Thursday, September 26, 2019

CLI provided an overview of the Executive Summary for the Final Report. Questions were asked by the Workgroup regarding the study and its results.

## Study Sample Questions

Q1. Did licensing reviews take place between the visits? If so, did it effect any providers?

A1. This information was not collected during the study as, the study assessors did not complete the screening form for the study sites. In addition, for the sites that were a part of the external validity (i.e. sites that received 2 or 3 visits), we also did not collect any data on licensing reviews that would have taken place during that timeframe.

Q2. Explain how CLI defined continuity of care in terms of the study?

A2. For the study, continuity of care was defined as stable caregiving staff in the classroom over time, as part of the stability rating subsample of participating providers (n=40) who received 2 or 3 assessments during the study period (see the Results section of the Final Report, initial exploration of external validity). Changes in caregiver were frequent in the sub-sample, with only 66% of classrooms having a stable lead caregiver across three assessments. 59% had stable caregiving staff (including both lead and co-caregivers) between visits 1 and 2. 38% of classrooms had stable caregiving staff across all 3 assessments.

Q3. What was the provider sample mix regarding private vs. non-profit?

A3. The sample included 128 providers: Private/for profit: 94; Non-profit, faith-based: 3; and Non-profit, other: 31

Q4. How many programs of the 128 that participated, were not TRS?

A4. 59 of the 128 providers participating in the study were not Texas Rising Star.

Q5. How many of the 128 providers that participated were TRS? How many of each star level (2-star, 3-star and 4-star)?

A5. 69 of the 128 providers participating in the study were TRS certified prior to or during the study period. Three of the six providers were assessed in 2015 and are now no longer participating in TRS. Another three were nationally accredited and received an overall star rating via the auto assign within the event log. According to the latest TRS assessment data in CLI Engage:

* 2-star: 5
* 3-star: 19
* 4-star: 42 (including 3 auto-assigned for national accreditation)
* No longer participating: 3

Q6. What is the definition of High, Medium and Low SES (in terms of the study)?

A2. This information is available in the Methods section of the Final Report. Using data from the US Census Bureau, CLI categorized communities into high, medium, and low SES groups based on the percentage of families with children under five years of age whose income in the last 12 months was below the poverty level indicator (aligning closely with the statewide SES range).

Study SES percentage range:

* High: 0.-7.1%
* Medium: 7.2-25.7%
* Low: 25.8-100%

Q7. Explain the rationale for the selection of the geographic area of the Study Sample (Houston/Dallas). Does CLI believe that if the study were conducted in another region it might yield different results?

A7. The diverse regions of Houston and Dallas were selected to facilitate more cost-effective data collection within communities of children that closely align with the state’s SES composition, based on data from the US Census Bureau. In selecting communities and providers to participate in the study, CLI ensured the SES of families being served by these providers aligns with the state’s SES range for low, medium, and high (see previous question for additional information).

## Category Recommendations and Highlights

Q1. If the removal of items with limited variations is recommended but we still want to keep the item, how can we improve the item to differentiate quality?

A1. Recommendations for item removal or significant revision have been updated in the Final Report (Appendix 5) since the initial presentation to the TRS Workgroup on September 26. Writing new items and/or changing the language of current items was not part of the scope of the study.

Q2. The worksheets that were used for scoring, were they used for TECPDS and/or non-TECPDS files?

A2. Appendix 7 of the final report includes sample worksheets used in the study to score category 1 items for Director and Caregiver qualifications, orientation, and training. Appendix 8 includes tables detailing the category 1 indicators that can be scored using TECPDS reports and/or on-site review.

Q3. What is the model for the alternate scoring method? Will an example/sample of the alternate scoring be provided in the final report?

A3. Appendix 7 of the final report includes the Facility Assessment Record Form (FARF) and Classroom Assessment Record Form (CARF) used in the study. CLI has provided information to TWC for the study’s scoring procedures for the alternate items, but this information is not included in the Final Report.

Q4. Is there only one measure for ratio/group size? Is there a way to have the measure be both observation based and look at policy?

A4. The current TRS Guidelines include one item for ratio/group size per classroom type. Writing new items and/or changing the language of current items was not part of the scope of the study. Recommendation 1 includes an adjustment to the scoring criteria for ratio/group size for the children present during the observation.

Q5. Explain the alternate scoring method for Category 2 in plain language.

A5. As part of the study, CLI examined for floor or ceiling effects (highly skewed items) that suggest a substantial portion of the providers in the sample are not distinguishable from one another. Field data from the study identified that some frequency-based TRS items (counting the number of times a behavior is observed during the observation period) were susceptible to this problem. CLI developed alternate scoring to test alongside the current scoring protocol for these items. Please see the category-level item analysis for additional information.

Q6. Wondering if the removal of special needs and diversity would water down the importance of inclusion?

A6. Writing new items and/or changing the language of current items was not part of the scope of the study. CLI recommends for curriculum, planning for special needs and respecting diversity to be included in the established CQI plan with director/staff interviews and document review produces qualitative scores in practices related to curriculum, planning for special needs and respecting diversity.

Q7. Instead of removing special needs and diversity items, is there a way to strengthen them, as well as Infant and Toddler lesson planning?

A7. Writing new items and/or changing the language of current items was not part of the scope of the study. CLI recommends for curriculum, planning for special needs and respecting diversity to be included in the established CQI plan with director/staff interviews and document review produces qualitative scores in practices related to curriculum, planning for special needs and respecting diversity.

Q8. Explain more on why items were marked for removal in Category 3 and 4 rather than strengthen them?

A8. Recommendations for item removal or significant revision have been updated in the Final Report (Appendix 5) since the initial presentation to the TRS Workgroup on September 25. Writing new items and/or changing the language of current items was not part of the scope of the study.

Category 3 is not functioning well in terms of internal consistency and distribution of scores. Substantial conceptual changes to the category are recommended to more meaningfully account for curriculum-related practices with TRS. Internal consistency for all items using both current and alternate scoring methods is in the borderline acceptable range for infants (.66 and .69), and toddlers (.60). Internal consistency for preschool items reaches good range for both current and alternate scoring. School-age is unacceptable for both scoring approaches (.51 and .47). See Category 3 highlights on page 39 for more information.

Category 4, specific to Indoor Learning Environments (ILE) for all ages is working well. Outdoor Learning Environments (OLE) is well with the exception of the infant age group. Nutrition items are not functioning well on their own and they do not combine well with ILE or OLE constructions. CLI removed items that have low correlations to the total score in an attempt to reach internal consistency in the good range. After removing two infant nutrition items (P-N-03 Infants are held and talk to in reassuring tones while bottle fed and P-N-04 Caregivers feed infants on infant’s cure and stop feeding upon satiety) that have low correlations with the total and were often excluded (i.e. 37% of the time), infant internal consistency was improved to the acceptable range. It is recommended that these items are removed for infant scoring.

Q9. How will the new nutrition licensing standards affect these standards?

A9. SB 952 from the 86th Texas Legislature, effective 9/1/2019, amends the minimum standards related to nutrition, but is not yet implemented by Child Care Licensing. Rule changes are expected, but not finalized at this time. According to documentation provided by Child Care Licensing, more detailed information regarding the criteria and rule changes will be provided at a later date.

Q10. What alternative options can be considered in addition to the recommendation of removing the items and placing them in the CQI?

A10. Recommendations for item removal or significant revision have been updated in the Final Report (Appendix 5) since the initial presentation to the TRS Workgroup on September 26. Writing new items and/or changing the language of current items was not part of the scope of the study.

Q11. When reviewing Director training, did CLI look specifically for Administrative training topics or just at the overall hours?

A11. Please see Appendix 7 for the worksheet used in the study to score Category 1 items related to director qualifications and training. Study assessors scored directors’ training based on the current TRS Guidelines, collecting data on the number of hours in business management; Texas Infant, Toddler, and Three-Year-Old Early Learning Guidelines; and Texas Pre-Kindergarten Guidelines, as well as the number of hours in child care-related training, and program administration, management, or supervision.

## Stability Assessments

Q1. Did facilities know that there would be a second or third visit in advance?

A2. CLI selected 40 of the participating providers to participate in the stability rating sub-sample. All 40 of these providers received two assessments, with a sub-sample of this group (16 facilities) receiving a third assessment. All recruited providers were asked if they would be willing to participate in the sub-sample, and potentially receive up to two additional assessments during the study period. The providers were notified of the subsequent visits and were scheduled in advance.

## Key Recommendations

Q1. Can you explain more specifically how CLI recommends weighting the categories? (old weighting vs recommended to better understand the implications and recommendation)

A1. There are multiple approaches for adjusting the relative weight. TWC requested an analysis of several re-weighting options, completed by CLI in October. In the long term, CLI’s recommendation is to first establish statewide reliability using the recommended structure, followed by a validity study that captures key outcomes aligned with TRS goals. Please see additional information in the Recommendations section of the Final Report (Recommendation 2).

Q2. If we change the standards to make TRS stronger, would it make sense to change weighting at the same time or hold off?

A2. In the long term, CLI’s recommendation is to first establish statewide reliability using the recommended structure (detailed in the final report), followed by a validity study that captures key outcomes aligned with TRS goals (e.g., gains in child skills and financial stability for providers). Please see additional information in the Recommendations section of the Final Report (Recommendation 2). The results of predictive analysis would be used to guide category weighting decisions, such that categories with low predictive validity across outcomes would receive less weight.

Q3. If all team members received rigorous training, what are the suspected reasons for the lack of reliability of 40% of the assessors?

A3. Section 2 of the Final Report details the training procedures for study assessors. Only study assessors who reached reliability were released for CARF and FARF assessments during the study period. Suspected reasons for why 40% of the assessors did not meet the reliability requirements for the Classroom Assessment Record Form:

* Difficulty in identifying various caregiver-child behaviors during a live observation.
* Individuals had different levels of experience with the different age groups which affected how they viewed quality caregiving behaviors.
* Had challenges in recognizing how certain teaching behaviors can overlap across different subscales. For example, a caregiver defining a word that a child does not understand would be considered in Warm and Responsive and in Language Facilitation and Support.

Q4. How would the consistent assessor training work, as the program is based on provider interest?

A4. As part of the study scope of work, CLI developed the TRS Assessment Training and Certification System for TRS mentors and assessors. The TRS Assessment training designed for both assessors and mentors includes online training modules and practice assignments, with additional tiered support for assessors/mentors who are not able to meet reliability criteria (including small group feedback sessions and individualized feedback sessions) as part of the Certification. Appendix 9 includes an overview of the components of the TRS Assessment Training and Certification System, designed to be implemented for all TRS assessors and mentors across the state, including initial training and certification, then quarterly reliability training to maintain reliability over time.

Q5. How would rigorous training be accomplished on a statewide level on an on-going basis?

A5. Appendix 9 includes an overview of the components of the TRS Assessment Training and Certification System, including initial training and certification, then quarterly reliability training to maintain reliability over time. Based on data collected during the study assessor training period, the TRS Assessment Training and Certification System is designed to be implemented online and across the state concurrently, including initial training, ongoing quarterly training, and tiered, remote feedback for additional support.

Q6. What is, or would be, the difference between a CQI Plan and a TA plan?

A6. Recommendation 6 details the continuous quality improvement (CQI) framework, with additional artifacts in Appendix 5. Technical assistance delivered by TRS mentors is recommended to be implemented through a targeted CQI approach to systematically guide providers to higher levels of quality and increase participation in the program. The CQI framework provides opportunities for intensive and individualized technical assistance targeted to each provider’s specific needs.

Q7. Describe in more detail the rigorous training that was involved and what it would look like for current TRS Assessors.

A7. Training procedures for the study assessors is detailed in the Methods section of the Final Report. Phase 1 training included 3 major components: 1) understanding TRS program standards and guidelines, 2) building foundational early childhood education and care content knowledge, and 3) TRS scoring practice with feedback and certification. Our goal for training development in phase 2 was to transition away from face-to-face didactic sessions and move toward self-paced web-based training content that would later feed into the online training and certification system that would be implemented across the state. Appendix 9 includes an overview of the components of the TRS Assessment Training and Certification System, including initial training and certification, then quarterly reliability training to maintain reliability over time.

Q8. How many total measures are there for center-based programs?

A8. This information is provided in the Introduction (section 1) of the final report. The tables below indicate the number of items for center-based programs at the facility-level and classroom-level by age group.

TRS Classroom-Level Assessment Total Number of Items by Age Group

|  |  |  |  |
| --- | --- | --- | --- |
| Infants | Toddlers | Preschool | School-age |
| 47 | 53 | 60 | 51 |

TRS Facility-Level Items

|  |  |
| --- | --- |
| Number of Points-Based Items | Number of Met/ Not Met Items |
| 10 | 17 |

Q9. What does the “A” stand for on the chart for removal (ex: Item Label – P-LPC-02A)?

A9. In the previous version of the item revision and removal tables shared with the TRS Workgroup, the “A” indicated an item with alternate scoring tested as part of the study. This has been updated in Appendix 5 for clarity, in the tables detailing the Items Recommended for Revision (Table 1) and Items Recommended for Removal or Substantial Revision (Table 2).

## External Validity Exploration Questions

Q1. What happened to the lead and/or co-lead teachers that left? (move classrooms or left center)

A1. CLI has this data as part of the study but would need to prepare an additional analysis to share this information.

Q2. Out of the 18 nationally accredited providers, which accreditation were they? (NAEYC, NAC, etc.)

A2. The 18 nationally accredited providers were accredited by National Accreditation Commission for Early Care and Education Programs (NAC, 9 providers), AdvancED Quality Early Learning Standards (QELS, 5 providers), and National Association for the Education of Young Children (NAEYC, 4 providers). This information is detailed in the Results section of the Final Report, in the initial exploration of external validity.

Q3. Is there a higher correlation between staff training and higher quality than group size?

A3. CLI examined for correlations between all category 1 caregiver-focused items and TRS classroom measures and a fairly consistent pattern of correlations suggest:

* Providers with more qualified staff have higher scores on category 2 and 4 measures, and category 4-star rating
* Caregiver staff training topic alignment is moderately related to category 3 scores

See the Results section of the Final Report, initial exploration of external validity, for additional information.

Q4. CLI mentioned that they excluded the structural measures (met/not met) when looking at scoring for TRS2, 3, and 4 -star. How did they assess TRS 2-star if it currently is only defined by the structural standards?

A4. The study sample included both TRS providers and non-TRS providers, and not all of these met the required (met/not met) items. In the analysis, CLI assumed all sites in the sample met these items since they are required for TRS participation and do not offer differentiation in provider scores.

For the study sample, only the points-based measures were used to calculate the average category score. Therefore, any study sample site with an average category score of less than 1.80 resulted in a category star rating of 2-star. A provider’s overall star designation is based on the lowest star level achieved across the five categories.

Q5. How did CLI ensure that the alternate scoring was not subjective by the assessors?

A5. The study assessors were trained on the TRS measures, and were trained to reliability on the original scoring as well as the alternate scoring in categories 2 and 3. In addition to the debriefs after reliability assessments, there was also a weekly coding session facilitated by the four CLI master coders to prevent drift and ensure items were being scored consistently and in accordance with the Technical Scoring Manual and coding clarifications. As detailed in the Results section of the Final Report, category 2 requires a high degree of training for assessors to reliably score the items.

CLI examined for floor and ceiling effects that suggest a substantial portion of the providers in the sample are not distinguishable from one another. Based on scoring patterns observed in field data, CLI identified a specific type of item that seemed susceptible to the problem (frequency based) and developed alternate scoring criteria to test alongside the current scoring criteria. See the item level screening for category 2 for additional information

Q6. How did CLI define consistency scoring for those measures using alternate scoring?

A6. The current scoring method involved the number of instances that the caregiver behavior occurred. The alternate scoring focused on the quality of the caregiver's typical style for using that behavior during the one-hour observation.

## Other Questions

Q1. What is the timeline for assessor training?

A1. TWC will work in collaboration with CLI in implementing the TRS Staff Certification Course to align with the recommendations approved by the Commission. There is a target date of Fall 2020 for the release of the TRS Staff Certification Course. Additionally, TWC is in the planning stages of providing up regional trainings, webinars and at least 1 Austin-based TRS revision training for 2020. TWC will share those details as they are confirmed.

Q2. How do other state’s measure these important items (Diversity/Special Needs) in their QRIS?

A2. TWC will provide the Workgroup with a summary document of the data found from the QRIS Compendium. The QRIS Compendium Report Generator is a useful tool when questioning how other states implement related topics within their QRIS. It can be found here: <https://qualitycompendium.org/create-a-report>

Q3. What are the next steps to talk through these recommendations?

A3. The Workgroup will have numerous opportunities to reflect and discuss the data and recommendations made within this report via the in-person meetings and upcoming conference calls. TWC encourages the Workgroup to consider these recommendations and the findings provided as applicable when determining considerations for the Workgroup’s discussion. The timeline for the TRS 4-year review can be amended as needed to incorporate additional calls or meetings to ensure ample opportunity and time is allowed for the Workgroup’s discussion and review.

Q4. How can we encourage and/or incentivize continuity of care?

A4. Continuity of care is a topic worthy of discussion and brainstorming. TWC looks forward to hearing ideas and considerations on how Texas’ early education stakeholders, such as the Texas Early Learning Council, can support and encourage this format in early learning programs across the State.