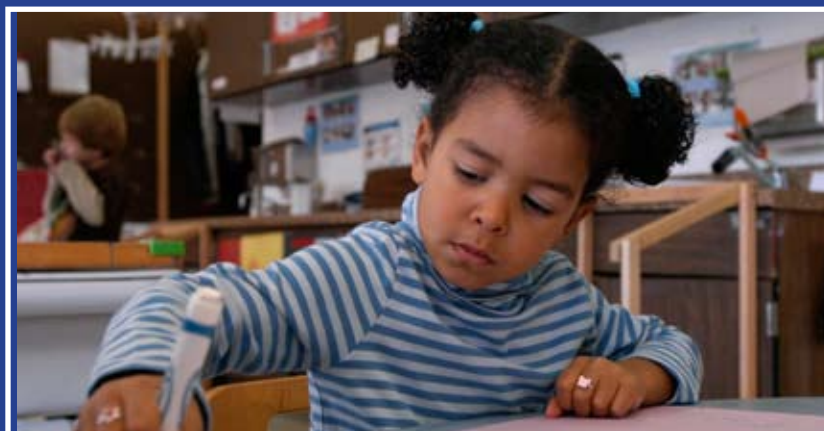


Rhode Island's 2009 Child Care Center & Preschool Quality Study



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Several people worked hard to complete this study and report. The FPG team included Kelly Maxwell, principal investigator; Donna Bryant, investigator; Syndee Kraus, project director; Gina Walker, administrative assistant; Elizabeth Gunn, Lloyd DeWald, and Michelle Lemon, programmers; Angelia Baldwin, data entry. Gina Harrison helped design the report. The Rhode Island team included Leanne Barrett, policy analyst, Rhode Island KIDS COUNT and Tammy Camillo, director, and staff of the Rhode Island Association for the Education of Young Children, which is the implementation agency for BrightStars. The FPG and Rhode Island teams worked closely to conduct this study. FPG provided guidance, helped design the study and develop data collection tools, analyzed the data, and wrote the report. RIAEYC provided guidance and was responsible for recruitment and data collection. Rhode Island KIDS COUNT helped design the study and provided guidance on policy recommendations. We would like to thank the administrators and teachers who welcomed us into their programs and classrooms so that we could better understand the care available to young children in Rhode Island.

NATIONWIDE, most young children are cared for regularly by someone other than their parents. Twenty percent (20%) of all infants and toddlers and 44% of all three- and four-year-olds are served in a center-based care arrangement.¹ Research has demonstrated a statistically significant link between the quality of early care and education and children's academic and social skills.^{2,3,4} Children who attend higher quality programs have better academic and social skills when they enter school. Research on brain development also has underscored the importance of providing high quality, enriching experiences for young children because those experiences form the foundation for later learning.^{5,6} Thus, improving the quality of early care and education is an important strategy for supporting children's development and readiness for school success.

To recognize and support quality early care and education, Rhode Island early childhood leaders developed BrightStars, a Quality Rating and Improvement System (QRIS) for early care and learning programs. A QRIS is a systematic approach "to assess, improve, and communicate the level of quality in early care and education programs."⁷ A state QRIS generally includes five common elements: quality standards, a process for monitoring the quality standards, outreach and support to programs and practitioners, financial incentives, and dissemination of ratings and information to parents and consumers.^{8,9}

Rhode Island developed its QRIS over the past few years; implementation began in 2009. Through a statewide planning period funded by United Way of Rhode Island, Rhode Island KIDS COUNT worked with a 30-member steering committee, national and local consultants, and families to draft a comprehensive set of quality standards and criteria for early care and learning programs (child care centers/preschools, family child care homes, and school-age programs). These standards and criteria were developed within a 5-level framework to be used as the basis for a QRIS. These frameworks were pilot-tested with a sample of programs.^{10,11} BrightStars leadership used the pilot data to finalize the *BrightStars Child Care Center and Preschool Quality Framework*¹² as well as the *BrightStars Family Child Care Quality Framework*.¹³ BrightStars began rating child care centers/preschools in January 2009 and began rating family child care homes in September 2009. The *BrightStars School-Age Child Care Quality Framework* will be finalized in 2010 and implemented statewide in January 2011.

"Early experiences determine whether a child's brain architecture will provide a strong or weak foundation for all future learning, behavior, and health."⁵

During the BrightStars development period, Rhode Island early childhood leaders decided to gather data to better understand the current quality of care across all three types of programs: centers/preschools, family child care, and school-age programs. Recognizing that implementing a QRIS is a strategy designed to help programs make incremental quality improvements over time, Rhode Island leaders wanted to better understand the quality of care as BrightStars' implementation began and to have data with which to compare future improvements in the state's early care and education system. Findings from this study of a random sample of programs can also be used to guide the development of focused quality improvement initiatives in Rhode Island. This report focuses only on child care centers and preschool programs. Future reports will describe findings from similar quality studies of family child care and school-age programs.

Study Description

The purpose of the Rhode Island Child Care Center and Preschool Quality Study (also referred to as the “Center Quality Study”) was to gather data to better understand the quality of care and education in child care centers and preschool programs, using key components delineated in the *BrightStars Child Care Center and Preschool Quality Framework*.

Program Selection

The Rhode Island Child Care Center and Preschool Quality Study was designed to build on the earlier Pilot Test of the *BrightStars Child Care Center and Preschool Quality Framework*. In the summer and early fall of 2008, BrightStars staff gathered pilot data from a random sample of 25 licensed/approved child care centers and preschools. The Pilot Test was designed to gather data to help the BrightStars Steering Committee refine the standards and criteria before formally implementing the *BrightStars Child Care Center and Preschool Quality Framework* in January 2009.

The goal of the Center Quality Study was to gather data on the quality of 50 infant/toddler and 50 preschool classrooms as well as program-level characteristics. For each program recruited, one classroom from each of the two age groups (infants/toddlers and preschoolers) was randomly selected for observation. Some participating programs served only one age group, so 69 programs were needed to obtain data from 50 classrooms of each age group.

Recruitment occurred in two steps. First, the randomly selected programs that participated in the Pilot Test were asked to be in this new study, and 23 of the 25 agreed. These programs needed only to allow a trained assessor to observe one or two randomly selected classrooms because the other program-level data had already been gathered as part of the Pilot Test. Of these 23 programs, 19 served both infants/toddlers and preschoolers and 4 served only preschoolers. Thus, an additional 27 preschool classrooms and 31 infant/toddler classrooms were needed to meet the goal of obtaining data from 50 infant/toddler and 50 preschool classrooms.

To meet this goal, the second step in the recruitment process required randomly selecting more programs. From a pool of 104 randomly selected licensed/approved programs across Rhode Island, 69 were eligible to participate (e.g., they were open, had a working phone number). Of those 69 programs, 46 agreed to participate in the Center Quality Study. This represents a response rate of 67%. (The response rate for the Pilot Test was 43%.¹⁴) Both program-level and classroom observation data were gathered from these 46 programs.

The 69 programs in this study were located across the state of Rhode Island. About half of the programs (55%) were located in Providence County. Twenty percent (20%) were in Kent County, 12% in Washington County, 9% in Newport County, and 4% in Bristol County.

Measures

Multiple measures were used to gather program-level and classroom-level data for the Center Quality Study.

Program-Level Measures

Program directors were asked to provide for review by BrightStars staff written documentation about licensing compliance, accreditation, program self-assessments, child assessments, family involvement, and program administration. Directors were also asked for basic information about their program (e.g., enrollment, number of children receiving child care subsidies, participation in Head Start). During each visit, BrightStars staff completed a facility observation checklist, which documented the observed group size and ratios for half of the classrooms

for each age group served (classrooms were randomly selected). The director and lead group teachers were asked to complete a questionnaire about their qualifications and, if possible, to submit documentation of their degrees, coursework, and credentials. Finally, the Rhode Island Department of Children, Youth, and Families provided data regarding licensing compliance for those programs in the Pilot Study.

Classroom-Level Measures

Classroom-level data about global quality were gathered through the *Infant/Toddler Environment Rating Scale-Revised* (ITERS-R)¹⁵ and the *Early Childhood Environment Rating Scale-Revised* (ECERS-R).¹⁶ The ITERS-R is a widely used instrument for examining global classroom quality. It is specifically designed for use in classrooms serving children birth to 2 ½ years of age. The ITERS-R measures the following aspects of classroom quality: Space and Furnishings (e.g., furnishings for relaxation and comfort, room arrangement, display); Personal Care Routines (e.g., greeting/departing, safety practices); Listening and Talking (e.g., helping children understand language, helping children use language); Activities (e.g., fine motor, art, promoting acceptance of diversity); Interaction (e.g., supervision of play and learning, peer interactions); Program Structure (e.g., schedule, group play activities, provisions for children with disabilities); and Parents and Staff (e.g., provisions for personal needs of staff, supervision and evaluation of staff). In this study, we did not complete the “Parents and Staff” items on the ITERS-R.

Scores on the ITERS-R can range from 1 to 7 with higher scores indicating higher quality. Total scores from 1 to 2.9 are considered “low” quality, scores from 3.0 to 4.9 are considered “medium” quality, and scores of 5.0 or greater are considered “good” or “high” quality.

The ECERS-R is a widely used measure of global classroom quality specifically designed for use in classrooms serving children 2 ½ to 5 years of age. The ECERS-R measures the following aspects of classroom quality: Space and Furnishings (e.g., furnishings for relaxation and comfort, room arrangement, display); Personal Care Routines (e.g., greeting/departing, safety practices); Language-Reasoning (e.g., quality of books and pictures, encouraging children to communicate); Activities (e.g., fine motor, art, promoting acceptance of diversity); Interaction (e.g., supervision of children, interactions among children); Program Structure (e.g., schedule, group time, provisions for children with disabilities); and Parents and Staff (e.g., provisions for personal needs of staff, supervision and evaluation of staff). In this study, we did not complete the “Parents and Staff” items on the ECERS-R.

Scores on the ECERS-R can range from 1 to 7 with higher scores indicating higher quality. Total scores from 1 to 2.9 are considered “low” quality, scores from 3.0 to 4.9 are considered “medium” quality, and scores of 5.0 or greater are considered “good” or “high” quality.

Procedures

Data collection began in late fall of 2008 and continued through summer 2009. Two BrightStars staff members were responsible for all data collection. They were trained to reliability on the classroom observation measures by the ECERS-R and ITERS-R scale authors. FPG and BrightStars leadership provided training on the program-level measures. Data collection in classrooms typically lasted 3 to 4 hours beginning in the morning. Program-level measures were typically completed in the afternoon of the same day. To maximize the inclusion of programs representing a range of quality, incentives in the form of a \$75 gift card were offered to programs.

Findings^a

The Child Care Center and Preschool Quality Study included a range of programs. Almost all of the participating programs (96%) served preschool-age children. About three-fourths (77%) served toddlers (age 19 to 36 months), and about half (54%) served infants (birth to 18 months). Seventy-four percent (74%) of programs served infants, toddlers and preschoolers. Fifty-one percent (51%) were not-for-profit organizations. A few programs (9%) reported receiving Head Start funds.

Programs varied in size, with a mean total enrollment of 61 children. Forty-one percent (41%) served fewer than 50 children; 48% served between 50 and 99 children; and 10% served 100 or more children. Many of the participating programs (86%) reported that they accept children whose families receive financial assistance through the Child Care Assistance Program at the Rhode Island Department of Human Services. Of the programs that reported accepting children with subsidies, 12% were currently not serving any children with subsidies; 51% reported that fewer than 25% of the enrolled children received subsidies; 11% reported that between 26% and 50% of the enrolled children received subsidies; and 25% reported that more than half of the enrolled children received subsidies. Finally, 58% of the observed preschool classrooms included at least one child with a disability, and 26% of the observed infant/toddler classrooms included at least one child with a disability.

Licensing Compliance

Eighty-five percent (85%) of the programs were compliant with critical areas of licensing; 15% did not meet basic licensing requirements. Licensing compliance was measured through a report produced by the Rhode Island Department of Children, Youth and Family's Child Care Licensing Office. The critical areas of compliance for child care centers, as defined by the Child Care Licensing Office, are: 1) staff/child ratio and maximum group size, 2) supervision of children, 3) prohibited disciplinary actions/corporal punishment, 4) licensed capacity, 5) use of passenger restraints/transportation, 6) items of potential danger to children, 7) reporting of child abuse and/or neglect, 8) staff background checks (criminal and child abuse and neglect, 9) proper procedures for administering medication to children, 10) room temperature/ventilation/lighting, 11) qualified personnel – head teacher (and nurse if serving children under 18 months), 12) safety of indoor and outdoor equipment, and 13) physically safe environment/clean and free of hazards.

National Accreditation

Sixteen percent (16%) of programs in this study were accredited by the National Association for the Education of Young Children (NAEYC). Most of these programs were accredited under the previous system of accreditation that was in place prior to 2007. This percentage is higher than the 2009 statewide percentage of accredited programs (11%¹⁷), suggesting that the sample of programs in this study may be of higher quality compared to all child care centers and preschools across Rhode Island.

^a Unless otherwise specified, the data presented in this section were obtained through observation or verified by data collectors (e.g., document review).

Classroom Quality

This section includes information about the observed quality of classrooms and is organized by the age of the children in the classroom: infant/toddler or preschool.

Infant/Toddler Classroom Quality

The *Infant/Toddler Environment Rating Scale-Revised* (ITERS-R) was used to measure the observed global quality of early care and education classrooms serving infants and toddlers. The mean ITERS-R total score in the 50 infant/toddler classrooms in this study was 3.65 (range = 1.71 to 5.50). As evident in Figure 1, almost three-fourths (74%) of the infant-toddler classrooms were rated as having medium quality (i.e., ITERS-R scores between 3.0 and 4.9). Twenty percent (20%) were rated as having low quality, and 6% were rated as having high quality. With the exception of Personal Care Routines, the ITERS-R mean subscale scores were in the medium quality range (see Table 1). The subscales of Listening and Talking, Interaction, and Program Structure were relative strengths compared to the other subscale scores.

Figure 1
Quality of Infant/Toddler Classrooms in Child Care Centers
(ITERS-R total mean = 3.65)

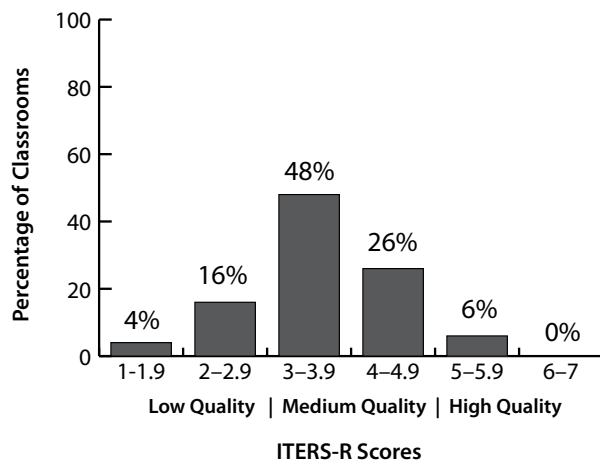


Table 1
ITERS-R Subscale Scores in Infant/Toddler Classrooms

Subscale	Mean	Range
Space and Furnishings	3.72	2.00 – 5.40
Personal Care Routines	2.61	1.33 – 4.83
Listening and Talking	4.42	1.33 – 7.00
Activities	3.68	1.25 – 5.56
Interaction	4.27	1.50 – 7.00
Program Structure	4.36	1.67 – 7.00

Preschool Classroom Quality

The *Early Childhood Environment Rating Scale-Revised* (ECERS-R) was used to measure the global quality of preschool classrooms. The mean ECERS-R total score in preschool classrooms was 4.09 (range = 2.89 to 5.49). As evident in Figure 2, 86% of preschool classrooms were rated as having medium quality (i.e., ECERS-R scores between 3.0 and 4.9). With the exception of Personal Care Routines, the ECERS-R mean subscale scores were in the medium or high quality range (see Table 2). Interaction, Language-Reasoning, and Program Structure were relative strengths compared to other subscale scores.

Figure 2
Quality of Preschool Classrooms in Child Care Centers and Preschool Programs (ECERS-R total mean = 4.09)

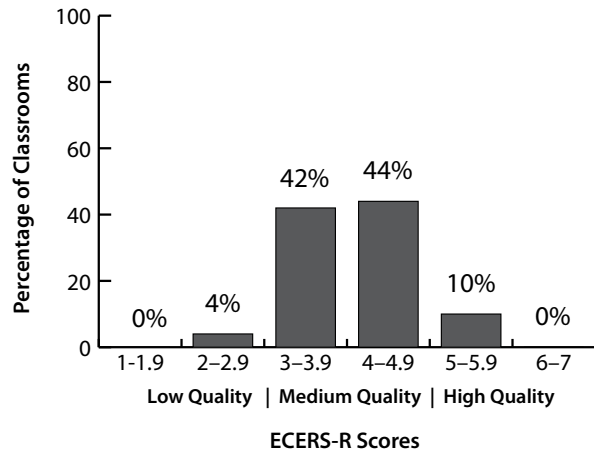


Table 2
ECERS-R Subscale Scores in Preschool Classrooms

Subscale	Mean	Range
Space and Furnishings	3.50	2.38 – 6.00
Personal Care Routines	2.74	1.50 – 3.67
Language-Reasoning	4.88	2.75 – 7.00
Activities	4.19	2.30 – 5.80
Interaction	5.23	2.00 – 7.00
Program Structure	4.82	2.00 – 7.00

Curriculum and Child Assessment

Twenty-nine percent (29%) of programs serving preschoolers used a curriculum that is aligned with the Rhode Island Early Learning Standards (i.e., curriculum referenced all domains of the RI Early Learning Standards). Seventy-one percent (71%) of programs provided written information to parents about the availability of Early

Intervention and Child Outreach screenings.

Eighty-two percent (82%) of programs gathered child-level assessment information for the purpose of guiding classroom instruction.

Table 3
Group Size and Ratio

	Mean	Range	RI Maximum Allowed
Group Size			
Infants (B-18 mos.)	5.79	2 – 11	8
Toddlers (19-35 mos.)	7.27	0 – 15	12
Three-year-olds	11.55	4 – 24	18
Four-year-olds	11.74	4 – 30	20
Five-year-olds	10.92	3 – 20	24
Ratio (Children per Adult)			
Infants (B-18 mos.)	2.68	1.33 – 4	4
Toddlers (19-35 mos.)	3.89	1 – 7	6
Three-year-olds	6.12	2.5 – 15	9
Four-year-olds	5.95	1 – 11	10
Five-year-olds	6.21	1.5 – 10	12

Group Size and Ratio

The total number of children in a class (i.e., group size) and the number of children per adult (i.e., ratio) are important aspects of quality because it is easier for adults to meet the health and developmental needs of each child if there are fewer children and more adults in a group. Eighty percent (80%) of programs met the group size requirements as specified in state licensing (see Table 3.) Seventy-two percent (72%) of programs met the stricter group size requirements based on the age of the *youngest* child in the classroom, rather than the age of *most* children in the classroom. Eighty-three percent (83%) of the

programs included only one group of children per room; 17% used a physical barrier to separate groups of children within the same room.

Ninety-one percent (91%) of programs met the ratio requirements as specified in state licensing (see Table 3). Eighty-five percent (85%) of programs met stricter ratio requirements based on the age of the *youngest* child in the classroom, rather than the age of *most* children in the classroom.

Director Qualifications

Although BrightStars staff requested transcripts and teaching certificates to verify information about the qualifications of program directors, it was not always possible to obtain these documents. Thus, the information reported below was self-reported by directors. Ninety-one percent (91%) of program directors had an Associate’s degree or higher (see Table 4). Of those with an Associate’s degree or higher, 63% majored in early childhood education or a related field.^b Only 11% of program directors reported having a RI Early Learning Standards Level III Certificate.

Table 4
Highest Education Level of Directors

Degree	Percentage of Directors
High School or GED	6%
Associate’s	13%
Bachelor’s or more	78%

Lead Group Teacher Qualifications

Although BrightStars staff requested transcripts and teaching certificates to verify information about teacher qualifications, it was not always possible to obtain these documents. Thus, the information presented in this section was self-reported.

Table 5 provides information about the highest educational level of lead group teachers.^c Sixty-six percent (66%) of preschool lead group teachers and 40% of infant/toddler lead group teachers had an Associate’s degree or higher. Of the preschool lead group teachers with an Associate’s degree or higher, 75% majored in early childhood education or a related field. Of the infant/toddler lead group teachers with an Associate’s degree or higher, 93% majored in early childhood education or a related field.

Table 5
Highest Education Level of Lead Group Teachers

Degree	Percentage of All Lead Group Teachers	Percentage of Infant/Toddler Teachers	Percentage of Preschool Teachers
High School or GED	17%	25%	10%
CDA*	10%	14%	8%
Some college (but no degree)	18%	21%	16%
Associate’s	20%	23%	16%
Bachelor’s or more	35%	17%	50%

*The CDA is technically a certificate, not a degree.

About two-thirds (68%) of preschool lead group teachers did not have a Rhode Island Early Learning Standards Certificate. A few (6%) had a Level I Certificate, 12% had a Level II Certificate, and 2% had a Level III Certificate. Seven percent (7%) of the preschool lead group teachers reported having a Certificate but did not indicate the level, and 5% of preschool lead group teachers did not provide any information about certification.

^b Majors in early childhood or a related field included: early childhood education, early childhood special education, human development, psychology, sociology, social work, education, pediatric nursing, home economics/family and consumer science, recreation, and child and family studies.

^c Lead group teacher is defined as the individual with primary responsibility for a group of children who occupy an individual classroom or well-defined space. The lead group teacher must spend the vast majority of time with one group of children who attend at the same time rather than divide time between classrooms or float between groups.

Sixty percent (60%) of the programs created individual professional development plans for lead group teachers.

Family Communication and Involvement

Program directors provided information about different aspects of communication and involvement with families. Sixty percent (60%) of programs offered parent-teacher conferences at least twice per year. Twenty-eight percent (28%) of programs had an advisory board that included families and met at least four times per year. Table 6

Table 6
Strategies for Communicating with Families

Strategy Offered	% Programs
Monthly newsletter	67%
Host a family meeting, social event, or workshop four times per year	69%
Offer ideas and suggestions to support learning at home at least four times per year	60%
Conduct an annual family survey	62%

presents information about other kinds of communication with families. Seventy-seven percent (77%) of programs offered at least two of the strategies in Table 6.

Program Management

Thirty-one percent (31%) of programs provided evidence that they had conducted a comprehensive program self-assessment during the past year.

Study Limitations

These data provide rich information about child care centers and preschool programs in Rhode Island. Information was obtained from different individuals (i.e., administrators, teachers), using multiple methods (i.e., observations, interview, questionnaire, review of documents). The information in this study, however, is not perfect. For instance, some administrators or teachers may have misunderstood some of the questions asked. Although data collectors were trained to use the classroom observation measures, there is always a certain amount of observer error. Further, there is a high probability that higher quality programs were more likely to participate than lower quality programs. For instance, a higher percentage of programs in the study were accredited by NAEYC compared to programs across the state (16% vs. 11%). Thus, the findings may be somewhat higher/better than that found in all licensed centers and preschool programs across the state. Readers should keep these limitations in mind when interpreting the findings. Even with these cautions, though, we believe the study provides important information about the quality of early childhood education in Rhode Island.

Conclusions and Recommendations

The data from this study suggest that program administrators and teachers are working hard to serve young children and their families. Ninety-one percent (91%) of programs met the Rhode Island child:staff ratio requirements, while 80% met the group size requirement. Eighty-two percent (82%) of programs gathered child assessment information to help guide classroom instruction. Sixty-seven percent (67%) of programs distributed a newsletter to communicate regularly with families and 77% used at least two strategies to communicate with parents.

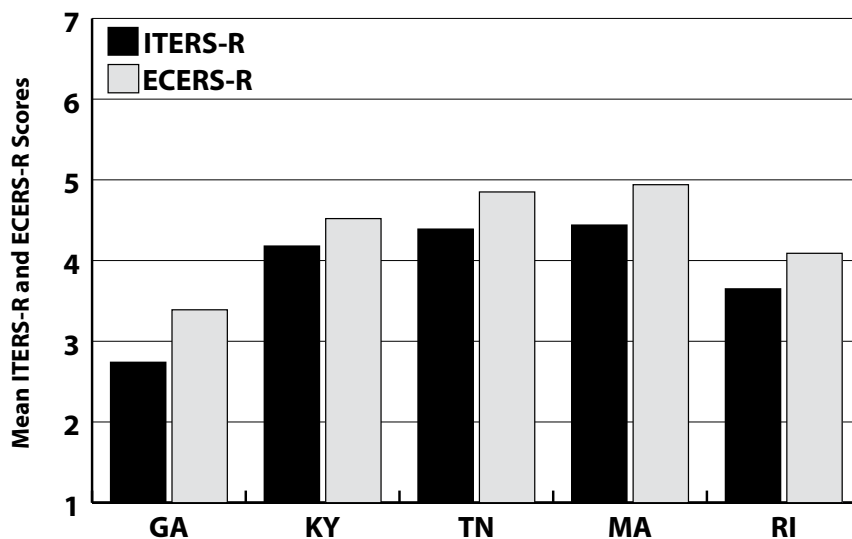
There is room for improvement in the quality of center-based care and education in Rhode Island. The quality of center-based care and education was mainly in the “medium” range. Quality could be improved by efforts that move programs from medium quality to high quality. Eighty-six percent (86%) of preschool classrooms and 74% of infant/toddler classrooms were rated as having a “medium” level of quality (i.e., ECERS-R or ITERS-R mean scores between 3.0 and 4.9). Medium quality is generally characterized by a fundamentally safe environment with access to good quality materials, although activities and interactions could be more enriching and purposeful to support children’s development and learning. Additionally, only 10% of preschool classrooms and 6% of infant/toddler classrooms were rated as having “high” quality.

Strengthening the quality of care for infants and toddlers is needed to ensure that the youngest children in Rhode Island have the high quality care and education needed to support positive development and later school success. The quality of infant/toddler classrooms in Rhode Island was not as high as the quality of preschool classrooms, with five times as many infant/toddler classrooms rated as having a “low” level of quality (i.e., 20% of infant/toddler classrooms had an ITERS-R mean score less than 3.0; while only 4% of preschool classrooms had an ECERS-R mean score less than 3.0). As evident in Figure 3, this pattern is similar to those in other states. With research documenting the importance of early brain development,¹⁸ it seems especially important to strengthen the quality of center-based early care and education for infants and toddlers in Rhode Island.

The quality of center-based care in Rhode Island was lower than some other states and higher than others. Figure 3 provides ITERS-R and ECERS-R means scores from four other states: Georgia, Kentucky, Tennessee, and Massachusetts. The states included for comparison were chosen because they had data that provided a broad picture of quality in that state. Many studies of child care rely on samples of convenience or of a specific sub-population (e.g., those applying for a high level on a state’s rated license), which do not reflect the broader early care and education system. Data from Georgia, Kentucky, and Massachusetts were gathered from random samples of licensed centers within each state. Tennessee data were from the entire population of licensed centers (and therefore representative of the child care system). Although no state is exactly like any other state in terms of their child care policies, investments in child care quality, and child population, these other state data help place the Rhode Island findings in a broader context. It is worth noting that Georgia does not have a QRIS. Kentucky and Tennessee have had a state QRIS in place for several years. Massachusetts began developing a QRIS in 2008. Additionally, 35% of licensed center-based programs in Massachusetts are accredited by the National Association for the Education of Young Children.¹⁹

Data from North Carolina, Tennessee, and New Jersey document that improvements in quality are possible with investments over time. When Smart Start first began in North Carolina in 1994, a study of 180 preschool classrooms across the state found that only 13% were of high quality. Five years later, 29% of 133 preschool classrooms visited were rated as high quality.²⁵ When Tennessee first began its Report Card and Star Quality Program, 31% of centers were rated as high quality. Seven years later, 46% of centers were rated as high quality.²⁶

Figure 3
Cross-State Comparisons of Center-Based Quality



Georgia: These data were collected in 2008-09 from 97 infant/toddler classrooms and 109 preschool classrooms in a sample of 112 randomly selected licensed centers.²⁰

Kentucky: These data were collected in 2007-08 from 39 infant/toddler classrooms and 61 preschool classrooms in a sample of 99 randomly selected licensed centers.²¹

Tennessee: These data were collected in 2007-08 as part of the TN STARS program from all licensed child care centers (1,315 infant/toddler classrooms and 1,972 preschool classrooms).²²

Massachusetts: The infant-toddler data were collected in 2004 from 102 centers serving infants and 104 centers serving toddlers. The ITERS-R mean presented in the table is an average of the ITERS-R for infants and toddlers. The preschool data were collected in 2000 from 90 centers serving preschoolers.^{23, 24}

Finally, the quality of the Abbott pre-kindergarten classrooms in New Jersey has improved over the last 8 years. In 1999-2000, the average ECERS score in pre-k classes in New Jersey was 3.9 and in 2007-08, the average ECERS-R score was 5.2.²⁷ These documented changes in quality demonstrate the improvements possible when investments are made to strengthen the quality of care.

Continued education and professional development are key strategies for improving the quality of early care and learning in Rhode Island. Moving programs to higher levels of quality will likely require a broad array of strategies including access to higher education and professional development opportunities. The professional development will need to be tailored to particular needs. Given that one-quarter of infant/toddler lead group teachers in this study had only a High School diploma or GED, the types of professional development and supports offered to these teachers will likely need to be different than those offered to preschool teachers, half of whom in this study had a Bachelor’s degree. Programs providing a low level of quality care may need basic information about health and safety practices and general child development. As decisions are made about developing, revising, and delivering professional development for the early childhood community, leaders should base their efforts on research. Research suggests that effective professional development is focused on specific content, actively engages participants, and is of sufficient duration.^{28, 29} On-site technical assistance also may be

useful in providing ongoing support to teachers to ensure that they have the depth of understanding and skills needed to translate knowledge into practice in the classroom.³⁰

Multiple strategies are necessary to support and sustain high quality early care and learning programs in Rhode Island. Strategies to strengthen the quality of center-based care may include continued education and professional development for teachers and administrators, technical assistance, teacher compensation initiatives, and program incentives for quality improvement.³¹ Strategies will be needed not only to *improve* the quality but also to *maintain* high quality early care and learning in Rhode Island. Compensation strategies, for example, will help attract and retain highly qualified individuals to ensure that Rhode Island’s young children have the best quality early learning experiences possible. Financial incentives, such as linking subsidy reimbursement to higher levels of quality, may also be useful in supporting high quality care and education.

Rhode Island leaders should use BrightStars to provide an overarching framework for organizing and aligning various aspects of the early childhood education system, including professional development. Organizing efforts around the BrightStars quality framework will help move Rhode Island toward an integrated, comprehensive system of early care and education.

In closing, Rhode Island KIDS COUNT and BrightStars leaders should be applauded for conducting a statewide study of child care. We hope that these findings will be useful in guiding Rhode Island’s future investments in improving the quality of center-based care and education for young children. ✍

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