improvement. A program action plan, based on assessment, is required for Level 3 in OH.</p> <p>Self-assessment: Required in OH. OK requires annually. NH and VT require a written improvement plan based on evaluation. ME requires a written improvement plan at Step 3, based on self-assessment.</p>	<p>Actually engaging in program improvement measures may be difficult to document. Consider requiring program improvement plan based on self-assessment.</p> <p>In other states, program improvement plans are more typically at level 3, and may be worth more than one point.</p>

Implementation Features and Proposals

Section/characteristic	Other States Experiences	Comments/Recommendations
Accreditation		
An alternative path to 5 stars in the MQRIS is through national accreditation.	Nearly all QRIS include national accreditation (NC, LA and MS do not). The three most common systems are NAEYC, NAFCC and the COA-SAC accreditation. The most common approach is that national accreditation plus some state-specific criteria defines the top level of a QRIS. Accreditation as an alternate path to the top is the next most common approach.	Efficient use of resources, recognition of national standard. Using national accreditation helps establish a point of inter-state equity among states' QRIS.
All accrediting organizations will be required to apply to the MQRIS for recognition of their accreditation system as a valid measure of a 5 star program	There is only one accrediting body for FCC and one for SAC. The issue is center-based accreditation of which there are many.	Efficient to require accrediting body to apply and show comparability.
Applicant accrediting body demonstrates comparability using the MQRIS Rubric A review team of 5-7 members will evaluate applications and make recommendations for acceptance of accreditation systems by the MQRIS.	This process seems feasible. As far as is known, a few other QRIS use a similar process (e.g., OK and DC), which have a rubric/process for determining which accreditations to accept. In others it seems to have been a one-time decision to accept whatever accreditations were popular at the time, e.g., more political than rational.	Consider the possibility that some national accreditations may not match MQRIS 5-star level and should be designated as a route to a lower star level. See CT report (attached). Include criteria about the process of accreditation in the rubric, e.g., standards revised on regular basis using latest research, accreditation decision procedures are reliable and timely. To what body is the review team recommendation made?

<ul style="list-style-type: none"> • Review team will be composed of a diverse group of early childhood professionals (center staff, family and day care home providers, Montessori staff, school-age providers, etc.). • Maintain consistent review team members to provide inter-rater reliability. <p>A renewal application is required every five years or if major revisions are made to the accreditation process.</p> <p>Appeals made by accrediting organizations denied recognition by the MQRIS will be handled by the Early Childhood Investment Corporation (ECIC).</p>		<p>Assume it is the ECIC or whoever is the administrator/manager of MQRIS.</p> <p>The composition of the review team might need to include some people with broader perspectives such as researcher, regulator. Given time constraints of provider/practitioners it may be hard to maintain a consistent team. The main point is that the team members are perceived as unbiased, trustworthy and fair.</p> <p>What is the rationale for ‘every 5 years’? Reapplication when major revisions are made is reasonable. You will need to clearly define major revisions.</p> <p>If the ECIC is managing MQRIS overall, appeals made to the ECIC makes sense. It might need to go to a ‘higher court’ e.g., state agency.</p>
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Implementation/Feature	Other States Experiences	Comments/Recommendations
Infrastructure		
Administration/management of MQRIS	State agencies are the manager/administrator of QRIS everywhere except in Colorado and Missouri (non-profit organizations). States generally manage the policy-setting and financial aspects of QRIS and contract aspects of QRIS operations to other entities such as higher education (on-site assessments, evaluation) and to other organizations (TA, PD). Obviously higher	It is not clear which state agency(ies) will manage MQRIS. It appears that ECIC is a player and possibly other entities. The critical point is that the state needs to be clearly in charge (this is a public responsibility). Equally important is that any entities managing aspects of MQRIS are trusted and have no apparent conflicts of interest. E.g., ECIC cannot both manage MQRIS and

Implementation/Feature	Other States Experiences	Comments/Recommendations
	education has a key role in providing PD.	conduct the evaluation thereof. A contract with an outside researcher is preferable. Similarly, the providers of quality improvement need to be clearly distinguished from those that assess/assign ratings so there is no conflict of interest. The same university faculty cannot conduct rating assessments and do the MQRIS evaluation.
MQRIS staff		
Coordinate system Evaluate programs Support program improvement		These are 3 of the major functions of a QRIS (another is communication and outreach). Generally, all functions are overseen by one entity although may be performed by several/many entities.
Technical assistance for programs		
Orientation sessions (MQRIS staff and others)	Very common to offer orientations. About 1/3 of states require participation in orientation.	These can be done in person and online.
On-line information, self-assessment materials, technical support pages	Several states make good use of online access to information about QRIS. Maine’s entire application and rating process is automated. No on-site assessment is conducted. Documentation is reviewed to complement the online application before a rating is assigned. NH’s QRIS is entirely based on document review (not automated, done by hand). Similar to Maine, it uses NAEYC/NAFCC accreditation as the top level. Thus the national accrediting bodies do the on-site observation, not at state expense.	Many MQRIS standards are documented with policies or materials that can be reviewed off-site, which is efficient. In a state the size of Michigan, automation will be essential to success for MQRIS.

Implementation/Feature	Other States Experiences	Comments/Recommendations
	<p>Self-assessment is related to QRIS in several ways:</p> <ul style="list-style-type: none"> • familiarize potential participants with the tools to be used in a QRIS and/or • may be part of the criteria to obtain a rating, and/or • may be a source of information for the quality improvement process. <p>About half of states use self assessment, as do some of the states developing QRIS e.g., Arizona and New York.</p>	
<p>Mentors/consultants, individualized technical assistance (for Star 3 -5) by Great Start Collabs and others</p>	<p>All QRIS offer some type of on-site assistance, but intensity varies from an hour to a day, frequency can be one-time to weekly, and almost always varies by need of program.</p>	<p>Assistance is most efficient when it is provider-driven/requested rather than mandatory (provided to all regardless).</p> <p>Technical assistance and support for quality improvement currently being offered can be re-aligned to focus on support for participants in MQRIS. The Regional Resource Centers and most (if not all) of the contracts for Quality Supports (CCDF quality funds administered by ECIC) can be re-programmed to more closely support MQRIS.</p> <p>This is efficient use of resources.</p>
<p>Enrollment and Initial Evaluation</p>		
<p>Center-based and group child care homes must be in business for one year and possess a regular license with the</p>	<p>This is fairly common practice.</p>	<p>QRIS work best as a consumer guide if all types of programs are included (and participation is high, i.e., broad scope and high density. Using licensing as the</p>

Implementation/Feature	Other States Experiences	Comments/Recommendations
<p>Office of Children and Adult Licensing, Division of Child Day Care Licensing (OCAL-DCDCL)</p> <p>Family child care homes must be in business for one year and possess a valid certificate of registration with OCAL-DCDCL.</p>		<p>‘gate’ may exclude prekindergarten programs in public schools and Head Start programs, and school-age programs operated by public schools if these are exempt from licensing by category (school-operated) or part-day status.</p>
<p>The OCAL-DCDCL licensing consultant will use a checklist to verify specific structural quality indicators.</p>	<p>Having licensing staff verify observable criteria is done in several states, e.g., NC, OK. Further, licensing data that is automated can be transferred to the QRIS database. Personnel registry info is very useful for licensors as a report generated for a site saves licensor’s time reviewing files for licensing purposes.</p>	<p>Efficient use of current resources.</p> <p>Data transfer/sharing seems to be possible/being done currently in the Great Start Database.</p> <p>Several of the MQRIS structural indicators are written policies or other documentation that can be reviewed off-site.</p>
	<p>Legally unlicensed/license exempt home-based programs are eligible to participate in Florida (Miami-Dade), Illinois and New Mexico (according to the new Compendium). Miami-Dade has no license-exempt programs participating and no further info appears to be available. New Mexico indicates it includes license-exempt but no information on how could be located. Illinois seems to be the only operating model for MI to learn from.</p>	<p>Given the large proportion of public funds expended in MI on ‘informal’ care, including these providers in the quality improvement and perhaps financial incentive aspects of MQRIS is reasonable. This may be accomplished already by the Tier 1 and 2 trainings for aides and relatives (and the higher subsidy reimbursement rate for Tier 2). It is not reasonable to publicize ratings of individuals who are by definition taking care of relatives and close friends. They are not ‘suppliers’ of child care to the general public.</p>
<p>Professional Development for Practitioners</p>		

Implementation/Feature	Other States Experiences	Comments/Recommendations
Informal and formal training	All QRIS offer formal training whose content is aligned with the criteria in the QRIS.	
Two and four-year early childhood education/child development programs	Most but not all QRIS include degrees in the staff qualifications criteria. Thus higher education is a resource for QRIS.	Access to higher education coursework and degrees will directly affect whether programs can reach the highest levels of MQRIS. Is there an IHE-ECE inventory/directory?
T.E.A.C.H. scholarships	Most QRIS offer scholarships (TEACH or other types) and give priority access, or sometimes limit access, to those participating in QRIS.	Consider giving MQRIS participants priority access to TEACH scholarships.
Monitoring		
Review annual reports of compliance from each rated program.	In about half the operating QRIS, ratings last for longer than one year. An annual report may be required but the on-site assessments are not done annually (range is up to 3 years)	
Conduct random, unannounced visits to check compliance.	This is common in licensing systems, and is an element of NAEYC accreditation, but do not think it is much used in QRIS.	MQRIS is mainly document review which would not need to be directly observed in a visit.
At a minimum, a program will be visited once per year.	Operating QRIS are about evenly split on the conduct of onsite assessment from once a year, every 2 years or every 3 years.	If this includes licensor visits, then may be feasible. May not be necessary if annual reports are submitted and reviewed, and licensing database is connected to MQRIS database. For feasibility, consider once every 3 years.
Ratings		
Rating is applied for annually	<p>In about half the operating QRIS, ratings last for longer than one year.</p> <p>The most common trigger for re-rating is a licensing</p>	<p>Annual rating may not be necessary.</p> <p>You will need to define both what triggers re-rating and how often a program can request re-rating. Both have</p>

Implementation/Feature	Other States Experiences	Comments/Recommendations
	violation. Others are change in ownership, location or director of a program, and in a few cases high teacher turnover.	cost implications for implementing MQRIS.
MQRIS staff designate rating based on information verified by the licensing consultant at the licensing visit (for star 1-3) and additional documentation for stars 4-5.	Seems to be fairly common for licensing information to be part of documentation for QRIS criteria.	Focusing the first star levels on licensor-verified data is efficient. At least at first, the vast majority of programs will be at those levels.
MQRIS will use the Program Quality Assessment (PQA) tools developed by the High/Scope Educational Research Foundation to measure process quality.	<p>Nearly every operating QRIS uses the ERS family of tools. To our knowledge, none use the PQA.</p> <p>Note that operating QRIS almost all aim for 85% inter-rater reliability on whatever observational assessment is used in assigning ratings.</p>	The PQA is a Michigan resource. Using it may be more efficient for MQRIS than using other tools. Several states now use other program assessment tools than the ERS, as self-assessment and/or quality improvement mechanisms. E.g., the Family Strengthening Self-Assessment for early childhood programs, ¹ tools from the National Center on Cultural Competence. ²
Ratings of all programs that participate in the MQRIS are public.	Website is the most common means to communicate with families, followed by written materials. Same is true for means of communication with providers. About half of QRIS translate information into at least one language other than English.	This is essential for QRIS to work as a demand side (consumer) intervention.
Except: programs that enroll for the first time may hold back their star rating for the first year to allow improvements	Unsure whether other states do this. Policy that has the same effect is the 'start with stars level in Pennsylvania Keystone STARS.	This is generous but may be costly, as programs may be rated twice in one year. You will need to define the 're-rating' policy carefully.

¹ Family Strengthening Self-Assessment at <http://www.strengtheningfamilies.net/>

² Cultural Competence tools at <http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist.EIEC.doc.pdf>

Implementation/Feature	Other States Experiences	Comments/Recommendations
to their programs before their ratings are made public.		
<p>Programs that do not participate in MQRIS are 'unrated.'</p> <p>A program may withdraw from the MQRIS, thus losing its rating and be classified as an unrated program.</p>	<p>QRIS websites that list rated programs do not also list unrated ones. If the basis of the list is all regulated programs (e.g., a state licensing website) it may also provide the additional information about ratings of those that have them.</p>	<p>Policy on withdrawal needs to be written clearly and enforced. NAEYC for example has to monitor programs with expired accreditation to be sure they do not continue to market themselves as accredited. This will be easier for MQRIS since you control the communication of ratings/rated programs.</p>
Incentives		
Recognition	<p>All QRIS recognize participating providers. It is essential to publicize ratings for consumers, which is economically speaking 'product differentiation' or quality recognition for providers.</p>	<p>The peer pressure of recognition has some effect as an incentive for improvement. QRIS are a carrot (as opposed to stick) approach. Creating an inclusive culture of continuous improvement across the industry, and supporting with financial and other help, is more effective than market competition alone.</p>
<p>Financial: Tiered subsidy reimbursements (5% increase for each star above 1)</p>	<p>Most but not all QRIS offer tiered subsidy reimbursement; the range of tiers is 3% to 25%. The value of these depends on the rate ceiling %ile the state is paying. Some offer a flat rate addition.</p> <p>Maine's experience has been that getting large increases in the quality differential is very acceptable (politically) while increasing the reimbursement rate ceiling is not.</p>	<p>This is good but not sufficient to support the cost of program quality, since only a fraction of children are supported with subsidies, usually less than 20%, and receiving the higher rate requires the program to charge the private paying parents the same rate, unless the addition is structured as a bonus or payment above the rate.</p>
<p>Financial: Quality bonus (one-time payment of \$100 to \$1000)</p>	<p>Most QRIS offer some amount of improvement grant, usually modest, one-time. This helps all programs, regardless of subsidy enrollment.</p>	<p>With limited resources, getting quality rate differentials established and making these very modest quality bonuses annual are probably attainable goals.</p>

Implementation/Feature	Other States Experiences	Comments/Recommendations
	<p>Most QRIS offer scholarships with priority access given, or sometimes access limited, to those participating in QRIS. Some QRIS provide wage/retention bonuses.</p>	<p>Consider giving MQRIS participants priority access to TEACH scholarships.</p>
<p>Financial: Tax credits/deductions</p>	<p>Best example of tax credits connected to QRIS is the School Readiness Tax Credits in Louisiana. See http://www.qrslouisiana.com/pg-17-26-school-readiness-tax-credits.aspx</p>	<p>This is a good revenue source if tax policy change is high on the political agenda. If MI has tax credits for other small business/industries, then a good argument can be made for establishing tax credits for ECE.³</p> <p>Credits are nearly always more valuable than deductions. Refundability is key – this makes tax credits available to non-profit (non-tax paying) entities) and to lower income families.</p>
Evaluation/Accountability		
<p>Surveys of participants at each contact Annual evaluation by ECIC Inter-rater reliability on the PQA</p>	<p>Most QRIS have some types of evaluation, either ongoing or at certain intervals (e.g., every 3 years). Nearly all do some type of internal evaluation (analyze and report on data, building continuous improvement into the QRIS itself). Most also use external evaluators. The next product of the federally funded QRIS project is an evaluation guide for state QRIS.</p> <p>As noted earlier, the goal for inter-rater reliability is 85%</p>	<p>Our experience indicates that few QRIS conduct frequent surveys; you might reconsider surveying at each contact.</p> <p>Annual report on MQRIS is good practice. Evaluations are not usually annual.</p> <p>It is good practice to set and monitor progress toward performance targets or benchmarks for the operation MQRIS, e.g., length of time between application and rating, satisfaction of participants. Benchmarks for</p>

³ This report may be helpful: **Using Tax Credits to Promote High Quality Early Care and Education Services** (Stoney & Mitchell 2007).
http://www.pewcenteronthestates.org/report_detail.aspx?id=34058

Implementation/Feature	Other States Experiences	Comments/Recommendations
	or higher	system outcomes are also essential, e.g., density of high quality programs matches density of child population in all areas of the state, increasing the proportion of low-income children in higher quality programs.