THE BELL POLICY CENTER PRESENTS

# Quality of Care in Colorado

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## Quality of Care

Care provided across generations, through direct care (support for older adults and people with disabilities) or early childhood education (ECE), is crucial to our communities. Both types of care allow family members to work, and have positive spillover effects in economic security, health, and well-being for the recipients of care and their family members.

Previous briefs explored the accessibility and affordability of care. This analysis surveys the quality of care in Colorado. Even if a family or individual can access and afford care, not all families are able to benefit from high quality care. Quality care is defined by four main characteristics: safety, effectiveness, person-centered, and equity. Currently in Colorado, high quality licensed child care facilities are found in areas with higher incomes and in child care centers. More data is needed in the direct care space in order to better identify who has access to quality care in Colorado.

### Licensed Child Care Facilities

Licensed child care facilities can be licensed child care centers or licensed family child care homes. While both are licensed, a center is operated in a commercial care space while a child care home is located in a residential space, often the owner's home.

## What Does Quality Mean?

There are multiple existing definitions of quality care that come from organizations like One Colorado, the Colorado Department of Early Childhood (CDEC), and the World Health Organization. Though each definition has differences, there are three important themes that are shared across them:

1. Care is *effective* and maximizes positive outcomes. When care is high quality and effective, positive outcomes occur as a result like improving health outcomes, child development, and school readiness.
2. Care is *people-centered* meaning it meets and responds to individual preferences and values. This includes the extent to which care is culturally responsive, or the ability to understand, relate, and respectfully respond to the different cultural backgrounds of the people they serve.
3. Care provided is *safe* and avoids harm.

   Finally, while it is not explicitly shared across all definitions, equity is a critical component of quality and we have included it as a fourth measure.
4. The quality of care is *equitable* and does not vary based on race, ethnicity, gender, sex, geographic location, or income.

To measure the prevalence of quality care, we will use the state's assessment and measurement of relative quality of licensed ECE facilities known as Colorado Shines Quality Rating and Improvement System (QRIS). We recognize that the QRIS system does not capture all measures of quality. As a result, we additionally explore gaps in the QRIS. In the direct care space, all licensed long-term care facilities and home care agencies are subject to federal and state safety regulations and undergo regular quality assurance assessments with citations recorded through the Colorado Department of Public Health and Environment. However, the state does not have a similar classification or rating system as ECE. Therefore, to measure the quality of direct care, we will look individually at the above measures of effectiveness, people-centered, safety, and equity.

## Why is Quality Important?

In previous briefs we have established that care is important. Care is intended to provide a safe and enriching environment for children, older adults, and people with disabilities. When care is high quality, we see additional positive outcomes. For older adults and people with disabilities, care can allow them to live as independently as possible. It enables individuals to live in their community of choice, maintain social connections, and remain healthy. ECE engages children in activities, helps them grow socially and emotionally, and allows them to gain foundational skills for their continued education.

In ECE, high quality care increases school readiness, advanced language skills, and reduces the achievement gap. In addition, children who receive high quality care in their first five years are more likely to graduate college and have higher earnings as an adult.

As was mentioned, quality care for older adults and people with disabilities impacts their health outcomes, social connections, and quality of life. In Colorado, health disparities exist among older adults, specifically older adults of color. Increasing high quality care has the potential to diminish these health disparities. The quality of care is important in realizing these impacts for children, older adults and people with disabilities.

## What Does Quality Look Like in Colorado?

### Early Childhood Education

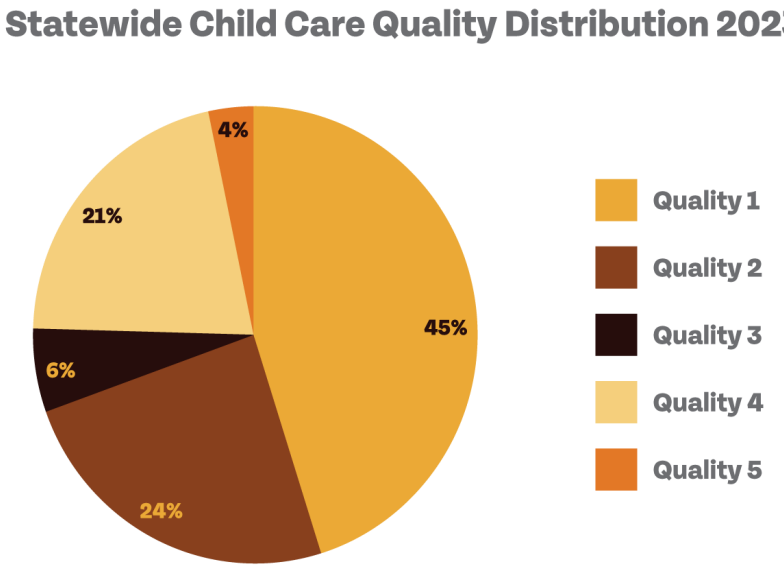
CDEC assesses and ranks licensed child care facilities' quality of care on a scale from 1, the lowest quality rating level, to 5, the highest, based on how well they meet the following criteria:

- Supports children's health and *safety*
- Ensures staff are well trained and *effective*
- Provides a supportive learning environment that teaches new skills
- Helps parents become partners in their child's learning
- Demonstrates good leadership and business practices

In 2017, Child Trends conducted a validation study of Colorado Shines' structure and validity in measuring quality. The study found that the measures included in the QRIS system are aligned with research in the field and tied to positive developmental and learning outcomes. While these measures are important in assessing certain parts of quality, the QRIS rating system does not address the extent to which the ECE provided is people-centered or include equity considerations. Below, we look at the distribution of quality licensed child care providers and where they are across the state and then explore the gaps of the QRIS system and how the need for person-centered care is being met.

## Is Care Safe and Effective?

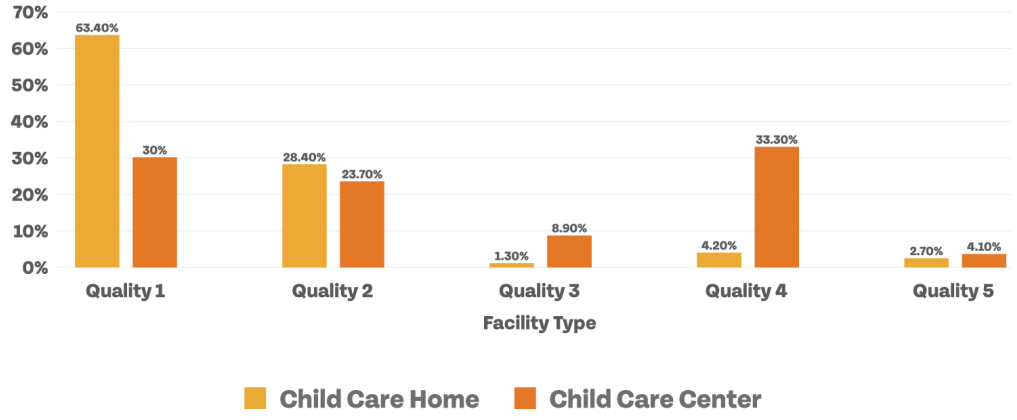
Notably, more than half of licensed providers are a QRIS level 1 or 2, while only 4 percent have a QRIS level 5 rating. Quality has increased compared to 2021. The total number of licensed providers has remained relatively similar to the number of providers in 2021, yet there has been a decrease in the proportion of licensed providers with a QRIS of 1 and 2, and an increase in providers with QRIS 3-5.




Source: Bell Analysis of 2023 CDEC Child Care Facilities Report

Importantly, when the quality level is disaggregated by facility type, level 1 providers are more likely to be licensed child care homes while the higher quality facilities are more often licensed child care centers. Though it should be noted that there are slightly more child care centers overall. Nationally, family child care homes are more prevalent in rural areas than child care centers. While a QRIS rating of 1 does not signify poor quality, children in rural areas have fewer opportunities to access higher quality-rated providers. Nationally, licensed family child care homes are most accessed by low-income families, Black and Latino families, and infants and toddlers.

## Child Care Quality Distribution by Licensed Facility Type (2023)

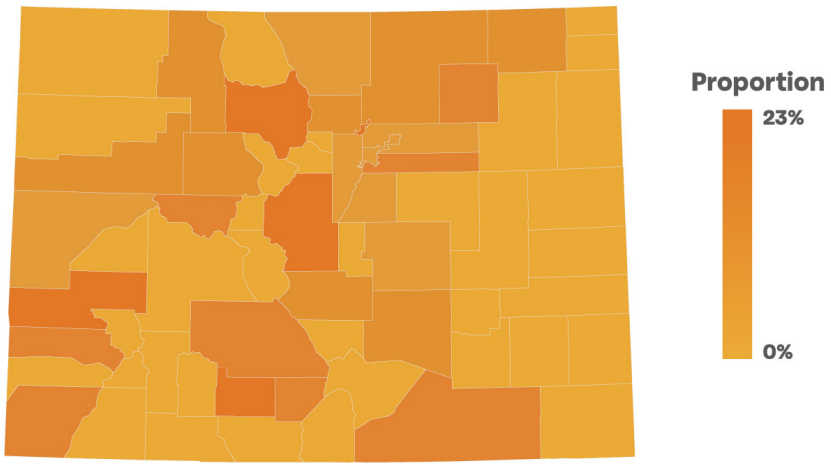



Source: Bell Analysis of 2023 CDEC Child Care Facilities Report; excludes preschool programs

All licensed facilities automatically receive quality level 1 as they meet basic regulations and requirements to be licensed by the state. From there, they are required to take additional training, professional development, and adhere to specific requirements to increase in quality. Increasing quality ratings requires additional funds and time to attend trainings. Anecdotally, we have heard that with long waitlists and the need to increase availability and staffing shortages that make it difficult to attend trainings, increasing quality may be less of a priority and could explain why we see higher proportions of QRIS 1 facilities.

In addition to differences in quality among facility types, quality can also be disaggregated by geography. Below, the map shows where the higher proportions of licensed providers with QRIS 5 exist.

## Proportion of Licensed Child Care Providers with QRIS 5




Source: Bell Analysis of CDEC Child Care Facilities Report 2023

While the map shows that, in fact, most rural and frontier counties do not have QRIS 5 licensed providers, this is not universally true. We also see differences among incomes. On average, counties with no quality level 5 providers have lower median household incomes, $58,000 on average, while those with at least one quality level 5 provider have higher median household incomes, an average of $73,000. However, this relationship is not linear. For example, while Montrose County has the highest proportion of licensed providers with a quality level 5, the median household income is $57,225 while Douglas County, with the highest median income, only has 1.4 percent of providers with a QRIS 5.

## Is Care Equitable?

The graphs above show us that care is not equitable across geographic locations, income, or care settings. Additionally, advocates have raised concerns regarding the ability for QRIS systems to address equity in quality care. For example, the QRIS system is meant to capture average quality in a licensed facility, but isn't designed to capture racial biases, or how individual children may experience care differently. Some advocates have criticized the QRIS framework for growing inequities due to a preference for center-based care over home-based care. For example, it is stated by child care home providers that the QRIS requirements are focused on making homes like "little centers" and ignore the relationships and benefits a home setting may provide. The paperwork process is more burdensome for family child care providers as providers note that centers have directors and staff roles to help fill out the paperwork and family child care homes simply don't have the same capacity to do so. This can lead to children of families with low-income or families of color, who are more likely to be in home-based settings, to have less opportunity for higher quality care. Some have also noted that without explicit measures of equity, the framework will disadvantage communities of color. Both of these sentiments were expressed in the Child Trends validation study, which reported that family child care homes perceived the QRIS system to be designed for centers. The report also showed a hesitancy among these providers to allow observation and monitoring in their homes or classrooms. This is especially true for marginalized communities that have historically been monitored by the government and for the possibility that the monitoring may be biased.

## Is Care People-Centered?

Related to the question of equity is whether or not care responds to individual needs, preferences, and different cultural backgrounds. The Colorado Shines QRIS does not include a specific measure on the extent a program is people-centered or culturally responsive. However, Colorado Shines training options include cultural responsiveness, many of which are provided in English and Spanish. The state has also developed Colorado Early Learning Guidelines that outline the development of children birth through 8 years of age and provide resources to families, caregivers, and educators that are designed to be responsive to diverse needs regarding culture, language, and ability. Additionally, while CDEC conducted a validation study to ensure the QRIS reflected quality, the validation study looked to what extent the Colorado Shines framework is supported by empirical literature and research. This points to the question of what do parents deem quality care? Further research into what quality means to parents and families is needed.

## Direct Care Landscape

As previously mentioned, to be a licensed home care agency or long-term care facility requires that certain safety and quality regulations are met. The code of regulations outlines that services provided should be safe, supportive, in a comfortable environment, and with a systematic review of quality of health care provided. However, the state does not have a rating system comparable to ECE to measure the extent that each provider achieves quality of care in the direct care space. However, the SCAN Foundation along with AARP, measure the performance and quality of long-term services and support (LTSS) across the country and publishes scorecards for each state to measure performance over time. The State Scorecard's measure the following:

- Affordability and Access
- Choice of Setting and Provider (person-centered)
- Quality and Safety of Consumers (safe and effective)
- Support for Family Caregivers
- Community and Integration

For the purposes of this paper we only use measures related to our definition of quality. Identified by the SCAN Foundation as "Quality and Safety" is defined as "consumers are treated with respect and preferences are honored, when possible, with services maximizing positive outcomes, and settings are adequately staffed and prepared." This will be used to measure safety and effectiveness of care. "Choice of Setting and Provider" is used to measure if care is person-centered as the definition states, "a person- and family-centered approach that allows for consumer choice and control of services and HCBS are widely available. Provider choice fosters equity, and consumers across communities have access to a range of culturally competent services and supports." While equity is considered in these definitions, the LTSS scorecards lack a specific measure of equity.

## Is Care Safe and Effective?

Colorado is ranked 5th among all states in safety of consumers and maximizing positive outcomes. As seen below, there have been no significant changes in outcomes from the base surveyed year 2015. However, Colorado has rates below the national average in percentage of high-risk nursing home residents with pressure sores and above average for the rate of employment among adults with activities of daily living (ADL) disabilities. This is important as many adults with ADL disabilities are not in the labor force even though they may have the skills and desire to be. Quality care and support may help them achieve this.

| Dimension and Indicator | Baseline Scorecard | | 2020 Scorecard | | | | | Change in Performance |
|---|---|---|---|---|---|---|---|---|
| | Data Year | State Rate | Data Year | State Rate | US Average | Best State Rate | Rank | |
| **Quality of Life & Quality of Care (Safe and Effective)** | | | | | | | 5 | |
| Rate of employement for adults with ADL Disabilities ages 18-64 relative to rate of employement for adults without ADL disabilities ages 18-64 | 2013-15 | 22.9% | 2016-18 | 24.9% | 21.4% | 38.1% | 15 | ‹—› |
| Percentage of high-risk nursing home residents with pressure sores | * | * | 2018 | 5.6% | 7.3% | 4.8% | 10 | * |
| Percentage of long-stay nursing home residents who inappropriately receive antipsychotic medication | 2015 | 15.4% | 2018 | 15.0% | 14.6% | 7.8% | 29 | ‹—› |
| HCBS quality cross-state benchmarking capability | * | * | 2015-19 | 2.0 | 1.3 | 3.6 | 12 | * |

Source: 2020 LTSS State Scorecard, Colorado

These outcomes are not tied to an agency or facility and are therefore difficult to further analyze who is realizing these improvements and where.

## Is Care Person-Centered?

Colorado's performance in person-centered care ranks 14th compared to other states.

| Dimension and Indicator | Baseline Scorecard | | 2020 Scorecard | | | | | Change in Performance |
|---|---|---|---|---|---|---|---|---|
| | Data Year | State Rate | Data Year | State Rate | US Average | Best State Rate | Rank | |
| **Choice of Setting and Provider (Person-Centered)** | | | | | | | 14 | |
| Percentage of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities | 2013 | 47.8% | 2016 | 58.7% | 45.1% | 73.5% | 7 | ✓ |
| Estimated percentage of Medicaid aged/disabled LTSS users receiving HCBS | 2014 | 65.2% | 2017 | 68.5% | 64.2% | 83.9% | 16 | ‹—› |
| Number of people self-directing services per 1,000 population with disabilities | * | * | 2019 | 15.0 | 30.4 | 149.1 | 19 | * |
| Home health and personal care aides per 100 population ages 18+ with an ADL disability | 2013-15 | 21 | 2016-18 | 24 | 22 | 47 | 14 | ‹—› |
| Assisted living and residential care units per 1,000 population ages 75+ | 2014 | 54 | 2016 | 52 | 49 | 102 | 22 | ‹—› |
| Adult day services total licensed capacity per 10,000 population ages 65+ | 2014 | 71 | 2016 | 53 | 61 | 171 | 15 | ✗ |
| Subsidized housing opportunities (place-based and vouchers) as a percentage of all housing units | 2015 | 4.4% | 2017-18 | 4.9% | 6.2% | 18.6% | 41 | ✓ |

Source: 2020 LTSS State Scorecard, Colorado

As is shown in the table above, there has been significant improvement in the amount of state LTSS funding and spending toward Home and Community Based Services (HCBS) for older adults and people with disabilities. This is important as there is a strong preference among most older adults to stay in their communities rather than relocate to a nursing home or long-term care facility. And while small, there was an increase in Medicaid users receiving HCBS. There has been a decrease in capacity among adult day services and little change in the number of assisted living and residential care units. It is difficult to decipher if this is due to market forces as people choose to stay in their homes and communities or if people are experiencing difficulties in accessing adult day services due to the decreased capacity. Overall, with an increased focus on HCBS, people with Medicaid will have more flexibility in choosing their preferred setting.

While the definition of "choice of setting and provider" includes cultural responsiveness, the measures above do not reflect meaningful information about a person's ability to receive culturally responsive care. For example, we cannot understand if people are receiving care in the language they prefer or that responds to their social and cultural preferences. Instead, while not specific to direct care, we can look to the Colorado Health Institute (CHI), which found that non-English speakers are more likely to forgo care due to language and fear of unfair treatment among other barriers. While this is only one example of the need for culturally responsive care, Colorado is a rapidly aging state and with changing demographics and an aging Latino population, it will be important to consider how Colorado's LTSS is responding to language needs among other cultural needs.

## Is Care Equitable?

Issues surrounding person-centered care can overlap with equity. For example, if culturally responsive care is lacking, specifically for non-English speakers as shown in the example above, and they forgo care as a result, we will see health disparities among the non-English speaking population. While anecdotal, it has also been reported that older LGBTQ adults face discrimination and challenges in accessing quality long-term care.

The SCAN Foundation recognizes equity in their definition and states the role that culturally responsive care and person-centered care plays in fostering equity. Some of the measures for person-centered care (or choice of setting and provider) do in fact impact equity. Increased state spending for HCBS Medicaid waivers and the prevalence of subsidized housing opportunities impacts equity, particularly along economic lines. Increased spending for HCBS and subsidized housing expands access to care in home settings for older Coloradans with lower incomes. However, an explicit measure of equity is important as was mentioned for the ECE system. Without the data to analyze who is realizing the above-mentioned improvements, it is difficult to identify further equity implications.

## Informal Care

The above measures were focused on the quality of licensed and formal caregiving, where better data is available. However, we recognize that these are not the only settings in which quality care is provided. Informal care plays an important role in not only filling a gap where there is limited availability of licensed care, but is also a choice for many families as it better suits their needs and preferences, providing competent, quality care.

Seeking informal care allows families and parents to choose a care provider that has flexible scheduling, speaks their preferred language, and has shared cultural understanding. "FFN, or family, friends, and neighbor care, for example, can better meet the needs of parents searching for child care who have nonstandard schedules (work hours outside of 8 a.m. to 6 p.m. or weekends). Nationally, only 8 percent of center based ECE providers and 34 percent of licensed home-based providers offer care during nonstandard hours, while 43 percent of children under 18 have parents who work nonstandard hours. Immigrants, specifically low-income immigrant communities, and dual language families are more likely to rely on FFN care due to a lack of multilingual staff and culturally responsive care in a licensed facility setting. Informal caregivers may be more prepared or already have the desired skills to provide culturally responsive care, despite initiatives to increase cultural responsiveness in formal care.

## Conclusion

Care is critically important for the wellbeing of our communities and high quality care leads to additional positive outcomes like improved health outcomes, decreased health disparities, and improved developmental and academic outcomes for children. Unfortunately, we still see gaps in who is accessing quality care. Particularly in ECE, within the formal system, people in rural areas and with lower incomes who are more likely to rely on family child care homes will have less opportunity to access high quality care. More data is needed, specifically in the direct care space, to fully understand who has access to quality care and how informal care is filling this gap. When considering how to increase quality, we must ensure that equity considerations are included and recognize that both formal and informal caregivers play an important role in providing quality care with positive impacts for the recipients of care.