

## **DEFINING AND MEASURING QUALITY IN HOME-BASED CARE SETTINGS**



**Research-to-Policy, Research-to-Practice Brief OPRE 2011-10d**  
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## **Defining and Measuring Quality in Home-Based Care Settings**

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This Research-to-Policy, Research to-Practice brief series focuses on issues related to the development and refinement of measures to assess the quality of early childhood settings. The views represented in this brief do not necessarily reflect the opinions of the Office of Planning, Research and Evaluation of the Administration for Children and Families.



Abt Associates Inc.



**OVERVIEW.** Fifty-seven percent of children under age six who are in non-parental care are cared for in a home, whether that of a relative or a non-relative provider. Just as with center-based settings, developing measures that accurately assess quality in home-based settings is vital to assuring positive child outcomes. To date, there is a paucity of evidence about which aspects of family child care are predictive of children's short-term and long-term cognitive, social, and academic outcomes and therefore which aspects of family child care environments should be included in a measure of quality of care. When designing and evaluating quality measures for home-based settings, the unique characteristics and variability of home-based care including mixed age groups, supports for parents, and different provider characteristics, must be considered. The continuing expansion in home-based care quality measures must keep up with the rapidly-growing research base on aspects of early development that appear to be linked to children's long-term social and academic success.

Home-based care (also referred to as family child care) is an important part of the early childhood education and care delivery system. It encompasses a complex variety of types, which vary on the provider's relationship to the children in and on whether the provider is part of the regulated care system or is unregulated, including license-exempt providers who care only for related children and unregulated providers who may or may not be exempt from regulation, depending on the number of children in care. Including all of forms of home-based care, it is estimated that about half of all child care is provided in home-based settings (West, Wright, & Hausken, 1996; Capizzano, Adams, & Sonenstein, 2000). The majority (60%) of children in the United States less than 6 years of age are in non-parental care, and 35 percent of these children are being cared for in the homes of relatives and 22 percent in the homes of unrelated providers (National Center for Education Statistics, 2005; Halle, et al., 2009). The percentage of children in home-based care settings is higher for infants and toddlers and for low-income and minority families than for preschool-age children and English-language speakers (Capizzano, Adams, & Sonenstein, 2000; NICHD ECCRN, 2004; Maher & Joesch, 2005; Rulf Fountain & Goodson, 2008). Further, these families are more likely to use relative care for their infants, by almost two to one compared with family child care by an unrelated provider (Casper, 1997; Capizzano, Adams, & Sonenstein, 2000; Snyder & Adelman, 2004; Maher & Joesch, 2005).

The fact that home-based care represents such a large part of the universe of early childhood education, combined with the preference for family child care among families whose children may be at increased risk for learning and developmental problems, makes it imperative that we can define and measure the quality of the care in these settings. It is especially important to have the tools to ensure that these children are in the kinds of care environments that promote learning and development.

Research on quality in the family child care system has lagged behind research on quality in center-based preschool programs. There has been relatively little research documenting the relationship between quality in home-based care and child outcomes, and all of the research has been observational as opposed to causal. The limited amount of research may be related to the lack of consensus about how quality should be defined across the different home-based settings, to limited options for measurement of quality, and/or the many challenges involved in conducting research on home-based care (for example, locating and recruiting a sample of providers who represent the entire spectrum of family child care, collecting data in settings under difficult conditions). There is a paucity of evidence about which aspects of family child care are predictive of children's short-term and long-term cognitive, social, and academic outcomes and therefore which aspects of family child care environments should be included in a measure of quality of care.

Although many studies have reported positive relations between quality of center-based care and children's outcomes, for family child care, there are fewer studies and their results have been inconsistent and small. The Study of Children in Family Child Care and Relative Care (Galinsky, Howes, Kontos, & Shinn, 1994) found three indicators of quality of family child care—provider sensitivity, provider responsiveness and global quality—that were related to the security of the child's attachment (as rated by the provider) and the child's cognitive development (as demonstrated by the complexity of their play with objects, but not to social competence). These relationships were reported to be similar for regulated, non-regulated, and relative providers, and for children from all demographic groups. A number of studies of the relationship of child care quality to child outcomes have used data from the NICHD Study of Early Child Care across the age range from birth through preschool. At 6 months of age, in homes as well as centers, small group sizes, low child-adult ratios, non-authoritarian child-rearing beliefs of the caregiver, and safe, clean, and stimulating physical environments were consistently associated with positive caregiving behaviors (NICHD ECCRN 1996). At age 3, children in center care performed better than children in other types of care, but earlier experience in child care homes was associated with better performance at age 3 than was experience in other types of care; this finding held regardless of the quality of the family child care homes or centers (NICHD ECCRN, 2000, 2001). A study of community care arrangements (child care centers and family child care homes) on the development of low-income children found that higher levels of child care quality were modestly associated with improvements in children's socioemotional development and extensive hours in child care were linked to increase in children's quantitative skills and decreases in behavior problems (Votruba-Drzal, Coley, & Chase-Lansdale, 2004). This study did not distinguish relationships of quality and outcomes for centers and homes.



The small number of studies that have examined the relationship of quality and child outcomes for home-based care, combined with the lack of evidence of a strong relationship in the studies that have been done, does not obviate the need to develop ways to measure quality in home-based care that are valid, psychometrically sound, and useful for answering research and policy questions. Developing quality measures for home-based care has been a challenging endeavor, because the field continues to struggle with important definitional issues.

One issue involves whether regulated and unregulated family child care is so different that no single definition of quality could be valid for all of them. A number of research studies have documented broad differences related to the regulatory status in provider characteristics, provider reasons for providing care, and qualities of the home environments. One side of the argument is that all children, regardless of the type of home-based care settings they are in, deserve the same opportunities and support for learning and development. The other side of the argument focuses on differences across types of care in the way the provider views herself (i.e., the grandmother may not perceive of herself as a teacher or facilitator of the child's learning), which would argue for different definitions and measures of quality. Although researchers have attempted to develop quality measures specific to informal care, to date the focus has been on formal home-based care.

Another third question is whether the definition of quality for family child care should include aspects of care that are unique to home-based settings and that are potential albeit untested factors in promoting children's developmental outcomes, such as mixed age groupings, care for siblings of different ages in the same setting, and supports for parents. While all early childhood care settings can be thought of as supporting parents by providing child care while the parent works, home-based care settings typically offer more flexibility to accommodate the often challenging work schedules of low-income working parents, by providing off-hour care or care on an irregular schedule or being flexible about times for pickup or drop-off. Also, because the home-based provider takes care of a relatively small number of children and multiple children in the same family, there may be a greater opportunity for parents and providers to develop personal relationships, which can be a source of social support for the parent.

Eleven observational measures of quality in home-based care are reviewed below. Until recently, researchers interested in systematic measurement of the quality of home-based care have had a constrained choice. Most of the research on quality in home-based care settings has relied on a single measure of quality, the Family Day Care Rating Scale (FDCRS, 1989; FCCERS-R, 2007). The measure relies on observation of a family child care home and a small set of questions for the provider, and produces a single quality rating ranging from 1 (inadequate) to 7 (high) based on scores on six subscales,. The FDCRS has been widely-used in research on family child care; it also has the unique advantage of having a "companion" rating system for center-based centers (ECERS-R, 2005), which has facilitated comparisons across setting types on level of quality. At the same time, there have been the measures. Some researchers have expressed concern that the FDCRS is inadequate in measuring environmental factors supporting children's language development and the acquisition of specific foundational skills in early literacy. As one senior member of the field has suggested, despite their advantages, the FCCERS-R (as well as the ECERS-R) does not provide sufficient information about "aspects of classrooms that are directly linked to supporting early literacy" (Dickinson, 2002, p. 28). Other concerns involve the philosophical approach embedded in the items that defines high quality in terms of child access to and choice of activities and materials. That is, for a substantial number of items on the scale, high scores depend on child-directed choice of materials and activities for most of the day, and adult involvement in these decisions lowers the quality rating. Third, there are questions about whether a quality rating should weight health and safety so heavily, as opposed to having those aspects of a care setting be the responsibility of the licensing agencies. Finally, there have been some criticisms of the format of the scoring system, since it is designed so that providers who fail to pass lower-quality items are not even assessed on some important higher-quality indicators (e.g., Layzer & Goodson, 2006).

In the last ten years, other measures of quality have been developed that, although having been used on a much smaller scale compared with the FCCERS-R, provide promise for extending our assessments of quality in home-based care both in breadth and in depth (Halle & Vick, 2007). Some of these measures reflect the now strong and compelling evidence that links the quality of developmentally appropriate language and literacy experiences with both school readiness skills (e.g., Dickinson & Neuman, 2005) and later reading achievement (National Early Literacy Panel, 2008). Many of the new measures of quality in home-based care have been described in a recent compendium of quality measures (Halle et al., 2007). Tables 1 and 2 describe ten observation measures in addition to the FCCERS-R, which either have been developed specifically for home-based settings or are reported to be valid for both home-based and center-based care settings. Table 1 describes some of the basic features of the measures and Table 2 describes the primary domains assessed with each measure.

**Table 1*****Observation Measures of Quality of Home-Based Care Settings: Basic Features***

Measure	Age Range	Description	Observation Period	Key Reference
<b>FCCERS-R:</b> Family Child Care Environment Rating Scale—Revised <sup>a</sup>	2.5-5 years	Provider interview and observation 43 observation items, each rated on 7 pt. scale	3 hour observation + 20 minute provider interview	Harms, Clifford, & Cryer, (2007)
<b>CHELLO:</b> The Child/Home Early Language and Literacy Observation <sup>b</sup>	Birth – 5 years	Literacy environment checklist –22 dichotomous items; provider Interview; and group/family observation—42 items rated on 5 pt scale	1.5 hours	Neuman, Koh, & Dwyer, 2008
<b>APFCCH:</b> Assessment Profile for Homes with Young Children <sup>c</sup>	Birth – 5 years	Provider interview and observation 178 dichotomous items	4 – 6 hours	Abbott-Shim, & Sibley, (1998)
<b>IT-CC-HOME:</b> Infant-Toddler Child Care HOME	Birth – 3 years	43 dichotomous items	1 hour	Bradley, Caldwell, & Corwyn, (2003)
<b>EC-CC-HOME:</b> Early Childhood Child Care HOME	3 – 6 years	58 dichotomous items	1 hour	
<b>CCAT-R:</b> Child Care Assessment Tool for Relatives	Birth – 6 years	Provider interview and observation. Time-sampled observation and summary items	2 – 2.5 hours	Porter, Rice, & Rivera, 2006
<b>CIS:</b> Caregiver Interaction Scale <sup>d</sup>	Toddlers – Kindergarten	26 items rated on 4 pt. scale	1 hour	Arnett, 1989
<b>CLASS:</b> Classroom Assessment Scoring System <sup>d</sup>	PreK & K-3 versions; toddler version in development	30-min. observe-code cycles; 10 dimensions rated on 7 pt. scale	2 -3 hours	Pianta, La Paro, & Hamre, 2007
<b>QUEST:</b> Quality of Early Childhood Care Settings: Caregiver Rating Scale <sup>d</sup>	Birth – 5 years	Environment Checklist—115 items rated on 3 pt scale and Provider Checklist— 69 items rated on 3 pt scale & 10 summary items	2 -3 hours	Goodson, Layzer, & Layzer, 2005
<b>ORCE:</b> Observational Record of the Caregiving Environment <sup>d</sup>	Birth – 5 years (available at 6, 15, 24, 36, 54 months)	Observation cycle includes coding of behavioral scales (in 30 second intervals) and qualitative ratings based on the entire observation cycle.	Two to four 44-minute observation cycles	NICHD ECCRN, 1996 & 2001
<b>C-COS:</b> Child-Caregiver Observation System <sup>d</sup>	1 – 5 years	Time-sampled observation & 3 quality ratings on 5 pt scale	2 hours	Boller & Sprachman, 1998

<sup>a</sup> Parallel version of measure is available for center-based care: ECERS-R (Early Childhood Environment Rating Scale—Revised Edition) and ITERS-R (Infant/Toddler Environment Rating Scale—Revised Edition)

<sup>b</sup> Parallel version of measure is available for center-based care: ELLCO (Early Language and Literacy Classroom Observation Tool--PreK)

<sup>c</sup> Parallel version of measure is available for center-based care: APECP (Assessment Profile for Early Childhood Programs: Research Edition II)

<sup>d</sup> Measure can also be used with caregivers in center-based care

As shown in Table 1, all of the measures are valid for home-based settings. Only one, the CCAT-R, is limited to inform home-based care settings. The measures are all valid for settings serving a range of ages, covering at least toddlers and preschoolers, and some extend the range downward to also cover infants. Eight of the measures focus on the provider and the home environment; two measures, the Observational Record of the Caregiving Environment (ORCE) and the Child-Caregiver Observation System (C-COS) focus on individual children and the behavior of the provider with that child. The measures range from 10 to nearly 200 items and specify 1 to 6 hours of observation. Table 2 shows that all of the measures cover multiple dimensions of provider/child behavior, and all but two also assess the resources, organization, and activities or schedule of the setting. The dimensions covered by these measures indicate that there is strong agreement that quality in home-based care is most centrally about the behavior of the provider with the children. In terms of what is assessed about the provider interactions with children, all of the measures include items on the quality of the affective relationship between the provider and the child (warmth, responsiveness, management style). The measures also include items on provider support for children's cognitive, language and socio-emotional development. At the same time, the measures tend to focus on general principles such as providing learning opportunities rather than on specific instructional practices and do not reflect the growing research-based understanding about effective instructional practices. The exception is the Child/Home Early Language and Literacy Observation, which examines specific instructional practices, in this case, to support children's language development and early literacy skills. Only the FCCERS-R and the QUEST also encompass health and safety issues. Only the FCCRS assesses the provider's relationship with the parent, and the FCCERS-R and the APFCH include items on the professional development of the provider.

Half of the measures can be used with both center-based and home-based care, primarily because they focus on the quality of the caregiver/child interactions such as the extent to which the caregiver is responsive and nurturing or whether caregiver/child interactions are characterized by rich, complex, individualized language interactions. The more broadly the quality measure focuses on aspects of the physical environment, the less likely it is that the measures for family child care are also appropriate for use in center settings.

On the question of whether formal and informal home-based settings should be evaluated using the same quality ratings, most of the measures state that they are valid for all types of home-based care (or do not address the distinction at all). It is not clear that most of the measures have ever been used with informal care, so this question appears to remain open to discussion.

A final question is the extent to which the existing quality measures focus on experiences that may be unique to home-based care. One possible strength of family child care as cross-age interactions in mixed age homes that could build children's social and emotional skills, but only the child-focused measures assess interactions among the children in care and these measures focus on the overall positive or negative tone of the interactions. If the field is interested in documenting ways in which home-based providers support positive interactions across age groups in care, including the strategies providers use to give older children roles in caring for and helping younger children learn, then the measures of quality will have to be extended to this area.

**Table 2***Observation Measures of Quality of Home-Based Settings: Domains Assessed*

Measure	Domains Observed													
	Provider/Child Interactions						Home Environment		Health & Safety	Parent		Provider		
	Emotional Support/ Responsivity	Management/ Discipline	Language interactions/ Simulation	Involvement	Support for learning/ Cognitive stimulation	Support for social development	Organization	Resources/Learning materials	Activities/Schedule	Child-child interactions	Physical safety	Health and nutrition	Communication/ Relationship	Supports for parents
<b>FCCERS-R:</b> Family Child Care Environment Rating Scale*—Revised <sup>a</sup>	X	X	X	X	X		X	X	X		X	X	X	X
<b>CHELLO:</b> Early Language and Literacy Classroom Observation <sup>a</sup>					X			X						
<b>APFCCH:</b> Assessment Profile for Family Child Care Homes <sup>a</sup>					X						X	X		X
<b>IT-CC-HOME:</b> Infant-Toddler Child Care HOME	X			X			X	X						
<b>EC-CC-HOME:</b> Early Childhood Child Care HOME	X		X		X			X						
<b>CCAT-R:</b> Child Care Assessment Tool for Relatives		X	X		X	X							X	
<b>CIS<sup>b</sup>:</b> Caregiver Interaction Scale <sup>b</sup>	X	X		X										
<b>CLASS<sup>b</sup>:</b> Classroom Assessment Scoring System <sup>b</sup>	X	X	X		X		X	X						
<b>QUEST:</b> Quality of Early Childhood Care Settings: Caregiver Rating Scale <sup>b</sup>	X	X	X	X	X	X	X	X	X		X	X		
<b>ORCE:</b> Observational Record of the Caregiving Environment <sup>b</sup>	X	X	X		X				X	X				
<b>C-COS<sup>b</sup>:</b> Child-Caregiver Observation System <sup>b</sup>			X						X	X				

Another possible strength of home-based care involves supports for parents, including flexibility in care hours and schedule to serve the needs of working parents with irregular or off-hour jobs, the convenience of parents having a single provider for their children of different ages, and the personal support that may be provided by families having a sustained relationship with the same provider both because a child may spend multiple years with the same provider or because a family uses the same provider for multiple children, which means their relationship with the provider could span an even wider range of years . None of the measures addresses any of these potential strengths of family child care. The CCAT-R asks about the relationship of the parent to the related provider and allows for the possibility that relative care may bring with it tensions as well as supports. One of the challenges of including these dimensions in measures of quality is that there is virtually no research to that has looked at the relationship of these dimensions to child outcomes. Although the options for assessing quality in home-based care are increasing, no measure provides comprehensive coverage of some of the areas where home-based care may provide unique advantages. Since it is unlikely that a single quality measure will be unable to fulfill all purposes, researchers need to be clear about why they are measuring quality and to select the measure that best meets their specific purpose.

## **Future Directions**

There is a need for continued development of a comprehensive definition of quality of care in home-based settings and measures to assess quality. Two areas merit increased attention. One area involves the question of whether and how to judge the quality of informal care; evaluating the quality of this form of care is an important policy issue, since informal care is a modal form of care for our youngest children, for children from low-income families, and children from minority language and cultural backgrounds. Rating informal care using existing quality measures, most of which were designed for formal settings, are likely to conclude that informal settings are not providing high-quality developmental and learning opportunities. Although it can be argued that the measures are not appropriate for informal care, it is also important that we understand the limitations of different types of care settings and develop strategies to support higher quality environments that provide children with enhanced rather than reduced opportunities.

A second area for additional development is ensuring that quality measures reflect the most up-to-date developmental research. For example, in the area of language development, we are only beginning to establish developmental goals for children who are multilingual or multicultural.. Any definition of quality of care for these children will need to include goals for strong oral language skills in both languages the child speaks, with potential priority for strengthening the home language for the youngest children. In the field of socio-emotional development, the theoretical “map” is changing with new research on how children develop adaptive behavior skills. This is crucial, since research increasingly points to the importance of cognitive self-regulation for the child’s ability to focus, attend and learn (e.g., Bodrova & Leong, 2007; Diamond, Barnett, Thomas, & Munro, 2007).

Increasingly, early child care and education is expected to function as an intervention for the children who are at-risk of reaching school entry without having developed the skills and knowledge that predict school success. That is, the care environments for at-risk children are expected to provide experiences likely to remediate gaps in children’s learning opportunities and to accelerate their developmental progress, so as to “close the gap” between their skills and those of their more advantaged peers. If this is to be a valid expectation, knowing what environmental factors in home-based care promote strong child outcomes and how to measure their presence in homes will be crucial for understanding how to support providers in delivering quality care to children.

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## **Overview for OPRE Research Brief Series on Measuring Quality in Early Care and Education Settings**

Measures to assess the quality of early care and education environments, originally developed as research tools and, in some cases, as guides for improving practice, now play a prominent role in the early childhood policy arena. Many states use information from on-site observations and environmental rating scales to make decisions about inclusion of programs in publicly funded initiatives and interventions, to target quality improvement dollars and to target incentives when programs meet higher quality standards. To date, the majority of states that have developed statewide Quality Rating Systems combine scores on observational measures of quality with other quality indicators to provide a rating that is available to the public. The intent is to provide better information to parents, and to provide a framework within which quality benchmarks, financial support, technical assistance, and monitoring create leverage for quality improvements in early care and education.

Yet the use of quality measures in “high-stakes” policy and programmatic decisions raises important new questions about their content, reliability, validity, and applicability with diverse populations across a broad range of settings. To address these questions, the Office of Planning, Research and Evaluation in the Administration for Children and Families of the U.S. Department of Health and Human Services and other federal partners convened a meeting of researchers, state policymakers, practitioners and other key stakeholders. The meeting provided a forum for analyzing current quality measures, engaging in critical discussion about the use of quality measures in the policy arena, and outlining the steps needed to improve measurement strategies.

The four coordinated research briefs in this series were developed based on presentations made at the meeting, with the intent of informing policymakers, researchers and practitioners about new developments in quality measurement being generated at the intersection of child development research and early childhood policy.

- The first paper (by Martha Zaslow, Kathryn Tout and Ivelisse Martinez-Beck) describes why and how quality measures are currently used in policy and practice contexts and the issues and concerns that arise as a result of this widespread use.
- The second paper (by Margaret Burchinal) reviews the literature on the dimensions of quality that have been measured in early care and education settings and identifies the quality dimensions that have received a more thorough treatment in the literature compared to those that have not been studied as extensively.
- The third and fourth papers review the quality measures that have been developed for use in center-based early care and education programs (paper by Donna Bryant) and home-based settings (paper by Barbara Goodson and Jean Layzer). In addition to highlighting the types of measures used, their psychometric properties, and their value in predicting child outcomes, the authors discuss the importance of the findings for policymakers and practitioners.

Overall, we hope that the four papers provide a useful review of the current state of the field of quality measurement and suggest important next steps that policymakers, researchers, and practitioners can take to assure the integrity of measurement strategies and the appropriate use of data on the quality of early care and education settings especially when measures are widely implemented in policy and practice initiatives.

Those interested in the issue of the measurement of quality in early childhood settings may also want to read these OPRE briefs:

Burchinal, P., Kainz, K., Cai, K., Tout, K., Zaslow, M., Martinez-Beck, I. & Rathgeb, C. (2009). *Early Care and Education Quality and Child Outcomes*, OPRE Research-to-Policy Brief. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Tout, K., Zaslow, M., Halle, T. & Forry, N. (2009). *Issues for the Next Decade of Quality Rating and Improvement Systems*, OPRE Issue Brief. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Zaslow, M., Tout, K., Halle, T., & Forry, N. (2009). *Multiple Purposes for Measuring Quality in Early Childhood Settings: Implications for Collecting and Communicating Information on Quality*, OPRE Issue Brief. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.