Quality Rated's Temporary Alternate Rating Option: Findings from Surveys and Interviews

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Introduction

The onset of the COVID-19 pandemic in March 2020 coincided with the implementation of Georgia's requirement that all child care programs receiving subsidy payments participate in the state's quality rating and improvement system, Quality Rated, by the end of 2020. Prior to the pandemic, an in-person classroom observation was one of Quality Rated's key components, but such observations were not feasible during the pandemic due to restrictions around in-person visits. Additionally, the new requirement that all child care programs receiving subsidies join Quality Rated led to a large influx of new programs into the system. To address these challenges, the deadline to join Quality Rated was extended until the end of 2021, and Georgia's Department of Early Care and Learning (DECAL) implemented a virtual process to rate programs. DECAL piloted the virtual process in late 2020, and four cohorts of programs went through the process in 2021: Cohort 1, Cohort 2, Cohort 3, and Cohort 4.

This virtual rating process—called the Temporary Alternate Rating Option (TARO)—offered three pathways for child care programs to earn a rating: Option A, Option B, and Option C. Programs that selected Option A were eligible for a 1-star rating and submitted a portfolio with documentation; this portfolio was the same as the portfolio submitted as part of the traditional rating process. Option B programs were eligible for a 2-star rating. These programs submitted their portfolios and participated in the Quality Rated Virtual Process (QRVP), a series of four learning modules (referred to as "topics") that programs completed independently. At the end of each topic, programs submitted video evidence demonstrating that they had implemented the content. Programs were only eligible for Option C if they had been rated previously under the traditional process and were now going through a re-rating. Programs that selected Option C were eligible for a 3-star rating; these programs completed the portfolio and QRVP (including one additional topic), and participated in a remote observation called the Live Observation – Virtual Experience (LO-VE), which is scored in real time. During Cohort 1, Option C was treated as a pilot and available only to a small number of programs, but the option was expanded in future cohorts.

Throughout the TARO process, Quality Rated Improvement Guides (QRIGs) and Technical Assistants (TAs) were available to support child care providers at participating programs. Each program participating in Option B or Option C was assigned a QRIG and TA. The QRIGs' main responsibilities were to lead TARO orientation meetings and score the evidence programs submitted as part of QRVP. TAs were responsible for shepherding programs through the entire process and provided ongoing support and feedback as programs completed QRVP and submitted evidence.

DECAL partnered with Child Trends, a nonprofit research organization, to learn more about TARO. This project had several components: analyzing TARO scoring data; fielding surveys with child care providers, QRIGs, and TAs; and conducting interviews with providers participating in Options B and C. This brief focuses on the experiences that providers from Cohort 1 and Cohort 2 shared during surveys and interviews, as well as results from surveys of QRIGs and TAs. (A later brief will focus on the TARO scoring data.) At the end of this brief, we provide future considerations for DECAL and Quality Rated as they continue to implement TARO and transition back to in-person visits.

Key findings

1. **Overall, providers, QRIGs, and TAs had positive impressions of TARO**. For example, the majority of providers (76%), QRIGs (83%), and TAs (62%) reported that their experiences with TARO were "positive" or "very positive."

2. **Technology was the main challenge for providers who participated in TARO, particularly for family child care providers.** While most aspects of technology got easier for providers over time, creating (17%) and uploading (26%) videos continued to be a challenge for some providers throughout their experience with TARO.

3. **Providers felt well-supported by both their QRIGs and TAs.** In general, providers reported strong relationships with their QRIGs and TAs, with almost all providers rating the quality of the support as "excellent" or "good" from both QRIGs (87%) and TAs (91%).

4. **Providers, QRIGs, and TAs had mixed opinions about how TARO should be integrated into the traditional Quality Rated process.** Almost half of providers (46%) endorsed a virtual component as a step toward earning a rating, and just over one third (35%) endorsed a virtual component for monitoring continuous quality improvement between three-year rating cycles. Among QRIGs and TAs, the most popular option for incorporating TARO was to add an introductory star to QR and allow providers to earn it through QRVP.

Methodology and Data

Child Trends collected data from Cohort 1 and Cohort 2 providers through four surveys:

- **Initial provider survey.** The initial survey with Option A, B, and C providers focused on characteristics of their child care programs, demographic characteristics of the providers, and a few questions about their expectations for participating in TARO. Child Trends fielded the survey before Option B and C providers started QRVP activities. For Cohort 1, this was from late January to late February 2021; for Cohort 2 it was in April 2021.[1]
- **Follow-up provider survey.** The follow-up survey included only providers who participated in Option B and Option C and focused on their experiences with QRVP.[2] Child Trends fielded the follow-up survey from late May to mid-June 2021 for Cohort 1 and from late August to late September 2021 for Cohort

[1] We fielded the initial survey again (in late May 2021 for Cohort 1 and at the same time as the follow-up survey for Cohort 2) for Option A providers who had not already completed the survey in an attempt to learn more about the population of providers participating in TARO.
[2] Providers who participated in Option B and Option C also received a subset of questions from the initial survey at this time if they had not completed it.

2, after all providers had received their final rating. We did not invite Option A providers to take the follow-up survey because they did not participate in QRVP.

Across Cohort 1 and Cohort 2, 329 out of 575 providers (57%) responded to the initial survey. For the follow-up survey, 159 out of 271 Option B and Option C providers responded (59%). Of the 362 providers who responded to at least one survey, 44 percent reported they were participating in Option A, 45 percent reported they were participating in Option B, and 11 percent reported they were participating in Option C.[3] The majority of survey respondents (78%) worked at a center-based program. Almost all survey respondents spoke English with children and families (99%), and a small group also spoke Spanish (13%). Almost two-thirds (61%) were Non-Hispanic Black. See Table 1 for more details.

Table 1. Program and provider characteristics

Characteristic	*n*	%
Child care program type (*n*=351)		
Center-based programs	275	78%
Family child care programs	76	22%
Current role (select all that apply for respondents who worked at a center-based program, *n*=273)		
Owner	109	40%
Director	198	73%
Assistant director	17	6%
Other	14	5%
Languages spoken with children and families (select all that apply, *n*=360)		
English	357	99%
Spanish	45	13%
Another language	16	4%
Race/ethnicity (*n*=356)		
Non-Hispanic Black	217	61%
Non-Hispanic White	85	24%
Hispanic (all races)	15	4%
Prefer not to answer	28	8%

Source: Child Trends analysis of Cohort 1 and 2 initial and follow-up survey data.
Note: Three of the 275 center-based programs reported being Georgia Head Start or Georgia Early Head Start programs. The rest were Child Care Learning Centers.
Note: Three percent of respondents indicated being American Indian/Alaskan Native, Asian, Native Hawaiian/other Pacific Islander, two or more races, or "a race, ethnicity, or origin not listed here."

[3] We asked providers to report which option they were completing at the time of the survey rather than relying on Quality Rated's administrative records because programs were allowed to switch options throughout the TARO process.

In addition to the surveys, we selected a sample of programs from each cohort for provider interviews.[4] Our team completed 11 interviews with Cohort 1 Option B providers and 29 interviews with Cohort 2 Option B and Option C providers.[5] The interviews covered many of the same topics as the surveys with the intention of eliciting more in-depth responses. We also asked Option C providers about their experience with LO-VE, which was a topic that was not covered by the surveys.

In the spring of 2021, Child Trends conducted a survey with QRIGs and TAs. The survey consisted of both closed- and open-ended questions eliciting feedback on experiences with TARO. There were 12 QRIGs and 43 TAs, all of whom responded, for a total of 55 respondents. Almost all of the TAs (41 out of 43) were supporting Cohort 1 providers; about two-thirds were also supporting Cohort 2 providers (29 of the 43).

Findings

Motivation for participating in TARO

Roughly three quarters of survey respondents (72%) indicated they learned about TARO from DECAL or Quality Rated, and almost half (42%) learned about it from their TA.[6]

Over three quarters of providers (82%) reported talking to their TA prior to deciding to participate in TARO. Of these providers, almost half (42%) reported that their TA did not encourage them to choose a specific TARO option. About one quarter of providers reported that their TA encouraged them to select Option A (24%), and one quarter reported their TA encouraged them to select Option B (27%). Only seven percent of providers reported that their TA encouraged them to select Option C, however, this may be reflective of the fact that Option C was only available for programs going through re-rating.

We also asked TAs how likely they were to recommend Option B or Option C to providers. The majority of TAs (79%) responded "somewhat," and the rest responded "extremely." When asked "why?", TAs offered both benefits and challenges of Options B and C. The most common challenge was program capacity to take on the workload (38%).[7] Many providers were experiencing challenges such as staffing shortages and could not dedicate the time to TARO. Another common response was challenges with technology (28%), especially for family child care providers. Some TAs mentioned the value of the process as a reason for recommending Options B or C (13%).

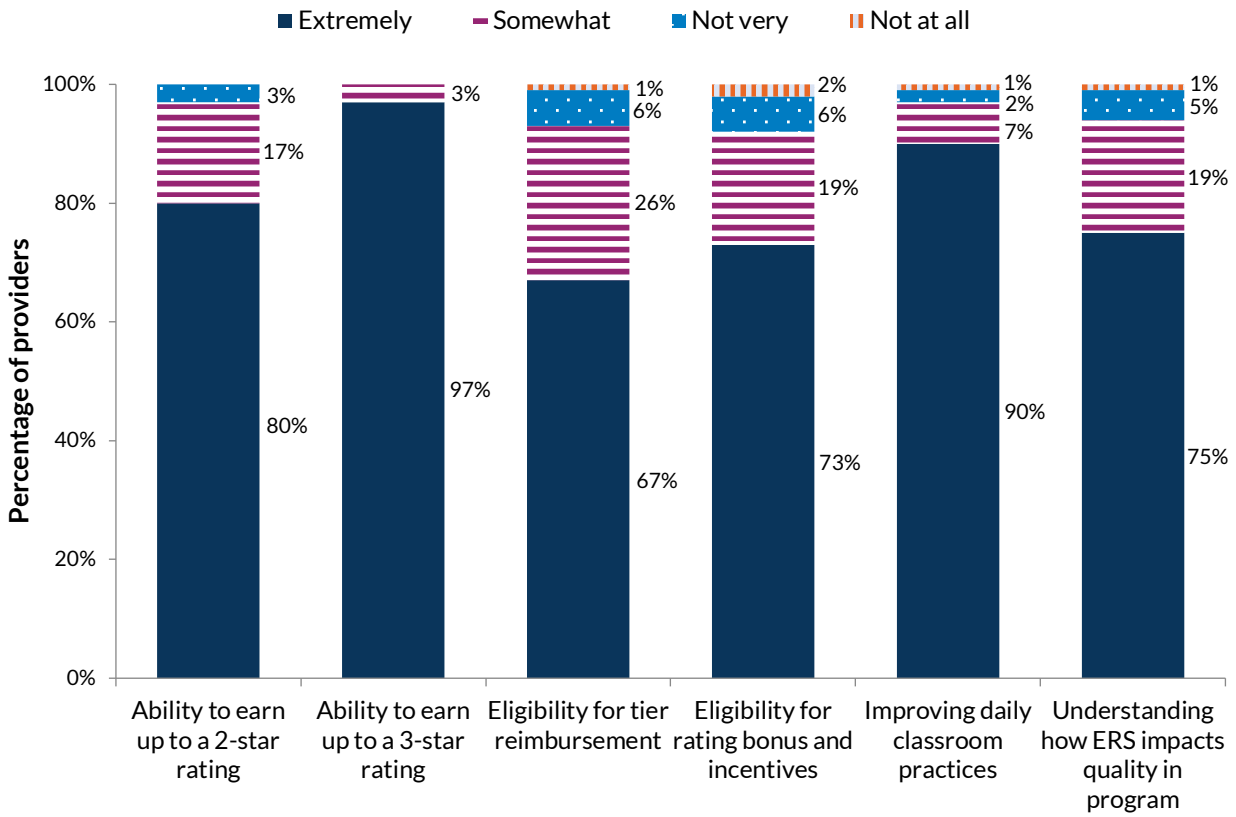
> *"I think this is a great process for providers that have a firm foundation with technology. This helps them practice their skills in a way that is less intimidating than an onsite observation. The topics lead to much discussion and reflection."* **—TA**

The follow-up survey asked Option B and Option C providers about the importance of a series of factors in influencing their program's decision to participate in TARO (see Figure 1). At least half of providers rated each item as "extremely" important, with almost all providers (90%) rating improving daily classroom

[4] Because Cohort 1 was effectively a pilot for Option C, we did not interview any Option C providers from that cohort.
[5] Our initial goal was to interview 20 Option B providers from Cohort 1, 20 Option B providers from Cohort 2, and 20 Option C providers from Cohort 2, for a total of 60 interviews. We intended to select programs across a range of characteristics, including whether the program was a center or family child care and whether the program was going through the Quality Rated process for the first time or was going through the re-rating process. In instances where the group was large enough, we randomly selected programs to participate in the interviews. In some instances, the groups were small enough that we selected all available programs; this was particularly true for family child care and programs going through re-rating. We did not meet our initial goal for these groups, both because there were not enough available programs and because we were not successful in recruiting all available programs. We invited all seven providers who spoke Spanish, based on DECAL's records, and two participated.
[6] Providers could select more than one response option.
[7] For open-ended QRIG and TA survey questions, we used the number of individuals who gave any answer (excluding "N/A") as the denominators for percentages.

practices as "extremely" important. Additionally, almost all Option C providers (97%) rated the ability to earn up to a 3-star rating as "extremely" important.

Figure 1. Importance of factors in programs' decision to participate in TARO



Source: Child Trends analysis of Cohort 1 and 2 follow-up survey data.
Note: Analysis of "Ability to earn up to a 2-star rating" was restricted to Option B providers, and analysis of "Ability to earn up to a 3-star rating" was restricted to Option C providers.

When asked about their motivations for participating in TARO, the 40 interview respondents gave similar answers to survey respondents. Interview participants expressed a desire to improve the quality of their program and ensure that they were providing the best services to their children and families (*n*=10). Others said the expiration of their current rating was approaching, and they were applying for a re-rating (*n*=11), with a few stating that they wanted to maintain their rating or achieve a higher rating than before (*n*=3). Providers also mentioned the benefits of being Quality Rated, including the ability to serve certain populations such as children receiving subsidies, Head Start, and children in the foster care system (*n*=5), recognition by families as a quality program (*n*=3), and financial incentives associated with star ratings (*n*=2).

Two providers said that the pandemic was beneficial because it provided an opportunity for teachers to focus on learning and improving quality while enrollment was low.

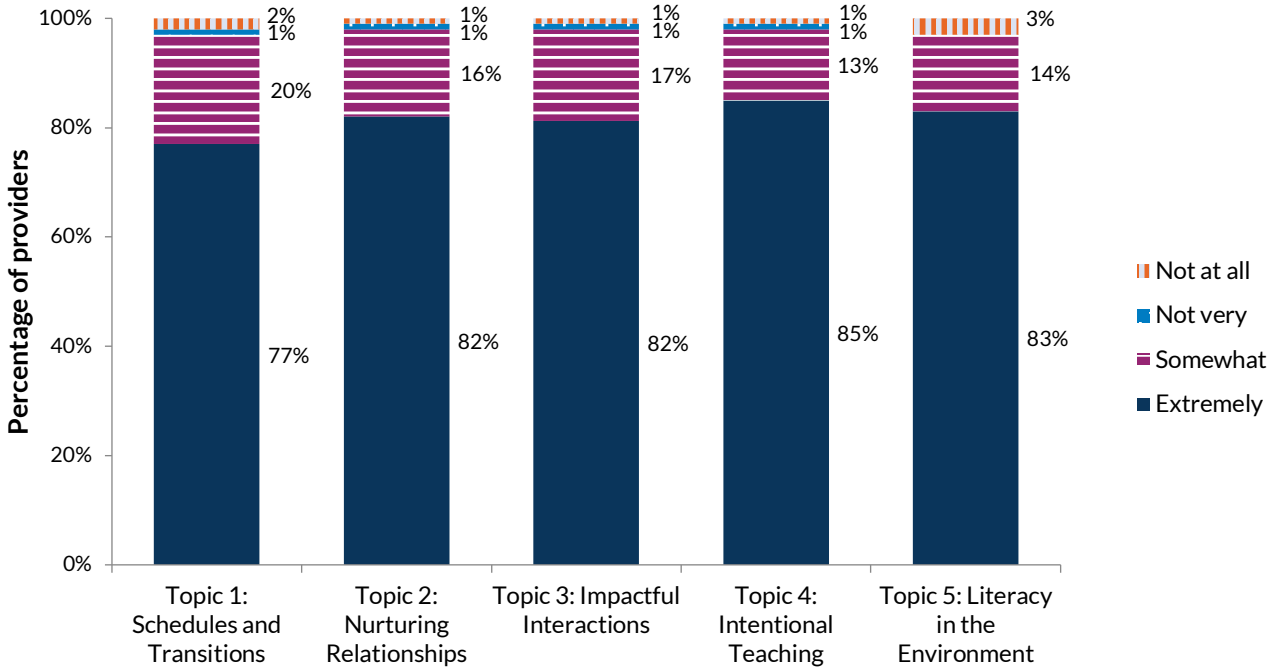
> *"A hunger for quality and professionalism [was my motivation]. I noticed we could improve, but I didn't know how to get it there without Quality Rated."* —**Center director**

"It was a good option to take the internal look and make sure we are focusing on having the best program for children. Making sure they are taken care of and nurtured and loved the best that they can be despite everything else happening." **—Center director**

Benefits of TARO

When asked to rate how beneficial each QRVP topic was for their program (four or five topics total, depending on whether the program selected Option B or Option C), the majority of survey respondents rated each topic as "extremely" beneficial (see Figure 2). Very few providers (less than 3% for each topic) said that any of the topics were "not very" or "not at all" beneficial. Survey respondents also had very positive opinions about the scoring rubrics and feedback forms, with almost all indicating they were "extremely" (over 60% for each) or "somewhat" (over 30%) helpful.

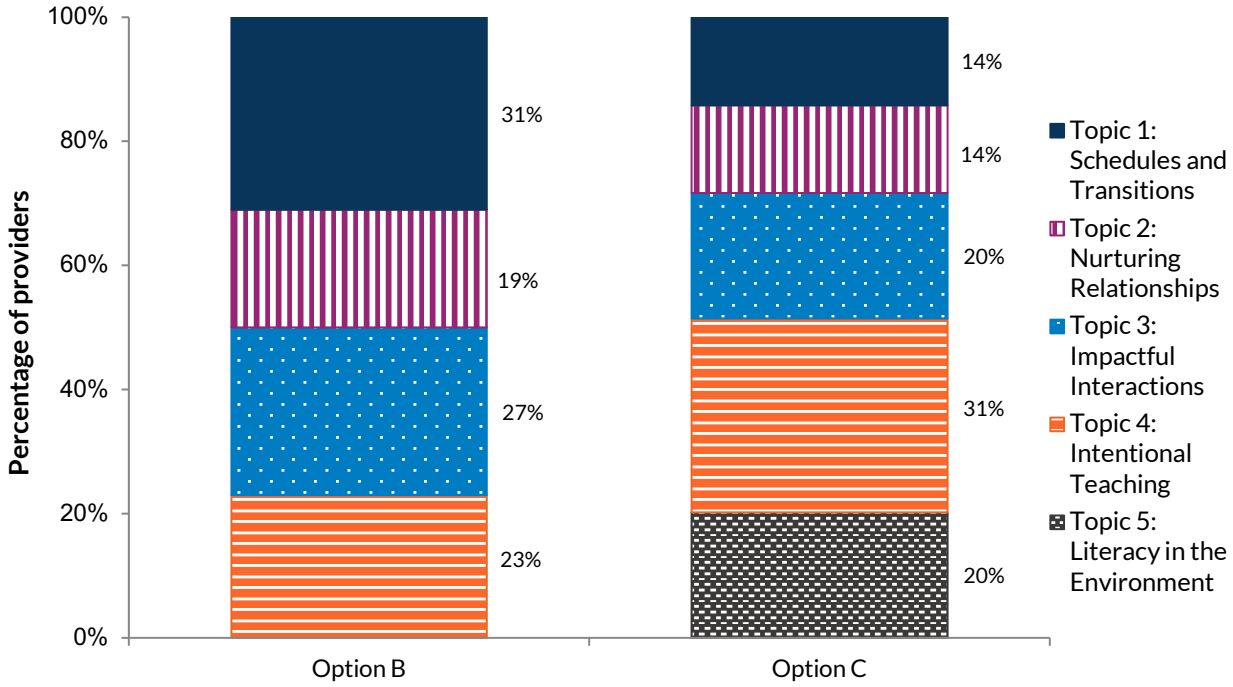
Figure 2. Providers' perceptions of how beneficial each QRVP topic area was to their program



Source: Child Trends analysis of Cohort 1 and 2 follow-up survey data.
Note: Topic 5 was only available to Option C providers.

When asked which topic improved their program the most, providers were fairly evenly split across the topics (see Figure 3). The largest proportion of Option B providers (31%) selected Topic 1 while the largest proportion of Option C providers (31%) selected Topic 4. The questions were slightly different for Option B and Option C providers because Option C had one additional topic (Topic 5).

Figure 3. Providers' perception of which topic improved their program the most



Source: Child Trends analysis of Cohort 1 and 2 follow-up survey data.

Overall, most providers who took part in the interviews thought the content of all of the QRVP topics was relevant to their child care context (*n*=27). Most also said that they learned something new (or were reminded to be more intentional about information they already knew) from each of the four TARO topic areas (range was 24-33, depending on the topic). Most providers also reported that it was easy to implement changes related to what they learned through QRVP.

During the interviews, most providers also indicated that the portfolio prompted them to make changes to their programs (*n*=23). The most common types of changes prompted by the portfolio included tracking staff professional development and credentialing (*n*=8) and changes to classroom routines and activities, such as purchasing new play equipment, arranging the classroom differently, and intentionally posting daily schedules and routines (*n*=4).

> *"We made sure we had all of our trainings up to date. It made us want to do some more trainings to complete for the portfolio. And the extra trainings that were part of the bonus points made us more aware of making sure our paperwork was in order."* **—Center director**

Among the 14 Option C interview participants, most said that the LO-VE observation process went smoothly for the providers and their teachers (*n*=8). Providers commented that it was easy to get used to the technology and being videotaped, and that reassuring staff that it was "just another day" was a useful approach. Interview participants offered the following suggestions for future Option C participants: approaching LO-VE as a "team effort" (rather than the director taking on the task alone), having directors talk to staff about what to expect well in advance, and offering multiple modes of support (e.g., TA, video trainings).

Challenges with TARO

In addition to asking providers how beneficial each QRVP topic was, the survey asked which topic was most challenging. About 40 percent of survey respondents indicated that Topic 4 (Intentional Teaching) was the most challenging for their program, and another third indicated that Topic 1 (Schedules and Transitions) was the most challenging. When asked "why," the primary reasons providers cited were difficulty implementing content in their program (27%), challenges with teachers adjusting their teaching approach (16%), and more work and time needed for that topic (15%).[8] Among providers who struggled with implementing the content, providers most often reported challenges around implementation of schedules and transitions (11%) and holding open-ended conversations with children (10%).

When asked which QRVP topic was the most challenging for providers, QRIGs and TAs also tended to select Topics 1 and 4, although at different rates. The majority of QRIGs (83%) selected Topic 1; more than half of TAs (58%) also reported that Topic 1 was the most challenging topic for providing support, while one quarter of TAs selected Topic 4.

In interviews, the challenges providers reported with TARO were predominantly related to short-term adjustments with initiating new routines and practices or adjusting to doing something different from what providers and children were used to. Six interview respondents said that the TARO content was not always applicable to their program because the practices were already being implemented, the information was not advanced enough, or the issues being addressed were not areas of need for their program (e.g., modules on toileting for a preschool-only program).

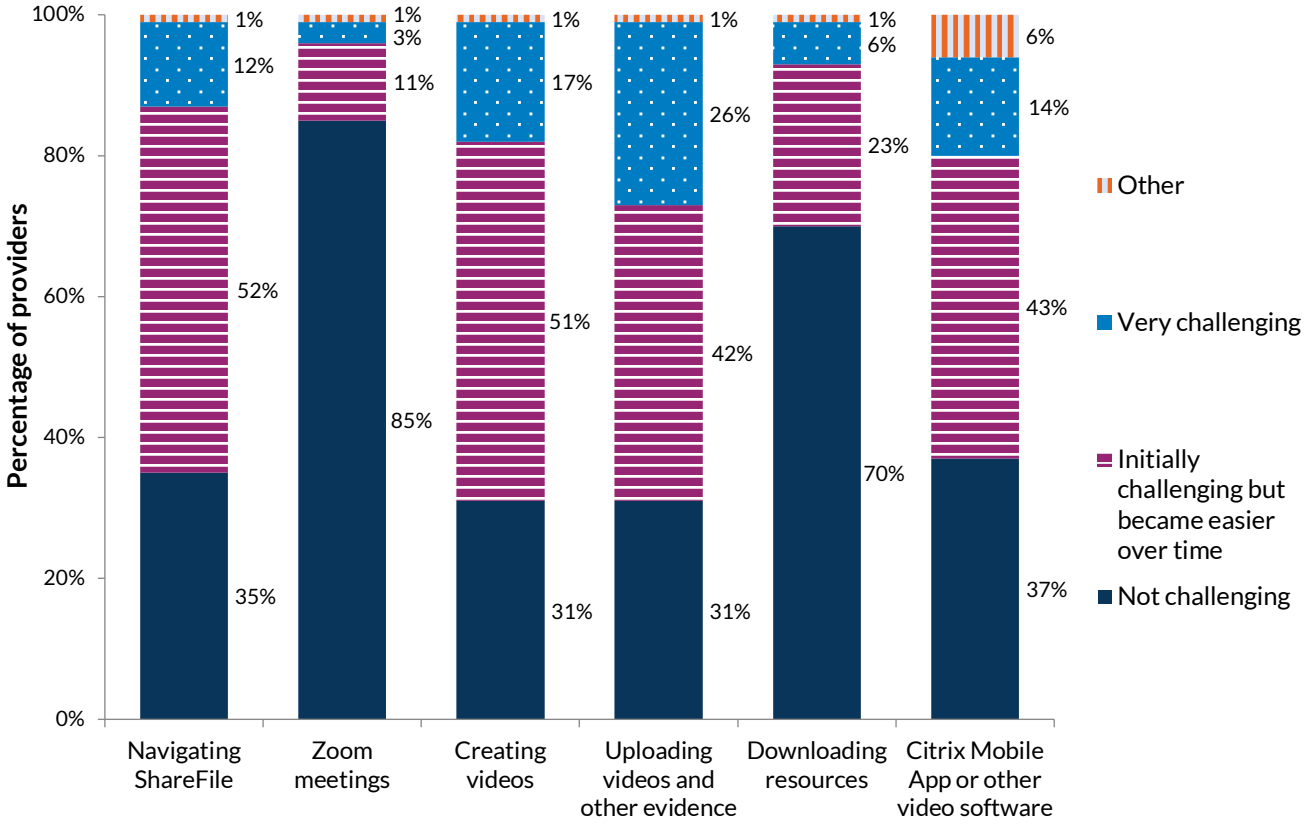
One provider reported challenges with LO-VE due to a personal preference for in-person observation, and another reported challenges with internet stability in a rural setting.

> *"I have 20 years of experience, so it wasn't really new information I was learning, it was more like a refresher for me. I prefer to use my time with learning something new or spending my time on areas I know I need improvement. Especially on the business side, I think that would have been more helpful to me in learning more about the administrative side of the business."*
> **—Family child care provider**

TARO required extensive use of technology, much of which was new for programs. For that reason, we asked survey respondents to share how challenging they found various technologies throughout TARO (see Figure 4). The majority of providers did not report any challenges with technologies such as Zoom and downloading resources. Around half of providers reported that the following technologies were "initially challenging but became easier over time": navigating ShareFile (52%), creating videos (51%), uploading videos and other evidence (42%), and the Citrix mobile app or other video software (43%). Some providers found certain technologies to be "very challenging." In particular, uploading videos and other evidence remained a challenge for roughly one quarter of providers (26%) throughout TARO.

[8] For open-ended provider survey questions, we used the number of individuals who gave any answer (excluding "N/A") as the denominators for percentages.

Figure 4. Challenges for providers in using technology during TARO



Source: Child Trends analysis of Cohort 1 and 2 follow-up survey data.

Similar to survey respondents, interview participants also talked extensively about problems with recording and uploading videos (*n*=23) when asked what did not work regarding TARO.

> *"It was hard to submit things via the app. So I'd have to save the video, send it to myself and submit via the website. That was time consuming because it took like two hours to upload, and you constantly had to make sure your screen was awake. I feel like it could have been faster had it been submitted through the phone."* **—Center director**

When asked whether there were barriers other than technology that made it difficult for programs to complete QRVP, roughly three quarters of survey respondents said "no." For those providers who said "yes," the two most commonly cited barriers were the ability of the program to take on the additional workload due to factors such as staffing shortages (40%) and the time commitment and time frame required by QRVP (33%). These findings were echoed by interview participants who also described challenges with staffing turnover and shortages (*n*=12) and difficulty with time management, specifically balancing TARO expectations and deadlines with regular program duties (*n*=12).

> *"[As a family child care provider], I have to do everything, versus a center that could break things down and give it to several teachers. And then finding the time to do those things, finding the time to record those videos, making sure that, once the kids are doing something that I'm capturing things. I had to work after hours to get all of this done, having to work extra hours and working all day, and putting my family aside to work on this at night. Those were the challenges I faced, just making the time to sit down and do this."* **— Family child care provider**

Support from QRIGs and TAs

When asked about the quality of the support they received from their QRIGs and TAs, survey respondents were overwhelmingly positive. Eighty-six percent of providers rated the overall quality of the support from their QRIGs as either "excellent" (57%) or "good" (30%). Similarly, 91 percent of providers rated the overall quality of the support from their TAs as either "excellent" (75%) or "good" (16%).

In interviews, providers reported varying levels of interaction with QRIGs. Most providers interacted with their QRIG for orientation only, or for one or two brief check-ins after orientation (*n*=21). The types of support providers received from QRIGs included general overview information on TARO, technical support, and deadline reminders for tasks and assignments.

All 40 of the interview participants reported frequent and ongoing contact with their TA on a daily to weekly basis. The majority of providers experienced TA support as proactive, responsive, and flexible in its ability to address their needs and questions. Several providers described the TA support as instrumental to their success in completing TARO.

When asked about what went well and the biggest benefits of participating in TARO, interview respondents overwhelmingly identified TA support as the most beneficial aspect of TARO (*n*=16), followed by leveraging technology for professional development (such as use of videos for training and feedback, *n*=11) and flexibility in the time and pacing of the program (*n*=8).

A handful of providers noted challenges with their TAs. One provider reported that their TA was primarily focused on deadlines and tasks, but not quality and content. Another reported they received inconsistent ratings and feedback between their QRIG and TA, which led to confusion.

> *"The TA was a godsend. She was accessible. If I emailed, if I called, I'd immediately receive a response. She was encouraging. She'd point out different resources. If she didn't know a response, she'd give me the direct source, so I didn't have to do the back and forth. I could not have done it without her."* **—Center director**

> *"My TA was awesome. Being able to connect with her, she seems to be readily available and was there. I'm not too sure how it would've been in person, with her driving to each spot, but with being at the computer at home, not having that in between travelling, I think it was better. That was a plus, especially because it required a lot of work. It was great having that ability to text or call, if not right away she would respond within the day."* **—Family child care provider**

Comparing TARO to traditional rating process

Among the 22 interview respondents going through re-rating, there were mixed responses regarding how TARO versus the traditional rating process affected the quality of their program and the rating they earned. Some providers thought that TARO improved their program's quality more than the traditional rating, and others disagreed. Eight providers said they thought their rating would have been higher with the traditional method, six said it would have stayed the same, four said it would have been lower, and four were unsure.

The QRIG and TA survey also asked, "Do you believe the program(s) you supported would generally have earned the same rating under the traditional Quality Rated rating process?" Roughly one third (32%) of QRIGs and TAs responded, "I don't know" while another third (30%) thought that the ratings would have been lower under the traditional rating process. The rest were fairly evenly split among the remaining three options: "yes, I believe the ratings would have been the same" (14%), "no, I believe the ratings would have been higher under the traditional QR rating process" (11%), and "other" (11%, with half saying that a mix of higher and lower stars would have been awarded to providers).

Providers generally agreed that TARO was less stressful than the traditional rating process. Of the 16 providers who spoke about this during interviews, eight said the traditional was more stressful, five did not see a difference, two gave mixed answers, and only one said TARO was more stressful. The most cited reason for the traditional rating process being more stressful was that having an in-person observer creates a stronger feeling of being monitored (*n*=5).

Interview respondents going through a re-rating provided a range of responses regarding how the provider's time commitment for TARO compared to the traditional Quality Rated process. Five said TARO was a bigger time commitment, one said it took less time, five said it was about the same, and seven were unsure or said that different aspects of both processes took longer. Only three interviewees spoke specifically to how the time commitment of their staff compared, and all three said it was about the same.

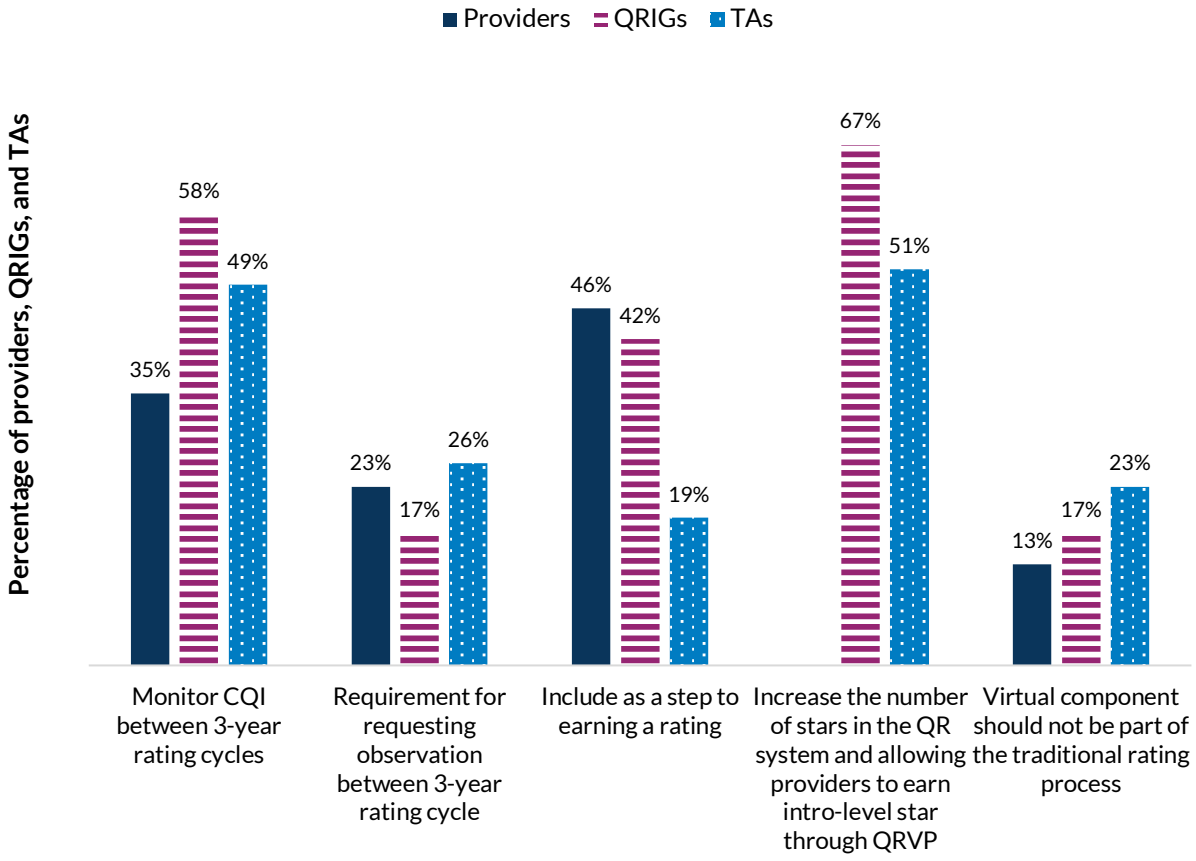
Overall, providers who took part in the interviews generally found the virtual component of TARO useful and thought that DECAL should continue to have a virtual aspect in the rating process (*n*=14). If there were a virtual component in the future, one provider suggested incorporating regular virtual check-ins with TAs. Another provider said they liked the virtual component of the observation and wanted that to continue.

> *"I think [a virtual observation component] probably would give them a truer version of what goes on in a classroom, because once you take a live body and put it in the classroom the children are going to react differently. It can cause stress for the children, so I think it would actually improve their ability to see a classroom more realistically."* **—Center director**

However, the two Spanish-speaking providers we interviewed said they preferred in-person interaction and the traditional rating system over a virtual format; challenges included technology barriers and having too much information in the content and activity requirements.

The survey asked providers who were going through re-rating how a virtual component should be integrated into the traditional Quality Rated process in the future; QRIGs and TAs were also asked this question (see Figure 5). Almost half of providers (46%) endorsed a virtual component as a step to earning a rating, and just over one third (35%) endorsed a virtual component for monitoring continuous quality improvement between three-year rating cycles. A small proportion of providers (13%) thought that a virtual component should not be part of the traditional rating process. The most popular option for QRIGs and TAs was to introduce an introductory star and allow providers to earn it through QRVP. This response option was not available for providers.

Figure 5. Provider, QRIG, and TA perceptions on how to integrate a virtual component into Quality Rated



Source: Child Trends analysis of QRIG and TA survey data and Cohort 1 and 2 follow-up survey data.
Note: Respondents could select more than one option.

Overall experience with TARO

When asked on the follow-up survey whether they felt the final TARO rating they received was fair, 84 percent of providers responded "yes." The 16 percent of providers who responded "no" were asked to explain why they did not feel the rating was fair. About half of these providers (48%) mentioned issues with the scoring and rating process, with some commenting on a lack of consistency between the instructions and the scores they received. A few interview respondents also mentioned that the rubric and instructions were not clear, leading to confusion. Another third of these survey respondents had issues with the TARO process as a whole (30%), commenting on challenges such as the videos not being representative of actual classroom experience and the process not allowing for corrections or explanations of mistakes. The remaining providers who did not feel their

> *"I think [TARO] was more based for a center than family in-home. But I think a lot of things when it comes to Quality Rated are. We're different in the in-home setting; we have different challenges than a center. Sometimes it's hard to fulfill the requirements of the center in home. One example is I got deducted a point for virtual observation for lunch, I wasn't sitting with the kids. It's hard to just sit with the kids, when I'm the only person serving, wiping hands, picking up. Some of the requirements from Quality Rated are really focused on center-based."* **—Interview participant**

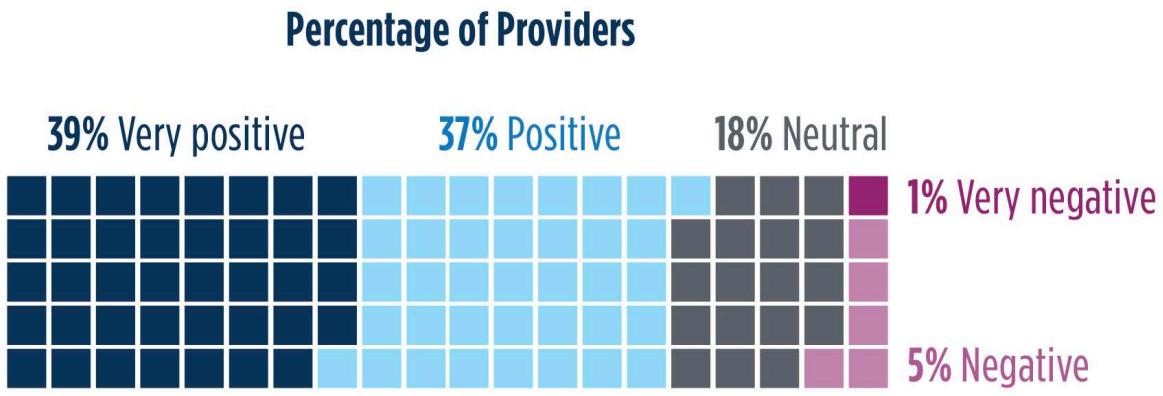
rating was fair reported that they did not have the resources to complete TARO and believed there was a lack of support throughout the process (13%).

The majority of QRIGs (91%) and TAs (73%) believed that TARO is a fair and equitable mechanism for awarding stars. When asked "why?", the most common responses were related to programs' quality improvement (15%), the rubric and scoring system being a good metric (13%), and the topics being beneficial and relevant (10%). For example, some respondents believed that TARO encouraged programs to evaluate the quality of their program and take steps to improve. On the other hand, a few expressed strong concerns that TARO was not fair, particularly regarding the technology requirement.

"Many of my providers that would likely score two or three stars with an onsite observation will not be able to confidently complete QRVP due to lack of technology or knowledge of technology. They are expressing extreme stress over having to use so much technology to complete the QRVP process." **—TA**

When asked how likely they were to recommend QRVP to another provider, the vast majority of survey respondents chose "extremely" (60%) or "somewhat" (29%). This is consistent with how survey respondents described their overall experience with TARO (see Figure 6). Just over three quarters of providers (76%) described their experience as either "very positive" (39%) or "positive" (37%), while only six percent of providers described their experience as either "negative" (5%) or "very negative" (1%).

Figure 6. Providers' overall experience with TARO



Source: Child Trends analysis of Cohort 1 and 2 follow-up survey data.

When asked about their overall experience with TARO, almost all QRIGs (83%) reported that their experience was either positive or very positive; only two QRIGs (17%) reported that their experience was neutral or negative. In contrast, 62 percent of TAs reported their experience was positive or very positive, while the remainder (38%) reported their experience was neutral. In response to the follow-up question "why?", respondents most often identified positive experiences with providers (23%), program growth and quality improvement (23%), and their own learning and growth (15%) as reasons. For example, respondents mentioned that they felt more connected to providers through this process and enjoyed watching their growth. Some also discussed how they themselves gained a better understanding of the system and learned how to better support programs.

"It's given us another avenue to support our programs in learning and implementing best practices within their programs. Through videos they are actually able to see themselves putting these skills into practice and seeing their growth with each step. It has also helped us learn where we can better support each individual program." **—TA**

Summary of Findings and Future Considerations

In general, the responses from surveys and interviews with Cohort 1 and Cohort 2 providers were consistent with the survey responses from providers who participated in the QRVP pilot. By conducting interviews and adding targeted questions for providers going through re-rating, we were able to learn more about providers' experiences as well as their thoughts on how TARO compared to the traditional Quality Rated process. We also gathered QRIGs' and TAs' impressions and feedback. This section summarizes the main findings and offers some considerations for DECAL as they move forward with future TARO cohorts and towards resuming in-person visits.

Continue gathering feedback on the rating process. Overall, providers, QRIGs, and TAs had positive impressions of TARO. From finding the QRVP topics beneficial to feeling that their final TARO rating was fair, providers who participated in surveys and interviews had largely favorable opinions of TARO across a wide range of metrics. Providers enjoyed the process and found the content that the Quality Rated team developed for TARO to be relevant for their work. As Quality Rated restarts in-person visits, we encourage DECAL to continue to gather feedback from participants regarding their experiences with the rating process. It may also be valuable to gather additional feedback from QRIGs and TAs as they gain more experience supporting providers through TARO.

Monitor providers' experiences with technology to reduce barriers to participation. Technology was the main barrier for providers who participated in TARO, particularly for family child care providers. While most aspects of technology got easier for providers over time, creating and uploading videos continued to be a challenge for some providers throughout their experience with TARO. DECAL introduced technology grants in Cohort 3, which may have eased some of these difficulties. However, if the Quality Rated process continues to include video recordings, it will be important to monitor providers' experiences with technology to ensure the process is not overly burdensome, particularly for family child care providers, smaller centers, or providers working in rural settings with less reliable access to the internet.

Providers felt well-supported by both their QRIGs and TAs, but it is important that the two teams provide consistent guidance. In general, providers reported strong relationships with both their QRIGs and TAs, although their interactions with QRIGs were more limited by design. Several interview participants cited TA support as a main driver for their completion of TARO. To the extent possible, DECAL should find ways to maintain these close, responsive relationships as the Quality Rated process shifts to resume in-person visits for observations. A small number of providers indicated that there were inconsistencies between the guidance they received from QRIGs and TAs. Ensuring those two teams are providing consistent information and that written instructions and rubrics align with that information could strengthen TARO.

Elicit input from broad audiences about whether and how TARO should be integrated into the traditional Quality Rated process. Providers, QRIGs, and TAs had mixed opinions of if and how TARO should be integrated into the traditional Quality Rated process. Around half of interview participants thought TARO improved their program quality, and half found TARO to be less stressful than the traditional rating process. In contrast, half of interview participants thought their rating would have been higher under the traditional process, and some thought TARO required a bigger time commitment than the traditional process. Similarly, there was no clear consensus among survey respondents about how TARO should be integrated into the traditional process. If DECAL is interested in maintaining aspects of TARO as part of the traditional Quality Rated process or structure, it will be important to elicit additional input from providers, QRIGs, and TAs to understand their perspectives. Forums such as listening sessions or focus groups could provide additional, richer ideas about how TARO could be incorporated into Quality Rated.

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