Public Policy Associates

Year 2 Evaluation of Michigan's Provider-Driven QRIS

EXAMINATION OF PROVIDER PARTICIPATION AND EXPERIENCES

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Public Policy Associates is a public policy research, development, and evaluation firm headquartered in Lansing, Michigan. We serve clients in the public, private, and nonprofit sectors at the national, state, and local levels by conducting research, analysis, and evaluation that supports informed strategic decision-making.

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Introduction

STUDY OVERVIEW

Public Policy Associates (PPA), in partnership with the Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) and the Early Childhood Investment Corporation (ECIC) is in the second year of a four-year implementation evaluation of Michigan's reimagined Great Start to Quality (GSQ, Michigan's quality recognition and improvement system or [QRIS]). The reimagined GSQ was formally launched in February 2023.

The evaluation seeks to answer five research questions, listed below, using a rigorous mixed-methods design employing both primary and secondary data sources. This Year 2 evaluation report will primarily focus on provider participation, perceptions, and experiences (i.e., research questions 1 and 2, bolded below). Using administrative data from July 2021 through May 2024, the research team compares provider participation and ratings in Michigan's GSQ in the 18-month period leading up to and the 17-month period following the launch of the reimagined system in early 2023. Insights from administrative data are supplemented by perspectives on the prior GSQ and reimagined GSQ gathered from provider surveys and interviews.

RESEARCH QUESTIONS

The study's research questions are:

1. **Does Michigan's reimagined GSQ result in higher participation by child care providers, and particularly for home-based child care providers?**
2. **Is the reimagined GSQ associated with higher quality levels, on average and across different types of providers? Specifically, does the reimagined system make it easier for home-based child care (HBCC) providers to achieve higher quality levels comparable with child care centers?**
3. Is the reimagined GSQ associated with greater equity of access, by community type (urban/rural, poverty level, racial diversity), child type (i.e., children with disabilities, age of child), and parental needs (i.e., non-traditional hours)?
4. What program characteristics reported by providers are most strongly associated with higher scores on classroom observations? Do child care staff with "weaker" credentials demonstrate comparable levels of classroom quality to credentialed staff, as measured by classroom observations?
5. How do staff shortages and staff turnover influence providers' ability to demonstrate quality on the reimagined GSQ? To what extent do shortages and turnover influence participation in GSQ, or act as a barrier towards

program improvement? Are there differences in these relationships by provider or community type?

ORGANIZATION OF REPORT

This report is organized into four distinct sections:

- **Overview of Michigan's reimagined GSQ**
- **Secondary Data Analysis and Results:** Trends in provider participation and quality ratings over time, both overall and by provider type
- **Primary Data Analysis and Results:** Trends in provider participation, perceptions, and experiences
- **Summary of Findings and Conclusions**

Overview of Michigan's Reimagined GSQ

The prior iteration of Great Start to Quality (GSQ) did not effectively measure quality and was not equitable for all provider types.

Michigan was prompted to reconsider its approach to quality assessment and improvement following the completion of a validation report of the prior GSQ iteration (Iruka et al., 2018). The prior GSQ launched in 2011, and participation was optional for providers. A provider's quality (1 to 5 stars) was designated primarily using the Self-Assessment Survey (SAS), which included 49 indicators across 5 categories (Staff and Professional Development; Family and Community Partnerships; Administration and Management; Environment; and Curriculum and Instruction). A provider's self-assessment of each indicator was assigned points that were summed across each of the five categories. Programs seeking the two highest quality ratings (4 and 5 stars) were also required to meet pre-established thresholds on classroom observations using the Program Quality Assessment (PQA) tool (see Table 1).

TABLE 1. PRIOR GSQ

	PRIOR GSQ
Star Rating	**Classification Criteria**
Non-participant	Meets licensing requirements but does not elect to participate.
1 star	Meets licensing requirements and elects to participate.
2 stars	Achieves minimum of 16 points in 2 of 5 SAS categories.
3 stars	Achieves minimum of 26 points in 3 of 5 SAS categories.
4 stars	Achieves minimum of 38 points in 4 of 5 SAS categories and PQA score higher than 3.5.
5 stars	Achieves minimum of 42 points in 5 of 5 SAS categories and PQA score higher than 4.5.

However, the validation study pointed to several issues with the validity of the existing system. Namely, the SAS included too many "easy" indicators for which nearly all programs received points, and the SAS items did not effectively distinguish between the five aspects of quality as intended. Reviews of the SAS from five national and local experts found that while the SAS effectively represented components of program quality, the items were less relevant for child outcomes, undermining a key purpose of quality rating and improvement systems (QRIS). Finally, independent measures of quality (using the

Environmental Rating Scales [ERS] and Classroom Assessment Scoring System [CLASS] for the validation study) were shown to be only modestly effective at differentiating between programs with different star ratings.

In addition to structural issues, Michigan received feedback from group and family home-based child care providers (HBCCs) that the prior rating system over-emphasized staff credentials and education, and thus was biased towards centers. These perceptions are backed up by the administrative data, which show both lower participation rates and lower ratings by HBCCs compared to centers. In December 2022, 64% of centers elected to participate, compared to 45% of HBCCs. At this time, more than half (60%) of participating centers had achieved a 4- or 5-star rating, compared to just 9% of participating HBCCs.

Other issues identified by the State included:

- Scoring that was difficult to understand for many providers.
- Indicators based on outdated research.
- A disconnection between scoring criteria and the cultural/emotional aspects of child care quality.
- A perception among providers that higher quality was achieved through "checking the box" to achieve higher scores in the different SAS categories.
- A common misconception among families that providers with 1- or 2-star ratings were "poor" or "bad" providers.

The reimagined GSQ emphasizes participation, promotes quality improvement, and aims for equitable access to higher quality levels for all program types.

Taken together, these concerns prompted the creation of the significantly reimagined GSQ, which launched in early 2023 following years of gathering feedback and recommendations, pilot testing of system changes, and making data system updates (see Graber et al., 2023, as well as the GSQ Revision page for additional details on the development and revision process).

The reimagined system drew on the "next generation" QRIS model proposed by Cannon et al. (2017). Whereas the prior system was voluntary (with only providers who elected to participate in GSQ receiving a star rating), under the reimagined system, all providers in good standing with licensing automatically qualify for Level 1, Maintaining Health and Safety. The reimagined system aims to instill a quality-improvement mindset in all providers by encouraging them to continuously strive for better quality; even providers at the highest quality level are encouraged to continuously reflect and set new goals for improvement.

Component terminology and classification changes accompanied the reimagined GSQ. Star ratings were replaced by five descriptive "quality levels" (from Level 1, Maintaining Health and Safety through Level 5, Demonstrating Quality; see Figure 1). At the time the reimagined system launched, providers with a pre-existing star rating transitioned to the parallel quality level and kept their same expiration date, while providers who did not participate in the prior system were published at the foundational level (which has no expiration date).

Figure 1. Reimagined GSQ

Instead of using the PQA for all on-site observation, providers seeking the highest quality level are given some choice among three on-site assessment tools. The options are:

- The **Environment Rating Scales (ERS)**, which emphasizes the overall environment in which children are cared for.

- The **Classroom Assessment Scoring System (CLASS)**, which is widely used for assessing the quality of interactions between a teacher and a child.
- The **Social Emotional Learning – Program Quality Assessment (SEL-PQA)**, which is used to evaluate programs serving school-aged children.

There are some limitations on tool choice. For example, home- and center-based programs that are licensed *only* for children ages 5-12 must use the SEL-PQA. Programs receiving Great Start Readiness Program (GSRP) or Head Start funding are required to use the CLASS. Other programs can choose among the three tools, which have different versions or guidance for providers in different settings and serving different age groups.

The SAS was replaced by the Self-Reflection tool, with a smaller number (40) of revised and simplified indicators across 5 categories. There is not a one-to-one correspondence between the old and new categories; some were combined, some were created, and some were removed. (In general, though, *Family and Community Partnerships* and *Professional Development* remained the same; Environment transitioned to *Inclusive Practices*; Curriculum and Instruction transitioned to *Curriculum, Instruction, and Learning Environment;* and Administration and Management transitioned to *Staff Qualifications*). The revised indicators were developed during the revision process based on input from families, providers, and content experts, and are aligned with a variety of standards, including those related to child developmental outcomes.[1] Instead of being scored, providers mark each indicator as one of the following: "Currently meeting," "Not meeting at this time, " "Not meeting at this time – Create a goal in Quality Improvement Plan," and "Not aligned to program philosophy."

The overall goal of the reimagined system is for all program types and philosophies to feel represented and able to demonstrate their quality. The reimagined system is "provider-driven" in that providers have flexibility in when, how fast, and what they choose to work on to enhance the quality of care they provide. As illustrated in Figure 1, program quality is assessed not just using a checklist of scored indicators, but also by recognizing a provider's progress towards quality improvement. The Self-Reflection tool is asset-based,

[1] According to the GSQ website, the indicators are aligned with Michigan's Early Childhood Standards of Quality (ECSQ); Michigan Out-of-School Time Standards (MOST); the National Association for the Education of Young Children (NAEYC); the National Association for Family Child Care (NAFCC); the National Accreditation Commission (NAC); the Program for Infant Toddler Care (PITC); the CLASS; and the ERS.

with provider-identified strengths affirmed and expanded, and areas for improvement identified. Goals can be based on the Self Reflection tool, the selected observation tool's self-assessment, or any other adjustments to improve the program (which can be recommended by coaches). The variety of on-site assessment tools allows providers to choose the tool that best highlights their program's strengths, which may differ based on setting (home- or center-based) and ages of children served.

Finally, the reimagined GSQ was designed to encourage provider engagement. Unlike the prior system, all providers are part of the reimagined system by default (i.e., if a provider is licensed, they are automatically assigned Level 1, Maintaining Health and Safety). In theory, this makes quality considerations a standard expectation rather than an optional choice. To support enhanced engagement, providers have support from regional Resource Centers as they seek higher quality levels. Expanded supports include technical assistance, goal coaching, and preparation for on-site observations.

A Note About Language. The reimagined GSQ has been designed for and is intended to be a provider-driven system of continuous improvement, rather than a quality rating system. Public Policy Associates' (PPA) State partners have stressed that the messaging should consistently and accurately reflect this aspect of the reimagined GSQ.

The research team is both supportive of and sensitive to its partners' messaging goals and efforts and would like to stress that the reader keep this distinction at the forefront as you read the results. Having said this, there are places in the results sections where the research team has used language such as: "higher," "advance," "increase," and "above" (and so on) to describe GSQ or comparisons between the prior and reimagined GSQ. This language appears largely in the context of describing analyses related to Research Question 2, regarding quality ratings/levels. The research team has used this language out of necessity for two key reasons:

1. **Natural Language Limitations.** Both ratings and levels are numbered, and providers proceed through levels sequentially. Additionally, the prior GSQ was a "rating" system, thus making comparisons more complicated to discuss, in the process of addressing the research question, without defaulting to more hierarchical language. Additionally, it makes for easier and more comprehensible reporting.
2. **Providers' Usage.** Providers often use language such as "higher," "increase," "better," and "advance" and so on, to describe both the prior GSQ and the reimagined GSQ. So, this language often comes out in interview findings.

A Note About Analyses and Data Limitations. The results of secondary data analyses and primary data analyses are a snapshot of a period (or moment) in time. It is not an estimate of the number of programs that will eventually participate in the reimagined GSQ, nor is it an indication of the quality level that programs may or will ultimately attain. In other words, it is important to note that active participation and programs' quality levels will fluctuate and may (or may not) change significantly over time. Continued evaluation and analyses will help us to better understand the true or lasting impacts of the reimagined GSQ.

The researchers believe it is worth highlighting a couple of systematic factors that may influence point-in-time findings:

- Because programs or providers may begin active participation in the reimagined GSQ at any time, many programs may not engage in the quality-recognition process until they are in the process of renewing their license or the expiration of their legacy quality rating. Thus, a significant number of programs that intend to (or will) actively participate in the reimagined GSQ may not have started this process within 17 months of the launch date.

- At any given moment there are a number of programs that are waiting for validation or on-site observations required to move to the next level. These programs will show up in secondary data at the lower quality level, not the level they are in the process of progressing toward.[2] Thus, shortly after our analyses were completed, it is very probable that some programs moved to a next quality level. It is not known whether the number of programs waiting on validation or observation would have been enough to impact the outcome of the analyses.

[2] Additionally, survey items related to assessing quality levels asked participants to report their current quality level. We did not ask providers whether they were waiting on validation or an observation.

Secondary Data Analyses and Results

METHODS

Data Source

To address research questions 1 and 2, Public Policy Associates (PPA) analyzed monthly administrative data on provider characteristics. Data were provided from child care licensing as part of a data-sharing agreement with the Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) and the Early Childhood Investment Corporation (ECIC). PPA maintains a monthly database of these data going back to 2014, and the most recent data are also publicly available as part of Great Start to Quality's (GSQ's) "Find Programs" tool.

The administrative data includes details on all licensed child care providers in Michigan (including those who did not participate in the prior star rating system). Data elements examined in this study include provider name, provider type, license number, address (i.e., geographic location), whether the provider serves Child Development and Care (CDC) Scholarship clients, provider capacity, and, most crucially, star rating (under the prior system) and quality level (under the reimagined system).

Analyses

The research team utilized a variety of statistical analyses at the aggregate level to determine whether the reimagined GSQ results in greater active participation by child care providers, particularly HBCCs (Research Question 1), as well as the extent to which the reimagined GSQ is associated with higher quality levels, both overall and for different provider types (Research Question 2).

Trends in monthly GSQ participation and mean GSQ ratings (both overall and by provider type) were analyzed using interrupted time series (ITS) analyses, which focused on the 18 months preceding (July 2021 – December 2022) and the 17 months following (January 2023 – May 2024) the launch of the reimagined GSQ. The intervention point was set to January 2023, in line with changes

observed in the administrative data.[3] The focus on this 35-month period allows for a clearer view of the direct impacts of the policy change while minimizing the influence of unrelated factors. In addition to ITS analyses, changes in mean GSQ ratings overall and by provider type were analyzed using t-tests and ordinal regression. Ordinal regression was also used to predict a provider's likelihood of obtaining each star rating/quality level in the pre- and post-implementation periods. Additional details on the dataset and analyses are reported in Appendix A.

Defining "Active" Participation for Secondary Data Analyses

As discussed previously, when the reimagined GSQ launched, providers with a pre-existing star rating transitioned to the parallel quality level, while previously non-participating providers were published at Level 1, Maintaining Health and Safety.

To more effectively compare the prior and reimagined systems, "active" GSQ participation is operationalized in our secondary data analyses as providers with a 2-star rating or above (under the prior system) and Level 2, Reflecting on Quality or above (under the reimagined system). As such, 1-star and non-participating providers are grouped together under the prior system and contrasted with providers at Level 1, Maintaining Health and Safety under the reimagined system.

The research team feels this approach is justified given that the number of 1-star programs is exceedingly small (in December 2022, there were just five 1-star rated centers and 63 1-star rated HBCCs). Additionally, 1-star and non-participating providers were treated similarly under the prior system in other respects (e.g., they received the same CDC Scholarship reimbursement rates). In some analyses, these providers are excluded entirely to focus on impacts to "active" GSQ participation.

Calculating Mean Provider Ratings

The research team measured mean star rating/quality levels on a scale from 2 to 5, since the influx of providers at Level 1 under the reimagined system by definition results in a decline in mean ratings following the introduction of the reimagined GSQ.

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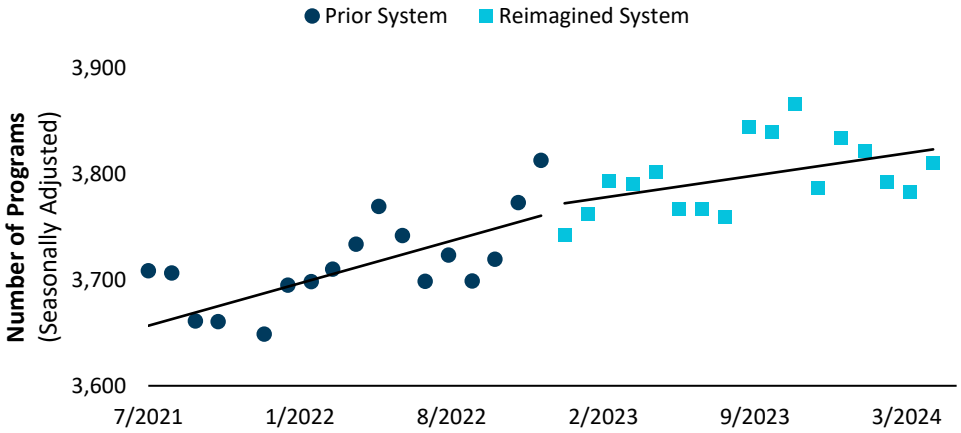
[3] This is slightly different than the date that MiLEAP and ECIC advertised as the launched of the reimagined GSQ (February 1, 2023).

ACTIVE PARTICIPATION RESULTS

The reimagined GSQ did not significantly increase the number of providers who move beyond the first quality level.

The research team conducted an ITS analysis controlling for monthly variation on aggregated counts of actively participating providers. Results show a significant increase in participation over time ($\beta = 6.04$, $SE_\beta = 3.08$, $z = 1.96$, $p = 0.049$). However, the implementation of the reimagined GSQ did not significantly affect the number of actively participating providers. As shown in Figure 2 below, while the slope of number of actively participating providers over time under the reimagined system is slightly shallower than the slope under the prior system, the slopes are not significantly different ($\beta = 3.00$, $SE_\beta = 1.85$, $z = 1.63$, $p = 0.104$).

Figure 2. Number of Programs Actively Participating in GSQ



While a similar number of centers actively participated both before and after implementation, the number of actively participating HBCCs declined.

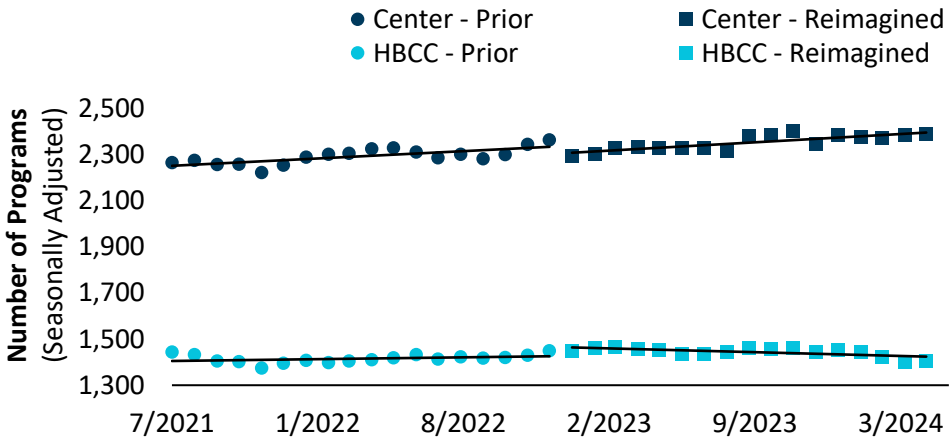
The research team conducted a second ITS analysis controlling for monthly variation where counts of active participation were disaggregated by provider type (centers and HBCCs). In line with the above results, the research team found an overall increase in active participation over time for centers ($\beta = 4.84$, $SE_\beta = 1.51$, $z = 3.20$, $p = 0.001$), but with no significant differences between the pre- and post-implementation periods.

Among HBCCs, far fewer actively participate compared to centers ($\beta = -845.93$, $SE_\beta = 21.35$, $z = -39.62$, $p < 0.001$), due in part to the smaller number of HBCCs

compared to centers in Michigan. (To account for differences in number of providers, the next section examines rates of participation for different program types). There was a trend towards lower overall active participation for HBCCs in the pre-implementation period, though it was not significant at the .05 level (β = -3.64, SE_β = 1.99, z = -1.83, p = 0.068). In the post-implementation period, there was a trend towards decreased active participation by HBCCs compared to centers (β = -4.35, SE_β = 2.33, z = -1.87, p = 0.062).

Most significantly, the difference in slopes between centers and HBCCs in the post-implementation period is significant (β = -7.90, SE_β = 1.34, z = -5.96, p < 0.001) (see Figure 3 below; the post-implementation slope for centers is positive, while for HBCCs, it is negative). Taken together, these results suggest that post-implementation, the number of HBCCs who actively participate is declining, while for centers, it is increasing.

Figure 3. Number of Actively Participating Programs by Provider Type



Active participation rates both overall and by provider type did not change pre- and post-implementation.

To this point, the analyses and results presented have focused on total counts of actively participating providers, and did not account for monthly fluctuations of number of providers, as providers open and close businesses. During the period between July 2021 and May 2024, the minimum number of licensed providers was 7,077 (in February 2022) and the maximum was 7,466 (in November 2023). Moreover, as stated above, there are more centers than HBCCs.

To account for the monthly fluctuation of providers and to more effectively contrast centers and HBCCs, the research team conducted an ITS analysis on the effects of the reimagined GSQ on active participation *rates* over time for centers

and HBCCs (see Figure 4). That is, did the relative percentage of licensed providers by type who achieved 2 stars/Level 2 or above change between the pre- and post-implementation periods?

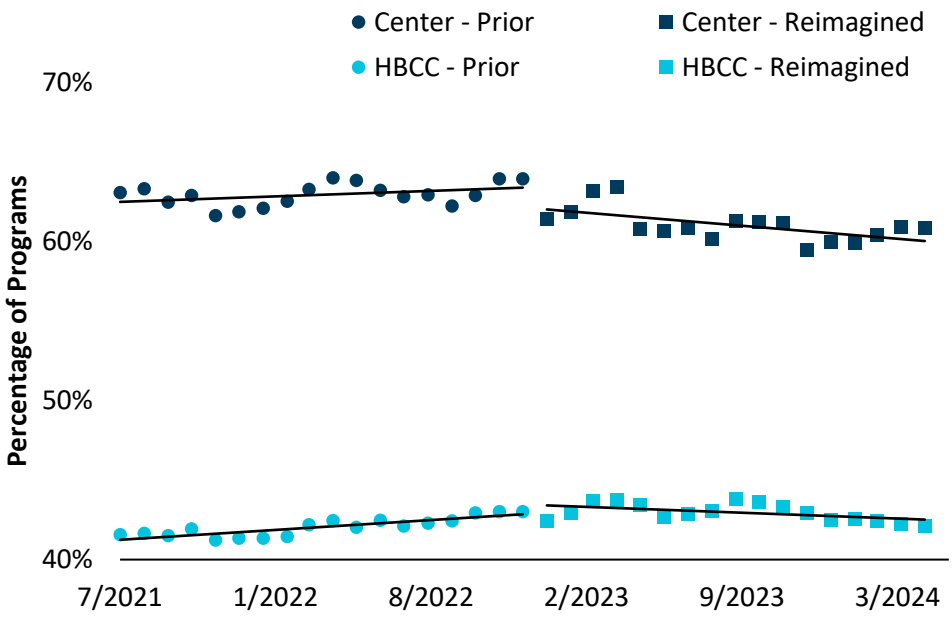
In line with what is already known about GSQ participation, the results point to significant differences in active participation rates between centers and HBCCs. Specifically, approximately 21% fewer HBCCs achieved 2 stars/Level 2 or more compared to centers ($\beta = -21.24$, $SE_\beta = 0.44$, $z = -47.73$, $p < 0.001$). In the pre-implementation period, center participation rates were stable over time ($\beta = 0.05$, $SE_\beta = 0.04$, $z = 1.48$, $p = 0.138$), and did not differ significantly from HBCC participation rates over time ($\beta = 0.04$, $SE_\beta = 0.04$, $z = 1.06$, $p = 0.291$).

Immediately following the introduction of the reimagined GSQ, participation rates declined for centers ($\beta = -1.42$, $SE_\beta = 0.66$, $z = -2.16$, $p = 0.030$), which persisted over time ($\beta = -0.18$, $SE_\beta = 0.06$, $z = -3.01$, $p = 0.003$). Relative to centers, HBCC participation rates increased immediately post-implementation ($\beta = 1.88$, $SE_\beta = 0.76$, $z = 2.48$, $p = 0.013$), though these immediate gains were not maintained over time ($\beta = 0.03$, $SE_\beta = 0.07$, $z = 0.41$, $p = 0.682$).

Post-implementation, participation rates over time declined significantly for centers ($\beta = -0.12$, $SE_\beta = 0.05$, $z = -2.49$, $p = 0.013$) and moderately for HBCCs ($\beta = -0.06$, $SE_\beta = 0.03$, $z = -1.84$, $p = 0.066$). There was not a significant difference between centers and HBCCs in trends of participation rates post-implementation ($\beta = 0.07$, $SE_\beta = 0.06$, $z = 1.17$, $p = 0.241$), though numerically, both provider types experienced a decline in active participation rates.

Taken together, these findings suggest that relatively fewer centers and HBCCs actively participate (i.e., achieve Level 2 or greater) under the reimagined system compared to the prior system. The patterns of active participation rates between provider types are maintained under both the prior and reimagined systems, and active participation rates appear to be declining over time.

Figure 4. Percentage of Actively Participating Programs by Provider Type



CHANGES IN RATINGS/QUALITY LEVELS RESULTS

The mean quality rating/level of actively participating providers declined following the introduction of the reimagined GSQ.

In addition to investigating active participation trends pre- and post-implementation, the research team examined whether provider's mean rating/quality level differs before and after the implementation of the reimagined GSQ (i.e., Research Question 2).

To account for autocorrelation and heteroskedasticity, the research team conducted a regression with Newey-West standard errors, which showed a significant decline in mean ratings of active providers following the introduction of the reimagined GSQ (β = -0.04, SE_β = 0.01, t = -2.66, p = 0.012) as well as an overall negative trend over time (β = -0.003, SE_β = 0.0008, t = -3.75, p = 0.001). Though the difference is statistically significant, it is not practically significant, since it represents a .04 absolute decline (on a scale from 2 to 5).

Providers are less likely to have high ratings under the reimagined GSQ.

The research team used ordinal regression to determine whether there was a significant change in the likelihood of providers having higher ratings under the reimagined GSQ. This analysis was conducted on all providers (i.e., including

those who did not participate or with a 1-star rating in the prior system, as well as those rated Level 1 in the reimagined system). The results showed that after implementation, providers were significantly less likely to have higher ratings, compared to the period before implementation of the reimagined GSQ. Specially, the odds of improving their GSQ ratings decreased by about 10% after implementation (OR = .901,95% CI [0.89, 0.91]). Under the prior system, the probability of being unrated or having a 1-star program was 45%, while under the reimagined system, the probability of being a Level 1 program was 47%

The decline in mean quality ratings/levels is largely explained by centers, while actively participating HBCCs' quality ratings/levels are unchanged.

To evaluate the extent to which different types of providers experienced declines in mean provider ratings, an ITS analysis was used to evaluate trends in mean GSQ ratings (on a scale from 2 to 5) for active providers by type.

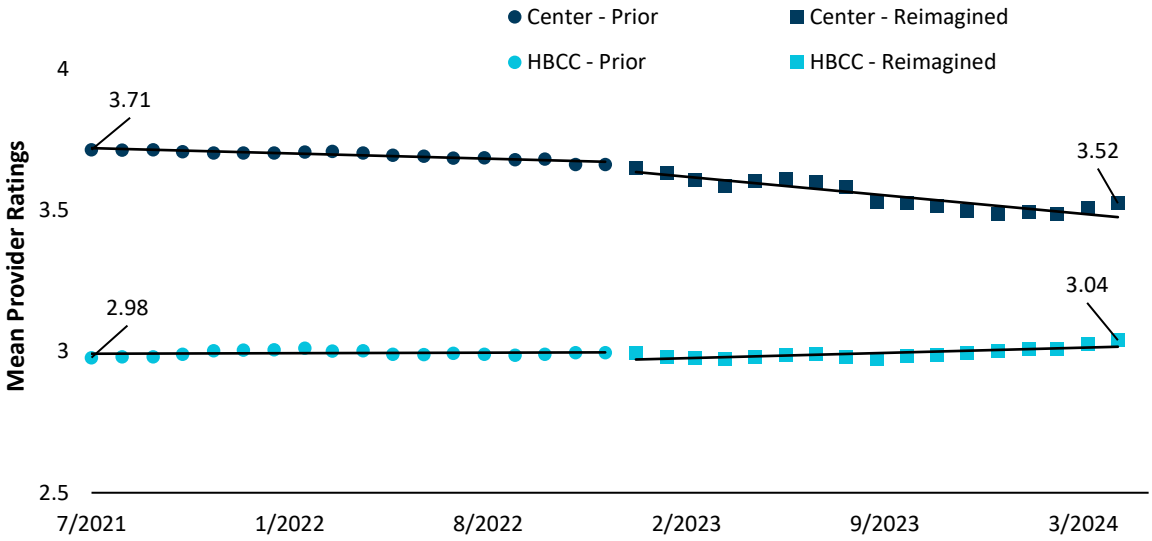
Confirming what is known about GSQ, mean ratings for actively participating HBCCs were significantly lower than mean ratings for centers by almost three-quarters of a star/level (β = -0.72, SE_β = 0.008, z = -89.14, p < 0.001). Additionally, in line with the results from the above regression, the ITS showed significant declines in mean ratings over time for centers (β = -0.003, SE_β = 0.0004, z = -7.97, p < 0.001), with stronger declines in the post-implementation period (β = -0.007, SE_β = 0.002, z = -4.72, p < 0.001).

These declines in mean ratings for centers occurred at the same time there were significant *increases* in mean ratings for HBCCs, both during the pre-implementation period (β = 0.003, SE_β = 0.0007, z = 4.54, p < 0.001), as well as significant increases in mean ratings for HBCCs in the post-implementation period compared to centers (β = 0.009, SE_β = 0.002, z = 4.85, p < 0.001).

During the post-implementation period, the slopes for centers and HBCCs are significantly different, β = 0.013, SE_β = 0.002, z = 7.27, p < 0.001 (visible in Figure 5 below; the post-implementation slope for centers is negative while the slope for HBCCs is positive).

The results suggest the "quality-level" gap between centers and HBCCs has narrowed, though the narrowing gap can be largely attributed to a decrease in centers' mean ratings/levels rather than an increase in ratings/levels for HBCCs. Between July 2021 and May 2024, HBCCs' mean quality ratings/levels increased modestly by .06 on average. The more substantial .19 average decrease in centers' mean quality ratings/levels is somewhat more concerning.

Figure 5. Mean Ratings/Quality Levels of Actively Participating Programs by Provider Type



Overall, HBCCs were more likely than centers to have higher ratings in the reimagined GSQ 18 months following its implementation.

The research team also looked at differences of likelihood of higher ratings under the reimagined GSQ by provider type for actively participating providers. Results show that HBCCs were 1.37 times more likely to have a higher rating after the implementation of the reimagined GSQ compared to centers [OR = 1.37, 95% CI [1.31, 1.44]).

Primary Data Analyses and Results

The primary data collection and reporting in Year 2 is focused on provider participation and experience with the Great Start to Quality (GSQ), in the form of a provider survey and provider interviews. Specifically, the research team wanted to better understand the patterns of participation revealed in the secondary data analysis and gain insight into providers' decision-making processes as they relate to participation in GSQ. The survey and interviews occurred in spring and early summer 2024. At the time the data were collected, the reimagined GSQ had been in existence for approximately 18 months. Thus, all results should be interpreted in the context of a point in time relatively early in the reimagined GSQ implementation.

Survey Overview and Participation. Potential survey respondents were selected via random sampling (see Appendix B for survey protocol). Survey analysis consisted of both descriptive and inferential statistics. Specifically, the research team employed paired-samples t-tests to compare respondents' responses related to the prior GSQ and the reimagined GSQ, and independent samples t-tests to examine differences in perceptions and experiences by provider type (center vs. home-based child care providers [HBCCs]) and by (prior) participation status. No significant differences were observed, thus only descriptive statistics are included in this report.

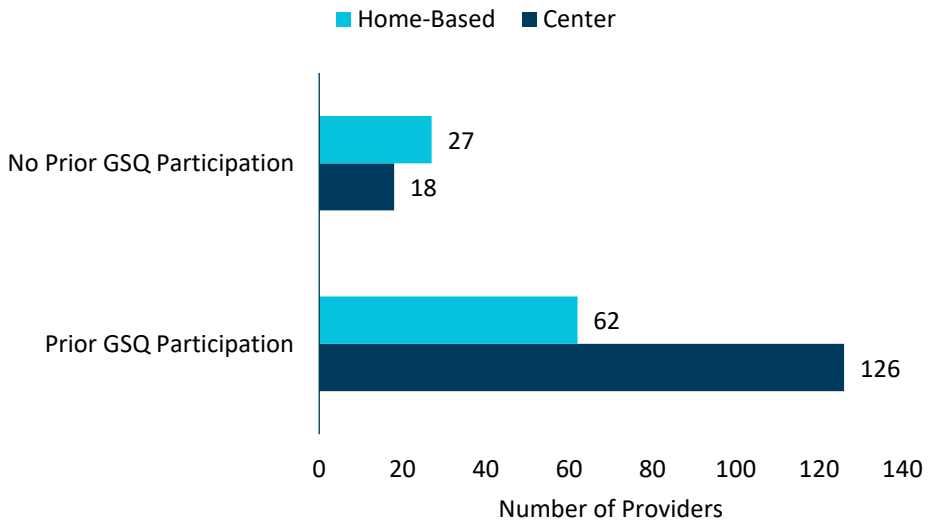
A total of 233 child care providers participated in the survey. Representatives from child care centers (CCCs) made up 61.8% of the sample and 38.2% of the sample were home-based child care providers (HBCCs, family and group). Nearly 81% (80.7%) of respondents indicated they participated in the prior GSQ (see Table 2 below). Compared to the composite of Michigan's licensed child care providers, CCCs and prior GSQ participants are overrepresented in the survey sample. While the relative lack of representation of HBCCs and providers who did not participate in the prior GSQ is not surprising, it is important to keep these limitations in mind as the research team interprets the survey findings.

TABLE 2. SURVEY PARTICIPATION IN REIMAGINED GSQ BY PROVIDER TYPE AND PRIOR GSQ PARTICIPATION (N=233)

PROVIDER TYPE	COUNT	%
Center	144	61.80%
Home-Based	89	38.20%
PRIOR GSQ PARTICIPATION	**COUNT**	**%**
Did Participate	188	80.70%
Did Not Participate	45	19.30%

As shown in Figure 6 below, approximately 70% (62/89) of HBCCs who completed the survey participated in the prior GSQ compared to 87.5% (126/144) of CCCs who responded to the survey.

Figure 6. Prior GSQ Participation by Provider Type Among Survey Respondents (N = 233)



Interview Overview and Participation. Potential interview participants were selected using purposive sampling based on license type (child care center, home-based family, or home-based group) and level of engagement with the reimagined GSQ. Interviewees were recruited via email and telephone (see Appendix C for interview methodology). Interview analyses were conducted in Dedoose (a qualitative data analysis software) to explore providers' perceptions and experiences with the prior GSQ and reimagined GSQ. A total of 35 provider

interviews were included in the analyses.[4] All HBCCs were grouped together for analysis to maintain continuity across findings from different data sources. Interviewees included 11 CCCs and 24 HBCCs. Three providers had been initially licensed after the implementation of the reimagined GSQ and therefore did not have any opportunity to engage with the prior GSQ.

A Note about Participation. As mentioned in the overview of the reimagined GSQ, in the prior system providers could choose to opt out or not participate in Michigan's QRIS. As a means to encourage providers to adopt a continuous improvement mindset, all licensed providers receive a level-designation and are technically "participating" in the reimagined GSQ even if they have no intention of advancing quality levels. In order to differentiate between those who are participating in the reimagined GSQ and those who are not as well as achieve and maintain consistency across data-collection activities, we operationalized "active participation" in the reimagined GSQ as a provider who is taking or had taken active steps in the reimagined GSQ to continuously improve (and move to different levels) *or* as a provider who is taking or had taken active steps in the reimagined GSQ to maintain a level-designation of Level 2 or greater[5].

REACTION TO THE NEWS OF THE REIMAGINED GSQ

Providers' reactions to the news of the reimagined GSQ were mixed and varied.

When asked to select words to best describe their reaction to learning about the reimagined GSQ**,** survey respondents' most frequently selected words were positive "hopeful" and "interested". Followed by words that are neutral "curious" and "ambivalent/mixed feelings", followed by the more negative "frustration" (see Figure 7 below[6]).

[4] Out of 36, one interview was removed due to concerns about reliability stemming from the interviewee's unclear licensing and quality level status.

[5] Note this operationalization of active participation is different than the secondary data analyses. We could obtain a more "sensitive" measure of active participation from the primary data collection.

[6] Larger words indicate higher frequencies of selection.

Figure 7. Word Cloud of Reactions to New System Among Survey Respondents (N = 204)

Similar to survey respondents, interviewees had varied initial reactions to the reimagined GSQ. Out of the 33 interviewees who responded, the most common initial reactions were negative (39.4%), followed by positive (30.3%), ambivalent (18.2%), and neutral (12.1%). Negative reactions stemmed evenly from CCCs and HBCCs and emphasized feelings of hesitancy and stress related to unclear communications and upcoming changes to quality levels. Providers expressed frustration due to perceptions that participation efforts would be more intensive than the prior GSQ, further impacting already hectic work schedules.

More HBCCs had positive reactions than CCCs. These reactions highlighted the perceived benefits of changes to the quality levels and requirements, easier level attainment, and stronger guidance and support for providers.

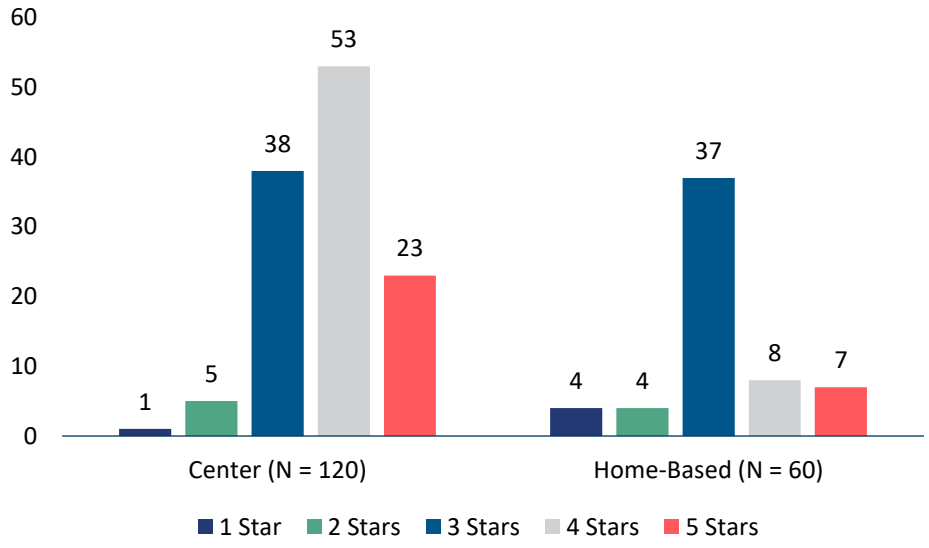
Both CCCs and HBCCs shared ambivalent reactions featuring an initial apprehension about the changes and potential administrative burdens, with a general open-mindedness and hope about upcoming changes and potential impacts on quality. Providers that held neutral reactions stressed their understanding about the reality of any system changes and the need to work out initial kinks in the system. Overall, survey and interview respondents' reactions to the news of the reimagined GSQ could be best described as ambivalent to cautiously optimistic.

PARTICIPATION IN GSQ

Providers' participation in the prior GSQ appears to be the biggest predictor of participation in the reimagined GSQ.

As previously stated above, 188 (80.70%) of the 233 survey respondents reported that they participated in the prior GSQ. Of the 180 respondents who provided their most recent "star rating" under the prior GSQ, over 90% (92.22%) had a rating of "3-Star" or higher (see Figure 8 below). It is important to note the differences between CCCs and HBCCs with respect to the distribution of quality (star) ratings. Whereas very few providers in both groups reported having 1**-** or 2-Stars as their most recent **p**rior GSQ rating, the distributions were demonstrably different between CCCs and HBCCs at the 3**-**, 4**-**, and 5-Star levels with CCCs having a much higher percentage of providers attaining 4**-** and 5-Star ratings (63%) compared to HBCCs (25%). Please see Figure 8 for a detailed breakdown of respondents' **p**rior GSQ star-ratings.

Figure 8. Most Recent Prior GSQ Rating by Provider Type Among Survey Respondents[7]



As with participation in the prior GSQ, most survey respondents (82%) reported they were currently actively participating in the reimagined GSQ (see Table 3

[7] Twelve (12) providers were "unsure" of their December 2022 star rating.

below). As shown in Table 3, most providers that participated in the prior GSQ are currently actively participating in the reimagined GSQ and most of those who did *not* participate in the prior GSQ are *not* currently actively participating in the reimagined GSQ, suggesting that previous participation is a good predictor of current participation, at least at this stage of implementation.

Moreover, active participation differences between provider type are apparent (see Table 3). Approximately, 46% of HBCC respondents reported they are not actively participating in the reimagined GSQ compared to 18% of CCC respondents. The results indicate that HBCC GSQ participation may still be lagging behind CCC participation 18 months into the reimagined GSQ implementation.

TABLE 3. REIMAGINED GSQ ACTIVE PARTICIPATION BY PROVIDER TYPE AND PRIOR GSQ PARTICIPATION AMONG SURVEY RESPONDENTS

	CCC PARTICIPATION		HOME-BASED PARTICIPATION		TOTAL
	Prior GSQ N (%)	No Prior GSQ N (%)	Prior GSQ N (%)	No Prior GSQ N (%)	N (%)
Actively Participating	97 (88.99)	3 (23.08)	34 (69.39)	2 (11.11)	136 (72.00)
Not Actively Participating	12 (11.01)	10 (76.92)	15 (30.61)	16 (88.89)	53 (28.00)
Total	**109 (100.00)**	**13 (100.00)**	**49 (100.00)**	**18 (100.00)**	**189 (100.00)**

Of those respondents who were not actively participating in the reimagined GSQ, approximately 58% reported they did not intend to actively participate in the future or were leaning towards not participating in the future and 42% said they intended or were leaning towards participating in the future (see Table 4). Of those intending to or leaning towards participating in the reimagined GSQ, 68% participated in the prior GSQ. Of those not intending to or leaning toward not participating in the reimagined GSQ, 60% did not participate in the prior GSQ.

TABLE 4. REIMAGINED GSQ INTENT TO PARTICIPATE AMONG SURVEY RESPONDENTS

INTENT TO PARTICIPATE	CENTER PARTICIPATION		HOME-BASED PARTICIPATION		TOTAL
	PRIOR GSQ N (%)	No Prior GSQ N (%)	Prior GSQ N (%)	No Prior GSQ N (%)	N (%)
I am certain that I will not actively participate	1 (8.33)	2 (20.00)	4 (26.67)	6 (40.00)	13 (25.00)
I am leaning towards not actively participating	2 (16.67)	4 (40.00)	5 (33.33)	6 (40.00)	17 (32.70)
I am leaning toward actively participating	7 (58.33)	3 (30.00)	3 (20.00)	2 (13.33)	15 (28.80)
I am certain that I will actively participate	2 (16.67)	1 (10.00)	3 (20.00)	1 (6.67)	7 (13.50)
Total	**12 (100.00)**	**10 (100.00)**	**15 (100.00)**	**15 (100.00)**	**52 (100.00)**

While most responding providers' participation status is consistent between GSQ iterations, there are some exceptions. Seven providers who did not participate in the prior GSQ are intending to or leaning toward participating in the reimagined GSQ. A total of 12 survey respondents participated in the prior GSQ but indicated that they did not intend to or are leaning towards not participating in the reimagined GSQ. Interestingly, of those 12 respondents, nine (75%) were HBCCs (see Table 4).

The interview data from 35 providers is in quantitative terms largely consistent with survey results.[8] Thus, of the 28 interviewees participating in the prior GSQ (11 CCCs, 17 HBCCs, 80% of all interviewees), 21 were actively participating in the reimagined GSQ (75%; 7 CCCs, 14 HBCCs). Two CCCs and two group home-based providers with lower reimagined GSQ levels than their prior GSQ ratings had idiosyncratic reasons for the lack of active participation when their legacy 3-Star ratings expired, with all four stating an intention to begin active

[8] This consistency is likely due in part to the purposive nature of the provider sample for interviews. Percentages are rounded to the nearest whole number.

participation in the relatively near future.[9] Additionally, there were three HBCC who had taken an initial step but were not actively participating at the time of their interviews. Two of these still had legacy 3-Star ratings, and the third, had scheduled and was awaiting a Resource Center meeting to begin active participation.

Of the remaining seven providers who were interviewed, four had chosen not to participate in the prior GSQ (11% of interviewee total); the two family home-based providers of these were actively participating, and the two group home-based providers were not. The balance of the interview data concerned three family home-based providers (9% of all interviewees) that had opened after the reimagined GSQ went into effect, all of whom are actively participating in GSQ.

The interviews overall suggested one key reason for the continuity between prior and reimagined GSQ participation: like many individuals and organizations, providers' behavior reflects a desire to maintain not only a familiar routine, but also a desired "equilibrium" level of participation. To begin with, of the providers interviewed that had participated in the prior GSQ and were actively participating in the reimagined GSQ (or intended to do so), *none* had in fact advanced from their GSQ star rating.[10] In other words, at their first opportunity to attain a level through active participation in the reimagined GSQ (as opposed to their level assigned when it went into effect), these providers in effect reproduced their legacy star rating, at least initially. A substantial portion did not perceive any significant difference between the two iterations of GSQ initially,

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[9] All four providers' levels fell when their legacy 3-Star ratings expired, and they did not actively participate in a timely manner. However, one of the CCCs decided to wait until a license change and move to a new location were completed before re-engaging with the reimagined GSQ process, and the other had begun reengagement, attaining a Level 2 so far on its way to a Level 3 so it could participate in the Great Start to Readiness Program (GSRP). One of the two HBCCs had met with a Resource Center quality improvement specialist/coach (QIS/QIC) who helped prepare her to re-attain her Level 3 status, but the provider had failed to complete the steps due to concern over the time and effort required to compile and submit the required information. The other HBCC stated a future intention to re-engage with GSQ system at some point in the future, but for unexplained reasons had failed to pursue the matter.

[10] This included the two group home-based providers operating with a legacy star rating. Note, too, that three centers and three home-based providers in this group had a prior 5-star rating and had attained Level 5, so of course they could not advance further in the reimagined GSQ.

and the transition period for most providers was seamless, largely without significant effects.

Even those perceiving an adverse transition to or later experience in the reimagined GSQ nonetheless actively participated at least enough to avoid a decreased level, regardless of provider type or the level with which they entered the system (i.e., a level comparable to their last star rating). Although providers' motivations for participation in the reimagined GSQ are discussed in detail below, it is notable that providers identified reasons for participation that aligned with those for participating in the prior system.[11]

Providers' quality rating in the prior GSQ appears to be the biggest predictor of their quality level in the reimagined GSQ.

The distribution of current reimagined GSQ levels (see

Figure 9 below) is very similar to the distribution of prior GSQ ratings for responding providers (see Figure 8). Overall, nearly 85% (134/158) of responding participants (who knew their quality level) reported being at Level 3 -Enhancing Quality, Level 4 – Enhancing Quality Validated, or Level 5 – Demonstrating Quality. However, differences between respondents from CCCs and HBCCs over half (53%) of CCCs indicated they were current at a Level 4 – Enhancing Quality Validated or Level 5 – Demonstrating Quality, compared to less than 20% (18.87%) of HBCCs

[11] Perhaps tellingly, interviewees often continued to refer to levels in the reimagined system as "stars" or "ratings."

Figure 9. Reimagined GSQ Level by Provider Type Among Survey Respondents

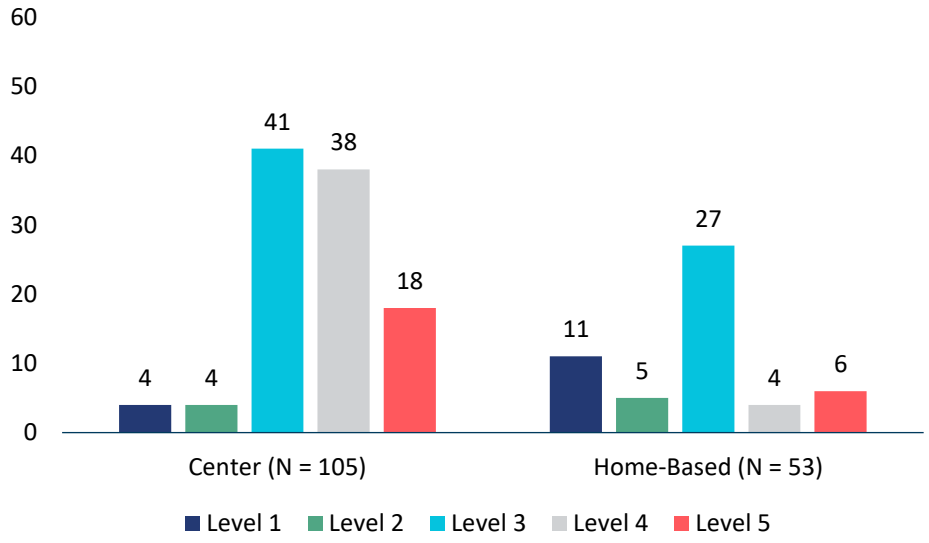


Table 5 (below) displays movement for respondents who provided their current reimagined GSQ Level.[12] Of the 139 respondents, nearly 75% their GSQ rating/level did not change from the prior GSQ to the reimagined GSQ. Curiously, less than 10% of responding providers had advanced from their prior GSQ rating and 17% reported a lower reimagined GSQ level than prior GSQ rating. It is important to note that this pattern of decreasing quality ratings/levels is also seen in the secondary data analyses. The exact reasons for this pattern are unknown and worthy of further investigation.

TABLE 5. FREQUENCIES OF OLD STAR RATING BY REIMAGINED LEVEL AMONG SURVEY RESPONDENTS

NEW	OLD				
	1 Star + Non-participators	2 Stars	3 Stars	4 Stars	5 Stars	Total
Level 1	2	0	5	0	0	7
Level 2	0	3	2	1	1	7
Level 3	0	0	50	10	2	62
Level 4	0	0	5	33	3	41
Level 5	0	0	2	5	15	22
Total	**2**	**3**	**64**	**49**	**21**	**139**

[12] Thirty (30) respondents – 17 of whom were CCCs and 13 of whom were HBCCs – were unsure of their current quality level.

Findings from the interviews align with and expand upon the survey results. Most providers continuing from the prior GSQ to the reimagined GSQ were "intentional maintainers"—that is, they had actively participated only until they attained the level comparable to their last star rating, which was also, of course, the level they were assigned when the reimagined GSQ went into effect. All 12 of these providers (five family home-based, four group home-based, and three centers) maintained a legacy 3-Star rating at Level 3. Further, as previously noted, three HBCCs and three CCCs maintained a legacy 5-Star rating at Level 5.

As noted in the prior section, these providers' varying descriptions seem to evince and apply a certain mindset from the prior GSQ, regardless of provider type and last star rating. For example, a CCC provider explained their approach:

… I think the experience is the same [in the prior and reimagined GSQ systems]. … Because you have to really tackle it the same way. It's basically a punch list checklist of things that you're looking at … So I rushed right into it. I was just like, "I've got to do this. I've got to move on."

… So again, you kind of look at things that I could get done in a hurry because I need to be done with this. … I put goals in that I could complete and be done with and sign off and move on until I have to do this again.

While this provider may have made the point in more blunt terms, interviewees for other providers that were "intentional maintainers" expressed similar perspectives. Thus, two other center providers stated:

The GSQ is just another task to do. It's just more boxes to fill off. It's just more paperwork to send in because at the end of the day, we have to because it affects our bottom line.

We're at the enhancing level. It wasn't left off that we had to do anything [further]. If we have an enhancing level, we're good for two years … That's what we're -- that's our plan. … Yeah, we're not going to try to go to whatever the next two levels are.

And a third provider pointed out that, "Once you're done with everything and you upload everything, you're not really going back to it unless you're looking to increase your rating [which this provider was not]. But outside of that, I don't use it for anything."

HBCC "intentional maintainers" took a similar position. As a long-time GSQ-experienced provider responded when asked if they had any interest in learning how to advance levels:

No, and maybe that's why because I probably told them [Resource Center staff] that I was content and happy with where I was. Mostly to the fact because I am looking to retire soon. And also, the fact that I don't see whether you're 1-Star – that was the way they rated it before – a 1-Star, 2-Star, 3-Star, four, or five. I don't see where any of the levels benefit a provider at all.

This provider pithily concluded that "I'm actively participating to just stay where I am, but not moving up."

Another HBCC would likely agree, as she explained her participation in both GSQ systems up to a 3-Star rating/Level 3 this way:

… To be honest, I mean, it's kind of something that I did, and then I've kind of put in the background. It's not something that I look at every day or once a week or once a month until I'm reminded that I need to do it again. It's not something that, I don't know, go to for anything necessarily.

Some providers become "intentional maintainers" because beyond a Level 3, they saw the system requiring changes in program that they did not want. Here is a general example:

We're at a standstill now [at Level 3] because, like I said, we got to the highest level we can get to without changing things in our program.

A more specific example is this:

Because [GSQ assessor or validator] [the State?] will tell us to change our classrooms. … So, there's a lot of different things that we feel get taken away from us and not given to us that we're already doing that maybe that certain person doesn't think would work. … So, we're not willing to do that, which is why we just want to stay at a three and enhancing.

In contrast to the "intentional maintainers" discussed above, the interview sample included a smaller group of six providers (three CCCs and three HBCCs) that had participated in the prior GSQ and *were* actively participating to advance from their star rating/legacy level in the reimagined GSQ. These "intentional advancers" saw the reimagined GSQ as encouraging further improvement, which they were eager to pursue with Resource Center support.

A second, group of "intentional advancers" were those new to the reimagined GSQ, whether because they did not voluntarily participate in the prior system (two family and two group home-based) or because they opened after February 2023 (three family home-based). The five family home-based providers in this group advanced in relatively short order, three to Level 5, one to Level 3, and one to Level 2 (at the time of interview).

When one provider was asked about the benefits or advantages they saw in the reimagined GSQ, they replied simply, "I see higher quality programs." Then, when another HBCC was asked whether the reimagined GSQ was encouraging and motivating advancement, they responded:

Yes, [it] definitely does. … I think that it helps you to see where you can improve. … So, I feel like it helps you learn a lot of new things that will help you, so that make[s] the environment and the classroom, the schedule go how it's supposed to go. At least for me it did. Like community and family partnerships, that was not something that I had thought about until I had seen that indicator, [and] like, oh, wow, this is something that I could do. This is something that I could improve on.

A theme common to most if not all "intentional advancers" was the indispensable assistance of Resource Center staff. All providers greatly benefited from timely, personal, and direct help, and most described positive, even "amazing" (used more than once), experiences working with individual Resource Center representatives. One HBCC noted that they would probably not have progressed through the system at all without it.

Still, a single negative interaction, whether an inability to obtain timely, accurate, and authoritative information, a malfunction of technology, or a perceived insult to provider competence or professionalism, could sour a provider's view of the reimagined GSQ. Even then, however, providers tend to follow their previous path laid down in the prior GSQ.

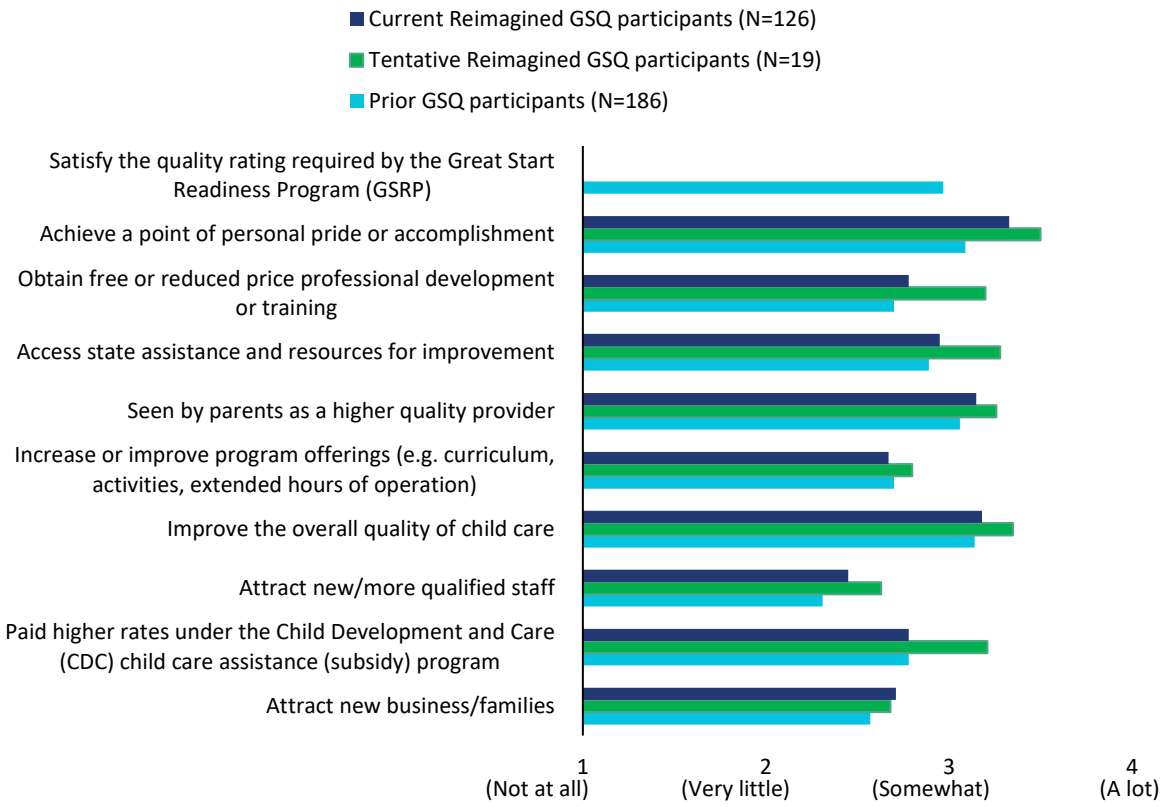
We want to be on board with it [reimagined GSQ], and we see the need for some of the things. But a lot of those things are very intrusive and another professional coming in telling us that we're not doing it right or telling us that we have to beef something up like a policy or something like that. We just do it to get the enhancing [Level 3].

PERCEPTIONS OF GSQ

Intrinsic motivation, recognition from parents, and CDC-reimbursement are the biggest factors in providers' decision to participate in GSQ.

On average, respondents reported that the factors or motivations for participating in GSQ (both prior and reimagined) listed on the survey had "very little" to "somewhat" of an influence on their decision to participate in the system (see Figure 10 below). The most influential factors for respondents' participation, on average, were "improve the overall quality of child care"; "achieve a point of personal pride or accomplishment"; and be "seen by parents as a higher quality provider", respectively. Interestingly, the data suggests participation in GSQ may be driven more by intrinsic motivations or reasons as opposed to extrinsic motivations or reasons (e.g., attract new business, obtain state assistance for improvement, attracting new/more qualified staff etc.). Perhaps unsurprisingly, respondents' motivations for participating in "old" and reimagined QRIS were nearly identical. As previously stated, no significant differences emerged between HBCC and representatives from CCCs.

Figure 10. Determinants of GSQ Participation Among Survey Respondents – Mean Impact on Decision



Notably, different descriptive patterns emerged for respondents who reported that they currently were not "actively participating" in the new system but were *intending* to participate or leaning toward participating in the future. Like prior GSQ participants and current active reimagined GSQ participants, this group of providers shows a pattern of intrinsic motivation, reporting factors such as; "improve the overall quality of child care"; "achieve a point of personal pride or accomplishment"; and be "seen by parents as a higher quality provider", influencing their decision to participate in the reimagined GSQ. However, this group also cited extrinsic factors such as: "access state assistance and resources for improvement", "obtain free or reduced professional development", and being "paid higher rates under the CDC child care program" as equally influential factors in their decision to participate in the reimagined GSQ.

Similar to survey respondents, interviewees reported participating in the reimagined GSQ for predominantly three reasons: maintaining or increasing

their reimbursement rates for CDC scholarship families, satisfying a personal or organizational desire for providing quality child care, and obtaining support and recognition for child care quality from GSQ system and parents. These motivations were expressed in interviews across provider types, although HBCCs new to GSQ who were "intentional advancers" somewhat tended to emphasize the latter two reasons by comparison to CCCs. While they seemed to align with survey results, providers' "intrinsic" and "extrinsic" motivations were often difficult to disentangle in the interview data.

A common instance of "mixed motives" involved the role of increasing CDC scholarship rates at enhanced GSQ levels. This was the single most explicitly cited reason for participation (13 interviewees). CCCs in particular often expressed intensity when discussing the change from the prior to the reimagined GSQ. One "intentional maintainer" CCC provider, for example, explained that, as its legacy 3-Star rating approached expiration:

Well, I just had to stop everything that I was doing and get it done to ensure that I can continue my star rating [sic] because that's how my tuition is based. Unfortunately, if I don't move heaven and earth out the way to take space for Great Start to Quality, I run the risk of the business's income being affected, so nothing else matters. And it's like you're put under so much pressure to get this done to ensure that your business is continuing this revenue.

I don't like the fact that it's almost like we're penalized for not being under this system or maintaining this rating in order for your business to continue on with this revenue.

Another center provider was even more blunt:

We just do it to get the enhancing [Level 3]. We don't do it because we think it's a great idea. We do it to get the three stars [sic].

A third Level 5 "intentional maintainer" agreed by claiming the converse that "[a]gain, if it wasn't for the step up in pay for DHS, I probably wouldn't participate at all."

At the same time, however, CCCs and HBCCs averred that they sought higher scholarship rates so that families did not have to pay the provider anything out of pocket.

My goal was, from the very beginning, I just wanted to have enough stars, enough [of] your levels, for my families not to owe [a] co-pay. That was my goal about the whole thing. So, as long as my families don't have a copay.

When a group home-based provider was asked how the reimagined GSQ "encourage[s] or motivate[s] you to work on advancing levels or staying at level three," they responded:

It really doesn't. … It's just the subsidy. It doesn't give me anything of value. … It's really for parents.

A CCC framed a similar view more empathetically:

So, our families can't afford that [a co-pay]. So, it's really kind of an outreach. I mean, one of the reasons why … we do the enhancing [Level 3], why we even bother with it, [is] because I just want to be honest, that then the parents aren't going to have to pay as much. Because those people tend to fall through the cracks, and they need quality care too.

Yet, as some providers conceded, they did benefit when parents did not owe a co-pay because the provider's income was then more certain, and they did not need to spend time and effort ensuring parents paid their co-pays.

The incentive of tying CDC scholarship rates to GSQ ratings/levels had its limits, which many providers reached at the tier when a step up in rates (and family contribution waiver) first occurred in both systems. These providers suggested that further advances depended on a sort of informal cost/benefit assessment. As one put it rhetorically, in a positive description of the reimagined GSQ: "I would say better, easier to maneuver through it. It's time consuming, but how bad do you want to get to the next level?"

One home-based provider explained the thinking:

Yeah. Level 3 was important to me. All of it is important to me, but like I said, you [interviewer] said motivation, so it's not motivating me to go, "Oh my God, I got to do whatever I need to do to go ahead and finish up to my Level 4." It's not doing it.

This provider returned to the theme as they further explained:

Now, like I said, for me, I would love to get the Level 5 or the highest level because that will increase the reimbursement. However, I reached my goal to not have that hanging over my head, [that is,] I have to try to get a co-pay out of people. The increase would be nice, but I don't have any incentives, for me, to really bust hell to get that far.

Interviewees identified the second most common motivation in terms of an internal drive to participate, whether as a personal or organizational challenge or as an achievement to aspire to (9 interviewees).

Examples of the former included two HBCCs. One, an "intentional advancer" then at Level 4, simply stated, "I love the challenge [of the reimagined GSQ]; it was a challenge, but I tried it." The other noted, "Anything that seems challenging to me, I just do it anyway, just do it because that's just my personality."

A CCC interviewee contributed an example of the latter type of internal motivation, stating, "Just the most obvious of which [reason to participate] is that we want to genuinely be a high-quality center." This provider, like others, went on to link this motivation to the third most common (6 providers), which involved demonstrating, and being seen to demonstrate, quality:

It's one thing to call yourself a high-quality center, but it's another to actually receive a credential or a rating from an outside source. So, we wanted to make sure that we were doing the things that would meet the criteria to be at those higher levels.

Later, this provider added another reason for participation as well:

…we also were drawn to the fact that the subsidy, the scholarship, I guess they're calling it now, is higher the higher levels that you are. Even right now we've got a good smattering of subsidy or scholarship families, but it's just something that we want to always have available. So, I'd say the two things, wanting to be quality and wanting to increase the scholarship dollars.

HBCCs also combined internal motivation and quality recognition. Here, for example, is a family home-based provider who did not participate in the prior

GSQ but had attained a Level 5 when asked why they decided to participate in the reimagined GSQ:

Yes, because I wanted to stand out as a child care provider in a daycare just having that rating. I know that people look for that and people feel more comfortable and confident in you when you have that rating. So, the last center that I worked at, they had it. So, I'm like, I think I want to try to get me a plaque saying that I'm in a good [daycare] because it looked good. Like to me as a person, if I had a kid and I was walking in and I [saw] that plaque, I'm like, that does look good. And I want to have that as well.

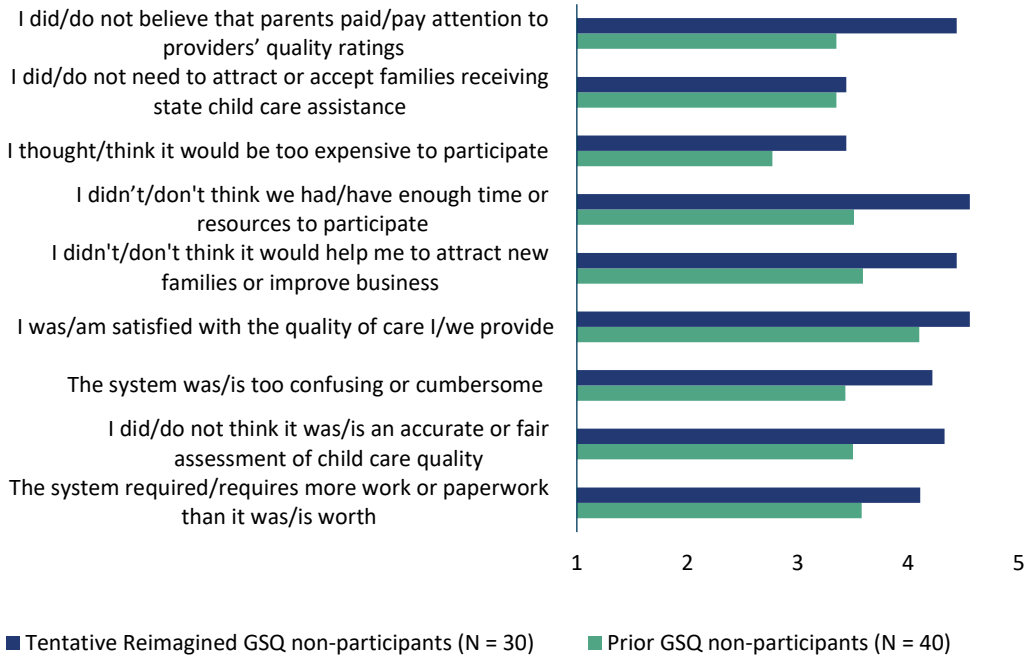
As a final example, a CCC interviewee made the point of emphasizing more concisely when they said that "I know what we do here, and it's a phenomenal facility. And that's what motivated me just to get that 5-Star, just prove to my families, [that] you're in a great daycare."

Satisfaction with current quality of care, time and administrative burden, and perceived lack of reputational or business benefits were among the biggest reasons for non-participation.

Survey respondents who indicated that they did not participate in the prior GSQ and those who reported they did not intend to participate or were leaning toward not participating in the reimagined GSQ, respectively, were asked to select their level of agreement with a list of potential factors that played a role in their decision (see Figure 11 below). The highest levels of agreement, and thus the factors most influential in their decision not to participate were: "I was satisfied with the quality of care I/we provided" and "I didn't think it [participation in GSQ] would help me to attract new families/business".

As shown in Figure 11 below, providers not actively participating in the reimagined GSQ agreed more strongly with nearly all statements for potential non-participation listed on the survey. Providers "agreed" or "strongly agreed" with the following reasons for not participating in the reimagined GSQ: "I am satisfied with the care I/we provide"; "I do not think we have enough time or resources to participate"; "I do not believe parents pay attention to GSQ"; and "I don't think it [participation in GSQ] would help me to attract new families or business".

Figure 11. Mean Ratings Reasons for Not Participating in Prior GSQ or Reimagined GSQ



Scale: *1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree*

The results suggest that non-participants do not think participation would help to enhance the quality of the care they provide in meaningful ways and/or may be under the impression that participation in Michigan's GSQ is for providers who need to improve their quality of care. Additionally, the findings suggest that providers may not participate, because they do not believe there is a business or reputational incentive for participating.

While very few interviewees identified as non-participators, two providers cited administrative burden (e.g., required paperwork, necessary time outside of normal working hours) as the main reason for declining to actively participate. Additionally, one these providers was busy providing non-traditional hours care and considered participation too intrusive, while the other intended to retire in the near future. As one provider stated, "I'm not gonna sacrifice time with my kids and everything like that to maintain the star rating [sic], I guess."

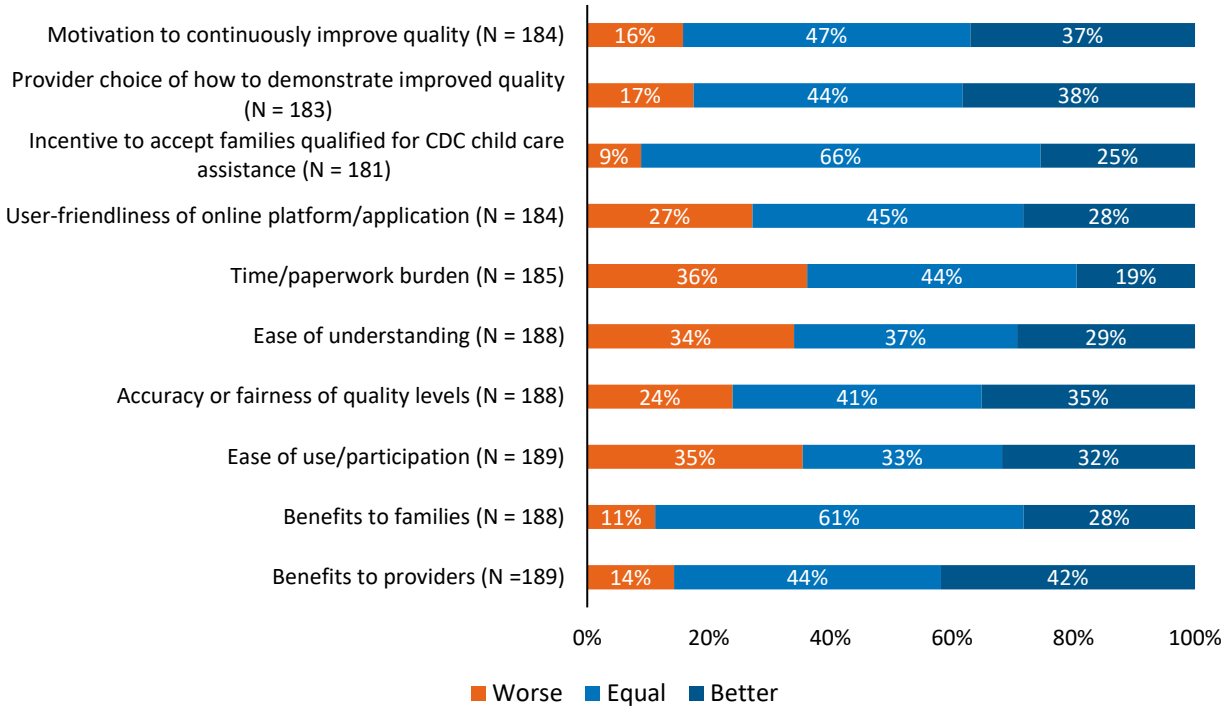
The majority of survey respondents rated the prior GSQ and reimagined GSQ as comparable on most dimensions.

The survey examined respondents' perceptions of the reimagined GSQ compared to the prior GSQ on variety of dimensions (see Figure 12). On most dimensions, the largest percentage of respondents reported that the reimagined GSQ was the same as or equal to the prior GSQ. Indicating that a high percentage of respondents view the prior GSQ and the reimagined GSQ as comparable. Notably, nearly 60% of respondents said their "incentive to accept families qualified for CDC child care" (65.75%), and "benefits to families" remained unchanged from the prior GSQ to the reimagined GSQ.

Moreover, in general, a higher percentage of respondents stated that the reimagined GSQ was better than the prior GSQ than perceived it to be worse on dimensions of interest. This was particularly true for perceived "benefits to providers", "motivation to continuously improve quality", and "provider choice in how to demonstrate improved quality." This finding is both unsurprising and encouraging, given the revisions to GSQ were intended to improve providers' experience and encourage continuous improvement.

Conversely, the results revealed that there are some dimensions in which more respondents perceived the reimagined GSQ as worse than the prior GSQ, as opposed to better. Specifically, more respondents perceived participation in the reimagined GSQ was a greater time burden, more difficult to understand, and more difficult to use. This is probably to be expected, because a system that allows for more choice is apt to be more time consuming and more complex than a more prescriptive system.

Figure 12. Provider Perceptions of Prior GSQ to Reimagined GSQ



…But a significant portion of interviewees identified features of the reimagined GSQ as improvements over the prior GSQ.

A minority of provider interviewees did not perceive a significant difference between the two GSQ systems. To take one example, a long-experienced, long GSQ-participating HBCC's initial reaction changed rather quickly:

I remember when I originally heard about it … and I was thinking, "Whoa! This is going to be crazy. This is going to be involved. This is going to be stressful. I'm not going to like this new system." But then when she [Resource Center representative] came, it seemed like it was identical to the previous. So, I was all kind[s] of nervous about it thinking, "Oh great, here we go again." But it wasn't. It seemed like it was the same.

When later asked to compare their experiences under the prior and reimagined systems, this provided responded that:

I don't really even notice a difference. They have us ranked differently and according to them on their end, it's different but as a provider, it doesn't seem any different. I can't even tell you the difference.

Other providers felt similarly, even if they had yet to develop definitive opinions more than a year after implementation of the reimagined GSQ. As another HBCC indicated:

I thought maybe it would be an easier system or friendly to use and more friendly towards the home daycares, but it's not. So, it's not really any different than the old system in my opinion. …

I haven't really been on it enough, probably, to give that opinion. As of right now, I would say that it's not any better. I feel like it's just as cumbersome as the last one … and the features seem pretty much the same. I'm not really exactly sure what they changed to be honest with you.

More generally, providers' comparisons of the two iterations of GSQ compared to the prior version ranged from positive (10 providers) to negative (7) to mixed or ambivalent (10).[13] Nearly three times as many interviewees identified aspects of the reimagined system that they saw as improvements in various respects to the overall system (14 to 5). This result may in part reflect differences in how far various providers progressed within the current system. Indeed, many providers seemed to lack familiarity with or a clear understanding of reimagined GSQ elements, including available supports, especially beyond Level 3.

Interestingly, with respect to those GSQ dimensions with which interviewees had personal experience in both systems, individual views within and across provider types often seemed diametrically opposed. Similar to survey results, interviewees had conflicting opinions concerning dimensions of administrative burden, such as which system was easier to understand, access, and use, or which took more time or required more effort. Providers also differed, sometimes sharply, on the relative use to parents of star ratings versus

[13] Five interviewees expressed a neutral stance because they did not have information or experience sufficient to make a meaningful comparison.

reimagined levels, whether the newer system was in practice more friendly to HBCCs than the prior one, and (much less frequently) the level, availability, and utility of Resource Center assistance.

To take one example, here are the views of two 5-Star/Level 5 HBCCs regarding the "paperwork" required in each system:

"Going online to do what we have to do is much more streamlined and easy to navigate [in the reimagined GSQ], and I think less time is involved …"

"I felt like the new system … there was a lot more bookwork involved versus the old. … I just felt like with this [reimagined] one, there was a lot more administrative work."

To be sure, there were several points of relative consensus. For instance, while the reimagined GSQ required that providers submit more evidence to support their responses to fewer indicators, Level 3 was consistently seen as more easily attained. However, even in these instances, interviewees disagreed on whether the benefits to accountability of more evidence or the ease of level attainment were net positives to providers.

Sometimes the same provider held varying opinions about the same system element or dimension. For example, one CCC provider in an assessment of the use and significance of numerical star ratings versus descriptive levels, stated:

As far as the vagueness of people's understanding [of levels], it's [reimagined GSQ] across the board worse. However, the compliance pieces to receive your [provider's] quality rating I feel like are more user friendly.

An HBCC gave this more detailed description of the perceived trade-offs between participating in the two GSQ systems:

If I had to choose between which one I wanted to do, I would say that that is a really big toss-up because … one is really user friendly and easy, and the other one though it's more complicated, seems a little bit more gracious. So, the new system is like as long as

you're continuing to improve yourself, you can stay at it, so you're not going to lose your three based on how many things you're submitting, and how many things you're doing. You get to keep it because that's your reward because you're continuing on your education, and I think that's great. So, there's, like it's a toss-up for which one I would choose because I think that those two benefits are very important to me.

Providers' contrary perceptions seemed informed largely by provider-specific factors such as each interviewee's personal and organizational capacities and scale (e.g., time, expertise, experience, attitude to change). As with GSQ participation more generally, a second strong influence seemed to be the nature, degree, and consistency of Resource Center assistance.

Many providers saw elements of the reimagined GSQ as contributing to an overall improvement in approach as compared to the prior system. This perspective was especially pronounced among "intentional advancers," who tended to take a "holistic" or systemic view. As one provider explained:

Yeah, it's absolutely an improvement, I think primarily because the new system I think takes a more holistic approach to what quality really means. But also, the new system is more clearly aligned with standards that make sense. … I mean it's holistic in that it's looking at everything involved in providing care. …

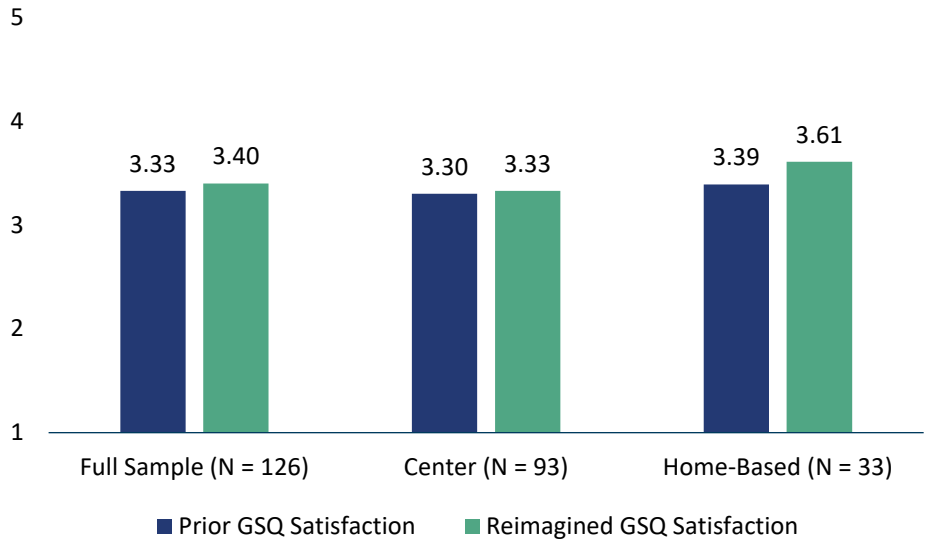
Before it seemed really siloed, the old system had the silo of teacher credentials and then the silo of classroom, the curriculum. My sense is that the new system takes things into account, but they're more integrated. It's like you're not going to lose points if everything is outstanding and then [there is one shortcoming]. … It just looks at it more as a whole.

On average, providers are neither satisfied nor dissatisfied with the reimagined GSQ, but neutral ratings may be attributed to lack of experience.

Overall, survey respondents who participated in the prior GSQ and the reimagined GSQ reported they were "neither satisfied nor dissatisfied" to "somewhat satisfied" with the prior GSQ and the reimagined GSQ (see Figure 13 below), indicating that respondents who had experience with both GSQ's find them equally satisfactory or do not, necessarily, view the reimagined GSQ as an

improvement over the prior GSQ at this stage of the implementation. Moreover, the average satisfaction level was comparable (and non-significant) between CCCs and HBCCs for both the prior GSQ and the reimagined GSQ.

Figure 13. Mean Ratings of Satisfaction with Prior GSQ and Reimagined GSQ by Provider Type Among Survey Respondents



Scale: 1 = *Very dissatisfied*; 2 = *Somewhat dissatisfied*; 3 = *Neither satisfied nor dissatisfied*; 4 = *Somewhat satisfied*; 5 = *Very satisfied*

In interview responses, when asked to describe their satisfaction on a scale from 1-5, less than half of providers (40.1%) reported high levels of satisfaction (4-5) with the reimagined GSQ. HBCCs typically reported higher levels of satisfaction, whereas CCCs held more neutral or slightly negative satisfaction ratings.

Although most ratings were very general, higher levels of satisfaction were strongly linked to the improved feasibility of quality level attainment or advancement in conjunction with the improved available supports, as reported from both CCCs and HBCCs. One CCC provider concluded in this connection:

I think the reason [for high satisfaction] is because it's become very easy to make quality or the quality attainment within reach and there haven't been any real barriers to participating in the process.

These links directly aligned with providers' positive reports about their overall experience with the reimagined GSQ. Those that provided neutral ratings felt

that they either have not had enough experience with the reimagined GSQ yet or that program communications and the necessary time to upload evidence into the system should be improved. Only two providers reported low satisfaction, citing a lack of incentive or benefit for providers to participate and a lack of interest or awareness from families. Additional factors related to providers' overall experience with the reimagined GSQ included administrative burdens (e.g., learning and understanding program requirements, time constraints) and perceptions about what accurately reflects child care quality. In short, as a group home-based provider stated:

I believe in what it's doing and how it's here to help us as providers to better our business. And I think it's just going to be easier for us to do what we need to do to better our business. I mean, it's doing what it's supposed to do.

Conclusions

The focus of this report was to examine provider participation, perceptions, and experiences with the reimagined Great Start to Quality (GSQ). The research team conducted secondary data analyses to test research questions 1 and 2 (see below) and gain insights into providers' motivations to participate (or not) in the reimagined GSQ as well as learn more about their perceptions of and experiences with the reimagined GSQ more broadly.

Research Question 1: Does Michigan's reimagined GSQ result in higher participation by child care providers, and particularly for home-based child care providers (HBCCs)?

Results of the secondary analyses revealed that active participation (counts or rates) has not significantly increased since the reimagined GSQ was implemented. Moreover, active participation for both HBCCs and child care centers (CCCs) has slightly declined compared to active participation during the pre-implementation period. The results indicate at 17 months following implementation, active participation has not increased. Moreover, the active participation gap between CCCs and HBCCs is not narrowing as hoped.

Findings from primary data analyses suggest that there is a great deal of continuity in active participation in the prior GSQ and the reimagined GSQ. Specifically, providers that actively participated in the prior GSQ tend to also actively participate in the reimagined GSQ, and those who did not actively participate in the prior GSQ are not actively participating in the reimagined GSQ. Very few providers who did not participate in the prior GSQ are actively participating in the reimagined GSQ, and vice versa. While providers can identify particular differences, even improvements, in the reimagined GSQ, they do not seem to see its overall purpose or application to the provision of child care as a true break from the prior GSQ. As a result, providers tend to approach both iterations of GSQ in similar ways.

This may be because motivations for participating (or not) remain largely unaltered or unaffected. Providers who participate are generally intrinsically motivated to improve the quality of care they provide, believe that "higher" quality ratings/levels improve their reputation with parents, and are motivated by higher CDC Scholarship reimbursement. Survey findings revealed that providers saw no significant advantages of the reimagined GSQ (compared with the prior GSQ) on dimensions or aspects related to these motivations. Interview

findings revealed varied opinions regarding the advantages (or disadvantages) of the reimagined GSQ compared to its predecessor.

On the other hand, increased participation may not be evident because some providers' reimagined GSQ levels that were assigned based on prior GSQ participation have yet to expire and, thus, they have not faced the decision whether to actively participate or be reclassified to Level 1.[14] Moreover, based on their past practice, a certain proportion of providers, perhaps now augmented by some who did not participate in the prior GSQ, may be prompted to consider active participation in GSQ around the time of child care license renewal. If this is the case, we would expect to see a bump in more active participation by early 2025 since by then all prior GSQ ratings will have expired, as will any license issued at or before the effective date of the current GSQ.

The research team will continue to track active participation trends over the course of the project to see if (and how) active participation trends change with time. Moreover, we will design primary data-collection instruments to help us disambiguate the reasons and motivation behind the trends and identify any factors that might boost active participation.

Is the reimagined GSQ associated with higher quality levels, on average and across different types of providers? Specifically, does the reimagined system make it easier for home-based child care providers to achieve higher quality levels comparable with child care centers?

Overall, providers' mean quality ratings/levels were lower in the post-implementation period compared to the pre-implementation period. Furthermore, providers were significantly less likely to improve their quality rating during the post-implementation period compared to the pre-implementation period. Additional analyses revealed that the decrease in post-implementation quality ratings was driven by CCCs; HBCCs had modestly higher mean quality ratings post-implementation compared to pre-implementation.

The pattern of decreasing quality ratings/levels was also observed in the survey data, where more providers self-reported their quality rating decreased (17%) than increased (less than 10%). It is not known why CCCs experienced a significant decrease in quality ratings post-implementation, but interview

[14] Two of the providers in the interview sample were still operating under a previously attained star rating/legacy level.

findings suggest CCC providers *may* be less satisfied with the reimagined GSQ than HBCCs. The research team's future research plans include monitoring trends in quality ratings/levels and gaining a better understanding of why CCCs' quality ratings/levels have declined.

The reimagined GSQ was designed, in part, with the objectives of increasing overall active participation in GSQ; bridging the gap between active participation rates of CCCs and HBCCs; improving provider quality; and decreasing the disparity of quality ratings/levels between CCCs and HBCCs. The empirical evidence suggests that the launch of the reimagined GSQ is currently not achieving or trending toward achieving these objectives. While this news may be disappointing to partners and key stakeholders, it is important to note the implementation remains in its fairly early stages. At this point, a potentially meaningful number of providers have not been prompted or may have otherwise delayed their decision (or action) to actively participate. Moreover, the results suggest some providers who are actively participating have little experience with many facets of the reimagined GSQ.

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Appendix A: Secondary Data Technical Details

Secondary data analyses were conducted on a panel dataset of providers' star ratings/quality levels and other characteristics over time. The analyses of trends in Great Start to Quality (GSQ) active participation and mean ratings over time used interrupted time series (ITS), where the interval period was monthly, and the number of time points (t) was 35 (18 months pre-implementation, 17 months post-implementation). The research team conducted a Breush- Godfrey test, which detected autocorrelation in the dataset. As such, Newey-West standard errors with a lag time of 2 were utilized to account for the autocorrelation as well as any heteroskedasticity. The lag time of 2 was chosen using a rule of thumb ($t^{1/4}$) and rounding down. Newey-West standard errors were also used in the regression comparing mean ratings before and after implementation of the reimagined GSQ.

The validity of many time series analyses requires that the underlying data is stationary. Dickey Fuller tests were conducted to test this assumption, as well as to evaluate the data for drift and trend. The tests showed that the dataset was stationary with trend. The inclusion of the trend line for ITS was sufficient to control for these issues. Additionally, many models had a seasonality component, so month was controlled for in analyses where noted. Some figures show seasonally adjusted results, where the effects of seasonality have been removed from raw data counts.

Ordinal regressions were conducted to evaluate the likelihood of having each star rating (under the prior system) and quality level (under the reimagined system), both overall and by provider type.

Logistic regressions were conducted to detect whether there were meaningful differences in active participation rates between the two periods. Tests were first conducted using fixed effects on a panel set of data. This, however, created a nesting issue, one that could only fundamentally be fixed with mixed-effects models. This solution proved to be computationally difficult due to the number of participants, time periods, and levels involved. Additionally, these results may result in bias due to mis-specification of the model.

Instead, a pooled logistic regression was conducted on the pre- and post-implementation periods. This did violate the repeated-measurements

assumptions of logistic regression. However, the research team ran models of randomly selected subject in the pre- and post-implementation periods to ensure that results of the pooled model did not significantly differ and result in any biases.

Appendix B. Supplementary Survey Information

This appendix includes the survey protocol that describes data-collection and analysis strategies as well as additional survey sample descriptives not included in the body of the report.

SCOPE AND METHODOLOGY

Purpose

The purpose of the Year 2 provider survey was to collect data on the perspectives and experiences of providers with the transition from the prior Great Start to Quality (GSQ) to the reimagined GSQ, as well as the implementation and impact of the reimagined GSQ during the time since its launch. Survey topics included:

- Perceptions and experience with the prior GSQ quality rating system
- Awareness, perceptions, and experience with reimagined GSQ quality levels system
- Workforce stability and impact on GSQ quality rating system participation
- Child care accessibility
- Demographics

Data collected from providers will contribute to addressing all five study research questions.

Target Participants and Sampling

The research team randomly selected approximately 2,000 licensed providers using license and contact information from our secondary data sources, with the goal of obtaining a sample of 350 survey respondents. Due to the limited size of the population of interest and the low participation rate by HBCCs, a flat randomization was employed rather than stratification. The research team believed this strategy would result in an oversampling of family and group home-based child care providers. Only providers or personnel who make decisions regarding participation in the Quality Recognition and Improvement System (QRIS) were invited to participate and only one person per organization/provider was sampled.

Recruitment/Outreach

Public Policy Associates (PPA) prepared outreach materials, including initial recruitment email and four reminder emails, which Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) approved and sent. Participants were contacted in cooperation with the Early Childhood Investment Corporation and MiLEAP in an effort to improve response rates. All outreach was conducted via email.

Data-Collection Mode and Procedure

The survey was administered online via SurveyMonkey and, on average, took participants 20-30 minutes to complete. Three cognitive interviews were conducted prior to the survey launch.

All survey responses were kept confidential, and all reporting was in aggregate. In order to potentially link survey responses over time or link survey responses with other data sources (i.e., secondary data) for the purposes of examining the potential mediating or moderating role of dispositional, staffing, or other variables in participation, PPA asked participants to *voluntarily* provide their license number. We offered an incentive of eight $100 gift cards for participating providers, selected at random from the pool of respondents.

Analysis

Descriptive analyses were completed in Stata for all variables that were included in the report. Additionally, the research team completed descriptive analyses by provider type and prior GSQ participation. The research team conducted inferential analyses (i.e., paired and independent samples t-tests) to test for significant differences in experience between the prior and reimagined GSQ and sub-groups. The research team was particularly interested in differences in perceptions, experience, and participation between providers from child care centers (CCCs) and home-based child care providers (HBCCs). No significant differences between provider types were found on any variables of interest. The results suggest that responding providers had similar experiences and perceptions. The research team did not conduct any analyses of mediating or moderation, because no significant differences were found, comparatively few HBCCs responded to the survey, and relatively few non-participating providers responded to the survey.

TABLE 6. PROJECTED TIMELINE FOR DATA COLLECTION AND ANALYSIS

ACTION		DATES (2024)	ORGANIZATION RESPONSIBLE
Year 2 provider survey instrument developed and shared with project partners		1/03/24	PPA, MiLEAP
Provider survey instrument revised based upon partner feedback; outreach materials prepared and shared with partners		01/26/24	PPA
With partner assistance, outreach to prospective provider cognitive interviewees		01/30/24	MiLEAP
Schedule and conduct cognitive interviews; revise provider survey instrument based upon interview feedback and share with partners		02/19/24	PPA
MiLEAP sends recruitment email (incl. survey link) to selected licensed providers; survey opens		02/26/24	PPA, MiLEAP
PPA sends reminder emails (up to 4) to respondents	Reminder 1	03/04/24	PPA, MiLEAP
	Reminder 2	03/11/24	
	Reminder 3	03/18/24	
	Reminder 4	03/25/24	
Survey closes		04/01/24	PPA
Survey data cleaning completed		04/15/24	PPA
Survey data (descriptive) analysis completed		05/24/24	PPA

Below are some additional demographic descriptive statistics from the survey sample.

Figure 14. Child Care Roles (N = 233)

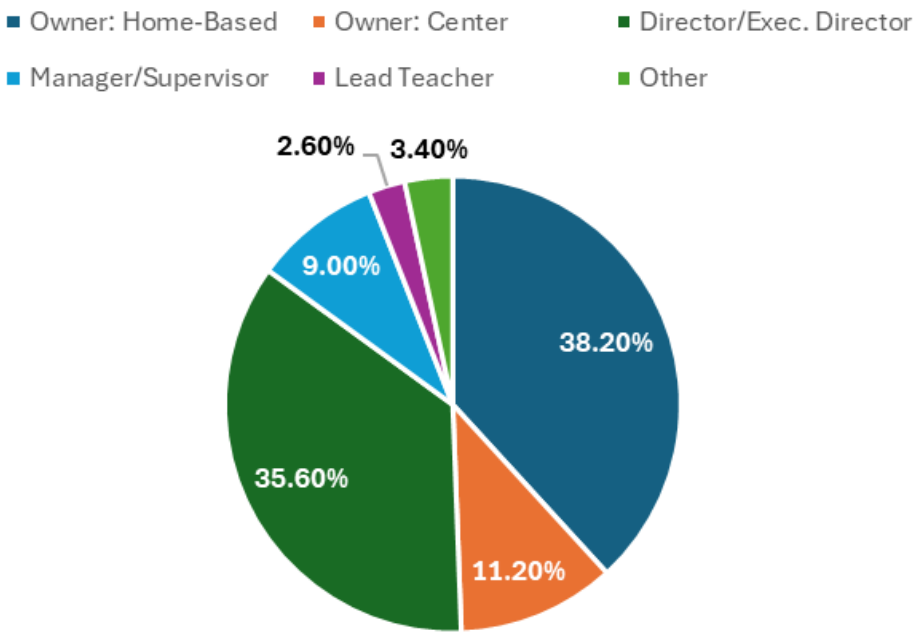
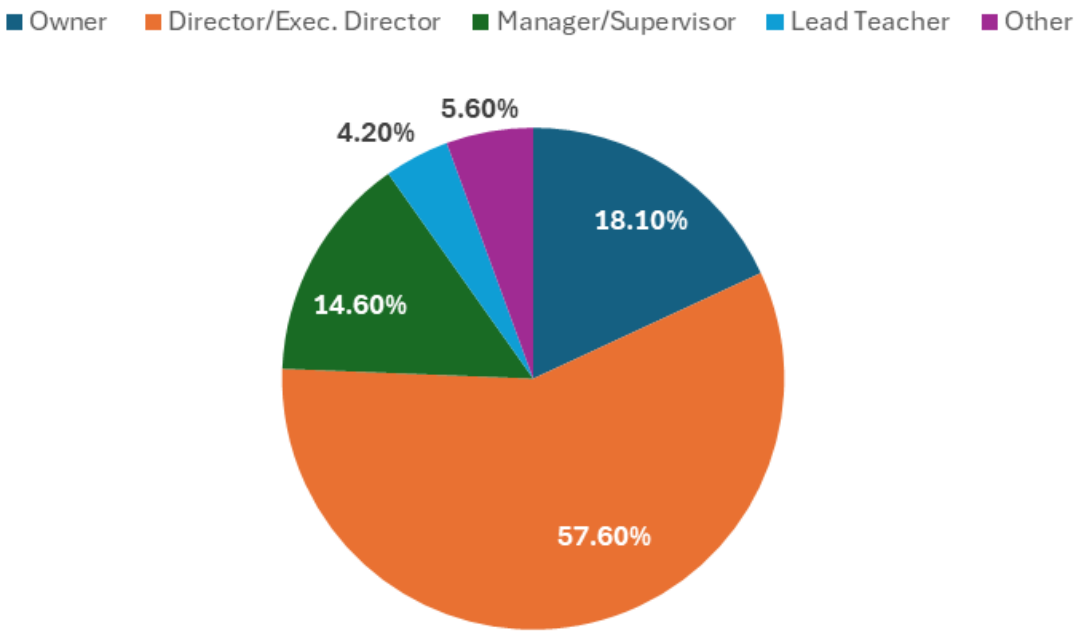
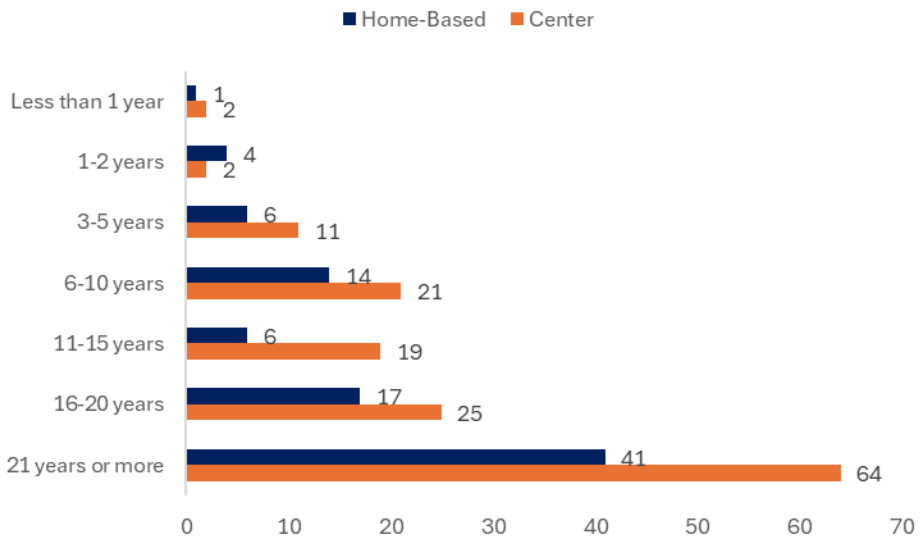


Figure 15. Center-Based Roles (N = 144)



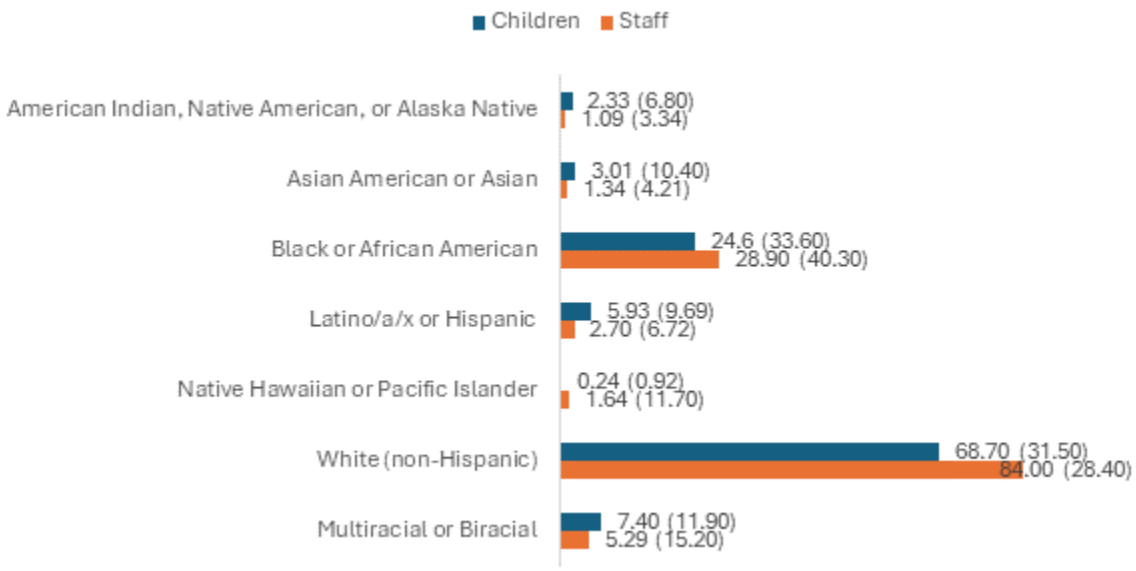
Of the 233 child care providers who completed the survey, over a third were either owners of HBCCs (38.2%) or directors/executive directors (35.6%). See Figure 14 for more details on the roles of survey respondents. Among those working solely at child care centers (N = 144), the majority held director or executive director roles (57.6%), followed by child care center owners (18.1%) and managers/supervisors (14.6%) (see Figure 15).

Figure 16. Years of Provider Experience by Provider Type (N -= 233)



Both CCC and HBCC survey respondents have extensive experience as child care providers. Almost half of CCC and HBCC providers have 21 years or more of experience (44.4% and 46.1%, respectively), followed by those with 16 to 20 years of experience (17.4% of CCCs and 19.1% of HBCC providers). See Figure 16 for a comparison of provider experience by provider type.

Figure 17. Mean Number of Children Served and Staff by Race and Ethnicity



Survey respondents serve children and employ staff from diverse racial and ethnic backgrounds. On average, the largest group of children served were white (non-Hispanic) (68.7), followed by Black or African American (24.6). The staff demographics were similar, with white (non-Hispanic) staff having the highest mean (84.0), followed by Black or African American (28.9). See Figure 17 for more details.

Appendix C. Supplementary Interview Information

PROVIDER INTERVIEWS

Thirty-six licensed child care providers participated in phone interviews about child care quality and their awareness of, experiences with, and perceptions of the prior and reimagined Great Start to Quality (GSQ) system. Interviews were conducted between April and July 2024. All interviews lasted up to an hour and each participant received a $50 electronic gift card for their participation.

From the most recently obtained Child Development and Care (CDC) program administrative data, Public Policy Associates (PPA) identified a purposive sample of providers based on license type and level of engagement with the reimagined GSQ (e.g., advanced levels, attempted to advance, or had the opportunity to advance).

Providers were initially invited to participate via email from Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP). PPA prepared de-identified email contact lists to support MiLEAP's outreach efforts. PPA conducted all follow-up outreach via email and phone calls. Participation was voluntary and providers who did not respond or who declined participation were replaced by comparable sample members. Recruitment required two rounds of initial outreach from MiLEAP and follow-ups from PPA. The research team utilized Outlook's Bookings for scheduling interviews.

Interview transcripts were cleaned to de-identify participants' names. The research team uploaded the transcripts into Dedoose (a qualitative analysis software) and developed an initial set of codes and subcodes (a codebook). To ensure reliability, the initial codebook was subjected to norming (e.g., two researchers code the same interview transcript, analyze consistency between coders, and adjust coding until they matched). Norming included one round of coding and comparison before being programmed into Dedoose. Coding was conducted between July and August 2024. Although interviewees were initially divided into three subgroups of 12 based on provider type (center, home-based family, or home-based group), all home-based providers were grouped together for analysis. One interview was removed due to concerns about reliability pending from one interviewee's unclear licensing and quality level status, leaving 35 total interviews for analysis.

Data limitations included occasional inconsistencies between interviewee's recall and state administrative data related to provider quality levels, as well as potential misunderstandings about how "active participation" in the reimagined GSQ is defined. Additionally, 80% of interviewees had 10 years or more of experience, which may limit the generalizability of findings to younger age or less experienced cohorts of providers. Interviewee characteristics are further described in Table 7.

Table 7. Interview Participant Demographic Characteristics (N = 35)

	CHARACTERISTIC	FREQUENCY	PERCENTAGE
Provider Type and Setting	Center	11	31.4
	Home-Based Provider	24	68.6
	Home-based family	12	34.3
	Home-based group	12	34.3
Prior GSQ Star Rating	No Participation – New Provider (see Note 1)	3	8.6
	No Participation	4	11.4
	1	0	0.0
	2	0	0.0
	3	18	51.4
	4	4	11.4
	5	6	17.1
Reimagined GSQ Quality Level (See Note 2)	Level 1, Maintaining Health and Safety	4	11.4
	Level 2, Reflecting on Quality	4	11.4
	Level 3, Enhancing Quality	15	42.9
	Level 4, Enhancing Quality - Validated	6	17.1
	Level 5, Demonstrating Quality	6	17.1
Urbanicity	Urban	28	80.0
	Rural	7	20.0
Prosperity Region	2	1	2.9
	3	1	2.9
	4	8	22.9
	5	2	5.7
	6	1	2.9
	7	3	8.6
	8	2	5.7
	9	7	20.0

	CHARACTERISTIC	FREQUENCY	PERCENTAGE
	10	10	28.6
Years of Experience	0 up to 2 years	1	2.9
	More than 2 to 5 years	1	2.9
	More than 5 to 10 years	5	14.3
	More than 10 to 15 years	5	14.3
	More than 15 to 20 years	5	14.3
	More than 20 to 25 years	4	11.4
	More than 25 years	14	40.0

Note 1. New providers who were not licensed before the reimagined GSQ launched and did not have opportunities to engage with the prior GSQ are labeled as "No Participation – New Provider".
Note 2. reimagined GSQ Quality Levels are reported as of the provider interview date.