

Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy

A Research-to-Practice Brief
OPRE Report #: 2016-46
May 2016

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Approximately half of all children under the age of three in the United States have a regular child care arrangement (nearly 44 percent of infants from birth to 12 months, 52 percent from 12 to 24 months, and 56 percent from 24 to 36 months; NSECE Project Team, 2015). The percentages of infants and toddlers in center-based care increases with age, with nearly nine percent of infants from birth to 12 months, thirteen percent of infants from 12 to 24 months, and twenty percent of toddlers 24 to 36 months of age in center-based care (NSECE Project Team, 2015). Research suggests high-quality care and learning programs that begin early in life have the potential to improve developmental outcomes as well as close gaps in educational achievement for young children

(Mayoral, 2013; NICHD, 2005; Yazejian, Bryant, Freel, Burchinal, & the Educare Learning Network Investigative Team, 2015). However, observed quality in infant and toddler settings is low in general (Phillips & Lowenstein, 2011; Vogel et al., 2011) and often lower than in preschool settings (NICHD, 2005).

Quality in infant and toddler settings includes various features such as low child to staff ratios, small group size, and specialized teacher education and training. However, given the unique developmental characteristics of infants and toddlers, a specific focus by practitioners and policymakers on developing and supporting relationships between young children and their teachers is needed

(Horm et al., 2016). (See Text Box 1) Relationships are critical for positive, healthy infant development and help provide a framework for exploration and future learning (Shonkoff & Phillips, 2000). When an infant is able to establish a relationship with a sensitive and responsive caregiver, the infant learns who to trust and turn to when needing support (Howes & Spieker, 2008). Additionally, a secure relationship provides a base from which the infant can explore the world and build knowledge. Sensitive and responsive caregiving can also impact child outcomes. When infants have sensitive and responsive caregivers, they are more likely to show greater language development and greater levels of peer play (NICHD, 2005).

Thus, relationship-based care practices are a priority area for practice and policy initiatives designed to strengthen quality standards in infant and toddler early care and education settings (Schmit & Matthews, 2013). This brief describes relationship-based care practices and the research support for a focus on relationships in infant and toddler care. We emphasize two specific relationship-based care supports – primary caregiving and continuity of care. We then present practice considerations for child care directors and owners regarding adopting or enhancing relationship-based care practices, and discuss the implications of state standards for incorporating these practices into programs that serve infants and toddlers.

This brief focuses on implementation and standards in center-based settings because family child care homes are already structured to support relationship-based care practices from infancy through age three due to small numbers of children and caregivers. However, considerations for implementation of relationship-based care practices in centers may also be relevant to group child care homes serving infants and toddlers.

What are Relationship-Based Care Practices?

Relationship-based care practices are elements of a child care program that help support relationships between staff and the infants and toddlers in their care. At the core of relationship-based care practices are policies, procedures, and practices (or specific components) that



support families, teachers, and children as they build relationships with and among each other. Through these interactions, families, teachers, and children begin to understand each other's specific needs, such as how to communicate with each other so that the child's needs are met. For example, teachers may take time to learn about families' cultural values and child-rearing practices and work in partnership with the family to honor those practices in the child care setting. Relationship-based care programs can also promote other ways of strengthening the family-teacher partnership by providing information to families on topics such as the child's development and sharing parenting information that may be helpful to the family. In turn, strong relationship-based care practices will make children feel safe and secure in their child care environment, make families feel welcome and feel like their child care provider can address their concerns in a positive manner and celebrate the milestones their child achieves (Raikes, 2009). In essence, relationship-based care practices build trust, comfort, security, and represent a partnership in the care of the child. These practices can positively impact the child's cognitive, language, and social-emotional development (McMullen & Dixon, 2009).

Two main practices underlie relationship-based care in child care settings: primary caregiving and continuity of care. Primary caregiving and continuity of care both include structural and process features of child care quality for infants and toddlers.

What is Primary Caregiving?

Primary caregiving is the practice of assigning one teacher the primary responsibility for the care of a small group of children within a larger group setting. The primary caregiver takes the lead role in establishing relationships with the children and families in their care by providing intentional and individual care for the child's routine needs such as feeding, sleeping, and diapering times. Additionally, the primary caregiver interacts with their primary caregroup to provide intentional learning experiences, documents the child's developmental progress, and communicates with parents on a regular basis.

What is Continuity of Care?

Continuity of care involves keeping children and their caregivers together for an extended time, preferably until children are 36 months old, instead of moving children to a new group or a new caregiver based on age or on the achievement of developmental milestones (Program for Infant/Toddler Care, n.d.).

The Importance of Relationship-Based Care Practices

Babies are born wired for relationships. They naturally seek interactions with others through their coos, babbles, cries, and facial expressions toward an adult, and generally parents are the first recipients of these bids for interactions. When adults respond in appropriate ways through imitation or by meeting infants' needs, they are not only building relationships with babies, but they are also building the foundation necessary for healthy brain development (Center for the Developing Child, n.d.; Lally, 2011). These exchanges help babies understand who to seek out when they need something and also helps

TEXT BOX 1

Quality in Child Care Settings

Relationship-based approaches fit well within definitions of structural and process quality for infant and toddler care (McMullen & Dixon, 2009). Aspects of *structural quality*, which include low child to staff ratios and smaller group sizes, can help create environments where young children receive more responsive care (NICHD, 1996; Ruprecht, Elicker, & Choi, 2015). These structural aspects of quality are generally set by state licensing regulations (see Appendix A) and have a more indirect impact on children's development (NICHD ECCRN, 2002).

Process quality features include the interactions and communication between children and caregivers. These features of quality are at the heart of relationship-based caregiving practices and have direct impact on child development (NICHD ECCRN, 2002; 2005). It is important to note that process quality is supported by structural quality factors (NICHD ECCRN, 2002) as well as other intentional relationship-based care practices such as keeping teachers and the infants they care for together for longer periods of time (Raikes, 1993).

shape their developing brain. When babies' bids for attention are met with responsiveness and sensitivity, they develop attachment relationships with their parents or primary caregivers. These attachment relationships help babies build and establish the strong social emotional base they need in order to help prepare them for later learning. This secure base gives babies the freedom to explore their world and gain experiences that are the foundation of learning (Ahnert, Pinguart, & Lamb, 2006; Howes & Spieker, 2008).

As young children grow and develop, these relationship-building tactics extend beyond the parent relationship and toward other adults who spend significant time with them.

When babies enter out of home child care, they naturally seek the same type of positive, responsive relationships with adults who provide care for them. Babies need opportunities and time to establish strong relationships with their child care teachers (Dombro & Lerner, 2006; McMullen & Dixon, 2009). Unfortunately, most child care programs do not have policies or practices that support relationship-based care practices such as primary care and continuity of care with young children (Cryer, Hurwitz, & Wolery, 2000).

Findings from the Research on Relationship-Based Care Practices

The research supporting relationship-based care practices is mostly based on studies examining attachment relationships between infants and toddlers and their child care teachers or on instability of child care staff, rather than on research that specifically examined relationship-based care practices. However, much can be taken from this research and applied to the practice of relationship-based care.

Previous research on both parental and non-parental caregiver attachment shows that infants who experience stable, consistent, sensitive, and responsive care from their primary caregivers develop more secure attachment relationships (Ahnert, Pinquart, & Lamb, 2006; Howes & Spieker, 2008; Raikes, 1993). These relationships provide a secure emotional base for the infant to explore their world and support their cognitive and emotional development, well-being, and social competence (Ahnert et al., 2006; Van IJzendoorn, Vereijken, Bakersmans-Kranenburg, & Riksen-Walraven, 2004). Relationship-based care practices can facilitate attachment between infants and caregivers by supporting the opportunity for caregivers to learn and respond to infants' cues and for infants to develop an understanding of their caregiver as a secure base.

Some studies on changes in caregivers and caregiving environments have found that, for children in non-parental care settings, changes were disruptive to young children's development. Research defines changes in various ways, such as any change in caregiver, the

length of time that a caregiver was with a child (e.g., a few months), or comparing children's interactions with caregivers who have spent more or less time with a child. These studies may not directly examine continuity of care, but can be useful to understand how disrupted caregiving may affect child development. For example, Howes and Hamilton (1993) found that children who changed caregivers before 24 months of age were less securely attached to their caregivers and were more aggressive compared to children who remained with their teachers. Other studies found children ages 18-30 months who experience multiple caregivers or multiple child care arrangements over a course of a day are more likely to have more behavioral problems (deSchipper et al., 2004; Morrissey, 2009).

Caregiver stability may impact young children's interactions with their caregivers in both stressful and non-stressful situations. Barnas and Cummings (1994) examined the responses of infants and toddlers ranging from 11 to 27 months to "stable versus non-stable" caregivers, operationalizing stable caregivers as those who had been with the children for more than 3 months, and found that when toddlers were distressed, they initiated greater proximity and comfort-seeking behaviors toward more stable caregivers. Even without immediate distress, toddlers more often sought out the more stable caregivers, suggesting they were using them as a source of comfort and security. Note that stability in other relationships in child care settings can also be beneficial for children, such as relationships between caregivers and parents and among peers, but the caregiver-child relationship is the focus of this brief.

The research on the effects of providing stable caregivers over time indicates there are positive developmental outcomes for children. However, the specific research on one relationship-based care practice – continuity of care, where stability of the caregiver is for a prolonged period of time (i.e., up to age 36 months) – is rare and findings have not been as consistent. Some research has shown that children in child care programs that promote continuous relationships have teachers who are more responsive and are more engaged with them (Raikes, 1993; Ritchie & Howes, 2003; Ruprecht, Elicker, & Choi, 2015). One study found that children enrolled in continuity programs had

caregivers that were more responsive, affectionate, and talked more to children compared to children who were not in continuity programs, with some variations by race/ethnicity (Owen et al., 2008) and some research has shown little impact on children's behavior and developmental outcomes (Cryer, 2007; Cryer et al., 2005). Furthermore, much of the existing research focuses on preschool age children rather than infants and toddlers (Ritchie & Howes, 2003; Owen et al., 2008).

Of the studies examining the impact of continuity of care practices with infants and toddlers, it has been found that caregiving continuity is associated with teacher knowledge and communication with families, and with young children's development and well-being. Continuity promoted teachers' more in-depth knowledge of individual infants and toddlers and positive working partnerships between families and teachers (McMullen, Yun, Mihai, & Kim, 2016). One study found teachers in classrooms whose centers attempted to implement continuity of care rated toddlers as having fewer behavioral problems compared to teachers in non-continuity classrooms. Toddlers in continuity classrooms also experienced more interactive involvement from their caregivers compared to toddlers in non-continuity classrooms (Ruprecht, Elicker, & Choi, 2015). In another study, Howes and Hamilton (1992) followed a sample of 72 children in child care from the toddler to the preschool years. They found when caregivers remained the same, attachment security was stable over time. However, when caregivers had changed, children were observed to be less secure with their caregivers at 24 and 30 months. In sum, while more specific research is needed, the small body of research to date suggests that relationship-based care practices can positively impact and support children's development and minimize the negative effects of frequent changes in caregivers.

Support in the Field for Relationship-Based Caregiving Practices

Although there have been few studies with mixed findings, there is support in the field and among prominent national early childhood organizations for the importance of creating and promoting environments where young children and

TEXT BOX 2

Examples of Early Childhood Organizations and Programs that Support Relationship-based Care Practices

National Association for the Education of Young Children (NAEYC) – national membership organization of early childhood professionals and programs that supports high-quality child care through its program accreditation standards. NAEYC recommends as best practice low child to staff ratios and group size (no more than 4:1 and group size of 8 for children birth-15 months); policies for keeping infants and toddlers and staff together for at least 9 months; and that “every attempt is made to maintain continuity of relationships between teaching staff and children and among groups of children” (NAEYC, 2015, p. 89).

Program for Infant/Toddler Care (PITC) – research-based policy and practice organization that provides recommended practices for high-quality infant and toddler group care. Its core activities include designing programs and training infant and toddler practitioners on how to implement small group size, primary care, and continuity of care. The PITC approach has six essential program policies: primary care; small groups; continuity of care; individualized care, inclusive care, and culturally responsive care (www.pitc.org).

Ounce of Prevention Fund – coordinates 21 Educare schools around the country for young children, birth to age 5 and their families living in poverty (<http://www.educareschools.org>). Educare promotes the principles of relationship-based care, including small groups and low child to staff ratio, primary caregiving, and continuity of care for infants and toddlers. Research on Educare programs has found that their programs provide high-quality infant toddler care and that early entry and consistent enrollment over time makes a difference in child outcomes in receptive language, with stronger effects for dual language learners (Yazejian et al., 2015).

their teachers have the opportunities to develop close relationships (see Text Boxes 2 and 3). Guidelines in *Caring for Our Children* (American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care, 2011) recommend that centers use relationship-based practices that promote consistency and continuity of care for infants and toddlers. The National Association for the Education of Young Children (NAEYC), Early Head Start, Zero to Three, the Program for Infant/Toddler Care, and the Ounce of Prevention Fund are examples of organizations and interventions that promote practices and policies that support continuous relationships between teachers and young children, low child to staff ratios, and smaller group sizes. While these organizations support relationship-based care practices through accreditation, training, and their own practices, few centers implement these practices (Cryer et al., 2000; Lally, 2009) and few state Quality Rating and Improvement System (QRIS) standards address these recommended practices for infants and toddlers. However, nearly half of all states have language addressing primary caregiving in state child care regulations (see Appendix A3).

In the next sections, we will present (1) practice considerations for child care directors and owners regarding adopting or enhancing relationship-based care practices in their own programs, and (2) policy considerations for federal and state policymakers regarding the implications of standards for incorporating relationship-based care practices in programs that serve infants and toddlers.



TEXT BOX 3

Relationship-Based Care Practices in Early Head Start

Through its performance standards, Early Head Start articulates the importance of relationships through primary caregiving and continuity of care by requiring:

Grantee and delegate agencies' program of services for infants and toddlers must encourage the development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time and trust and emotional security so that each child can explore the environment according to his or her developmental level.

Early Head Start recommends that programs consider assigning one primary caregiver to each child in center-based EHS programs, or one home visitor assigned long term in home-based programs. They also recommend limiting transitions within the day/week/month/year to ensure continuity of care.

The Notice of Proposed Rulemaking (NPRM) issued in 2015 proposes recommending that center-based EHS programs assign children in infant and toddler classrooms “a consistent, primary teacher to promote continuity of care,” and proposes that mixed-age classrooms be encouraged.

Early Head Start Performance Standards, 1304.21(b)(i). Head Start Program Performance Standards NPRM, 2015

Considerations for Implementing Relationship- Based Care Practices in Centers Serving Infants and Toddlers

A challenge facing early care and education program directors is how to implement the relationship-based care practices recommended by the research literature and promoted by national early childhood organizations. The implementation of relationship-based care practices has logistical consequences for center staffing, organization, and space and facilities, plus practical and financial impacts on center operations.

We emphasize there is no one way to implement these approaches that will work for every child care facility. We also emphasize these practices are not one complete package of activities and strategies that must be implemented all together. Various practices can be implemented one at a time, perhaps in stages, to ease the transition for staff, families, and centers. For example, programs may consider implementing the necessary structural elements such as small group sizes and low child to staff ratios before implementing the process elements of primary caregiving and continuity of care (McMullen & Dixon, 2009). Programs may also implement specific training and professional development activities to enhance the competencies needed to implement relationship-based care practices, such as learning about and embedding aspects of how to establish positive, responsive relationships with young children, learning about the different developmental stages of children birth-36 months, and how to engage in meaningful family engagement practices. The following section describes different ways to implement two of the relationship-based care practices, primary caregiving and continuity of care.

Implementing Primary Caregiving Practices in Centers Serving Infants and Toddlers

Implementing primary caregiving involves children, parents, the child care teacher, and director making decisions about which teacher will be primarily responsible for the majority of the care of the infant while in child care. It should not be confused with *exclusive* caregiving. Although one primary caregiver is primarily responsible for a small group of children, both teachers in the room assist each other when the other is busy or out of the room.

The following options address ways in which program administrators can implement this practice (see also Text Box 4, Primary Caregiving Responsibilities).

- ▶ **Assignment of a primary caregiver.** A child care program can assign a primary caregiver to each infant at the time of enrollment in the program, or the classroom teachers can decide which children will be in each primary care group. Some programs may consider having the children identify their primary caregiver, which they can determine by being attuned to which teacher the child responds to the most. The primary caregiver is primarily responsible for the child's care, keeping track of the child's development, and communicating with the child's family.

It is not enough for teachers and directors to make a primary care assignment. The primary care assignment should be based on each infant and toddler's specific needs and which caregiver can best respond to those needs. In addition, the family's characteristics and needs should be taken into consideration as well, particularly if there are family cultural contexts in which some teachers may have more experience than others.

- ▶ **Small groups.** To help promote attentive and meaningful interactions, the primary care group should be limited to three or four children (Snyder, 2011). Creating a small group with one teacher allows young children to get used to routines and schedules of the caregiving environment and enables the teacher to interact responsively and sensitively with each child.
- ▶ **Schedules and shifts.** Primary caregivers' shift and daily schedules can be arranged to facilitate availability to the children they care for at important bonding and caregiving parts of the day. These might include rest times and feeding times, and when the children in the primary group arrive and depart to facilitate the transitions between home and child care. Caregivers' absences during parts of the day, such as for planning time or breaks, could be scheduled around these times.
- ▶ **Communication with children and parents.** Ideally, the primary caregiver is the person who most frequently communicates with parents about the children in the primary care group to facilitate consistent care between the home and child care settings. Primary caregivers can talk with children and parents about absences, vacations, and other staff changes, and notify parents with whom they should talk in the primary caregiver's absence.

During times when the primary caregiver may not be available to each of the children in her group, continuity of care can be maintained by providing children with a familiar and stable set of **secondary caregivers**. Implementation may include:

- ▶ **Assignment of a secondary caregiver.** A secondary caregiver should be assigned to ensure that someone who is familiar to each child is responsible for that child's care at all times. The secondary caregiver may care for the child across teacher shifts and across temporary or longer-term absences of the primary caregiver.

TEXT BOX 4

Primary Caregiving Responsibilities

- ▶ Teacher assigned to a small group of children
- ▶ Primary caregiver interacts with primary care group during snack/meals and/or feeds infants in their primary care group at least 75% of the time
- ▶ Primary caregiver is responsible for diaper changes for the primary care group at least 75% of the time
- ▶ Primary caregiver soothes children in the primary care group to sleep 75% of the time
- ▶ Primary caregiver interacts with children in the primary care group via book reading, play time, etc.
- ▶ Primary caregiver takes the lead on documenting daily activities for children in the primary care group
- ▶ Parents have the opportunity to talk to the primary caregiver on a daily basis at either drop off or pick up times
- ▶ Primary caregiver provides information on children's development (i.e., completes developmental checklists, makes recommendations to parents about their child, points out achievement of developmental milestones to parents)

Drawn from a tool to assess how well programs are implementing primary care; (Ruprecht et al., 2015)]

- ▶ **Coordination among caregivers.** Pairs of infant caregivers with small primary care groups can work in teams, each developing a relationship with the other caregiver's group of children. Team meetings can support communication among caregivers.
- ▶ **Overlapping schedules for staff.** If the primary and secondary caregivers' schedules or shifts overlap, this will allow time for caregivers to communicate and for children to transition between one caregiver and another (Snyder, 2011).
- ▶ **Shifts.** The secondary caregiver can be responsible for the child during times that the child's schedule is longer than, or does not overlap completely with, the primary caregiver's schedule.
- ▶ **Weekly schedules.** A center can organize staff schedules to facilitate primary care relationships between children and caregivers, including assigning the primary caregiver to four-day shifts (Snyder, 2011):
 - **Start to the week:** To provide an easier transition from the weekend, each primary caregiver can begin the week with her primary care group.
 - **Longer shifts, fewer days:** Full-time staff could work long ten-hour shifts for four days each week. The primary caregiver would be with each child for the whole day on those days, and the secondary caregiver on the fifth day. The child would not experience changes in caregivers on any one day.

Implementing relationship-based care practices is not something that happens once and is not addressed again. Child care centers must thoughtfully and continually update their training, policies, procedures, and communication to parents and staff about the importance of these practices.



Implementing Continuity of Care Practices in Centers Serving Infants and Toddlers

There are two main approaches to implementing continuity of care in centers. Same-aged groups of children may be kept with the same caregiver while making age-appropriate adaptations to the environment, or mixed-aged groups of children may stay with the primary caregiver with children transitioning to another group at a set age. Each of the common approaches to continuity of care has implications for center operations and is described in Table 1 on next page.

Table 1. Approaches to Implementing Continuity of Care in Centers Serving Infants and Toddlers

APPROACH	DEFINITION	WHAT DOES THIS LOOK LIKE?	THINGS TO CONSIDER
<p>Same-age grouping</p>	<ul style="list-style-type: none"> ▶ Child care teachers and their primary care groups of children of approximately the same age stay together until they reach age three (often referred to as “looping”). At that point, the children move to a three-year-old classroom and the caregiver moves back to the infant room and begins with a new group of children 	<ul style="list-style-type: none"> ▶ Teachers and children may stay together up until children are 36 months old. Children in the group are generally similar in age. ▶ There are two common approaches to same-age grouping. In one approach, teachers and children move to a new classroom as a whole group when all the children are developmentally ready for the transition. In the other same-age grouping approach, teachers and children stay in the same classroom and furnishings, materials, and the room configuration change to suit the developmental needs of the children. ▶ Children in same-age groupings may have the opportunity to form peer relationships that may last throughout their early child care experience. Peer play and relationships with age mates can support positive affect, more complex play, and learning about conflict, the self, and other individuals (Wittmer, 2008). 	<ul style="list-style-type: none"> ▶ Same-age grouping may be difficult if the make-up of the children enrolled at any one time does not easily facilitate arranging classrooms of similarly-aged children, or if there are enrollment changes as children of various ages leave or join the program. However, new children within the same age group can be added to the classroom if one child leaves. ▶ Changing furniture and equipment to fit the children’s growing size and activity level may require storage space to swap items (cribs, indoor climbers, with the next stage of items (small chairs and tables, indoor climbers more suited to toddlers). Infant nap spaces may need to be converted to a suitable play space for older infants and toddlers, or centers may need to install low sinks and toilets to provide access to appropriate facilities.
<p>Mixed age grouping</p>	<ul style="list-style-type: none"> ▶ Children between birth and age three are grouped in the same classroom and stay with their primary caregiver until they reach age three and move to a three-year-old classroom with a new teacher. 	<ul style="list-style-type: none"> ▶ Mixed age grouping is more aligned with family child care settings and may provide for a more “real” representation of how children are raised in the context of their family life. Children in mixed age groups may learn important skills about caring for the youngest members of the classroom. Younger children may benefit from experiences with older, more capable peers through modeling or scaffolding. 	<ul style="list-style-type: none"> ▶ Mixed-age classrooms require environments that are flexible enough to accommodate young infants, mobile infants, and older toddlers at one time. In addition, caregivers need training not just in caring for each age individually, but in working with mixed-age groups. ▶ As children move or age out of the group, new children can be added. Some states may require special waivers for programs to group children birth-36 months of age together in one classroom.

Additional decisions to consider in implementing continuity of care in centers serving infants and toddlers

Implementing continuity of care requires child care centers to consider all aspects of their child care operations, from how and when to enroll children, to the nature of staff training, to strategies to reduce staff and family resistance, and other implementation aspects (Lally & Signer, n.d.). Implementing relationship-based care practices is not something that happens once and is not

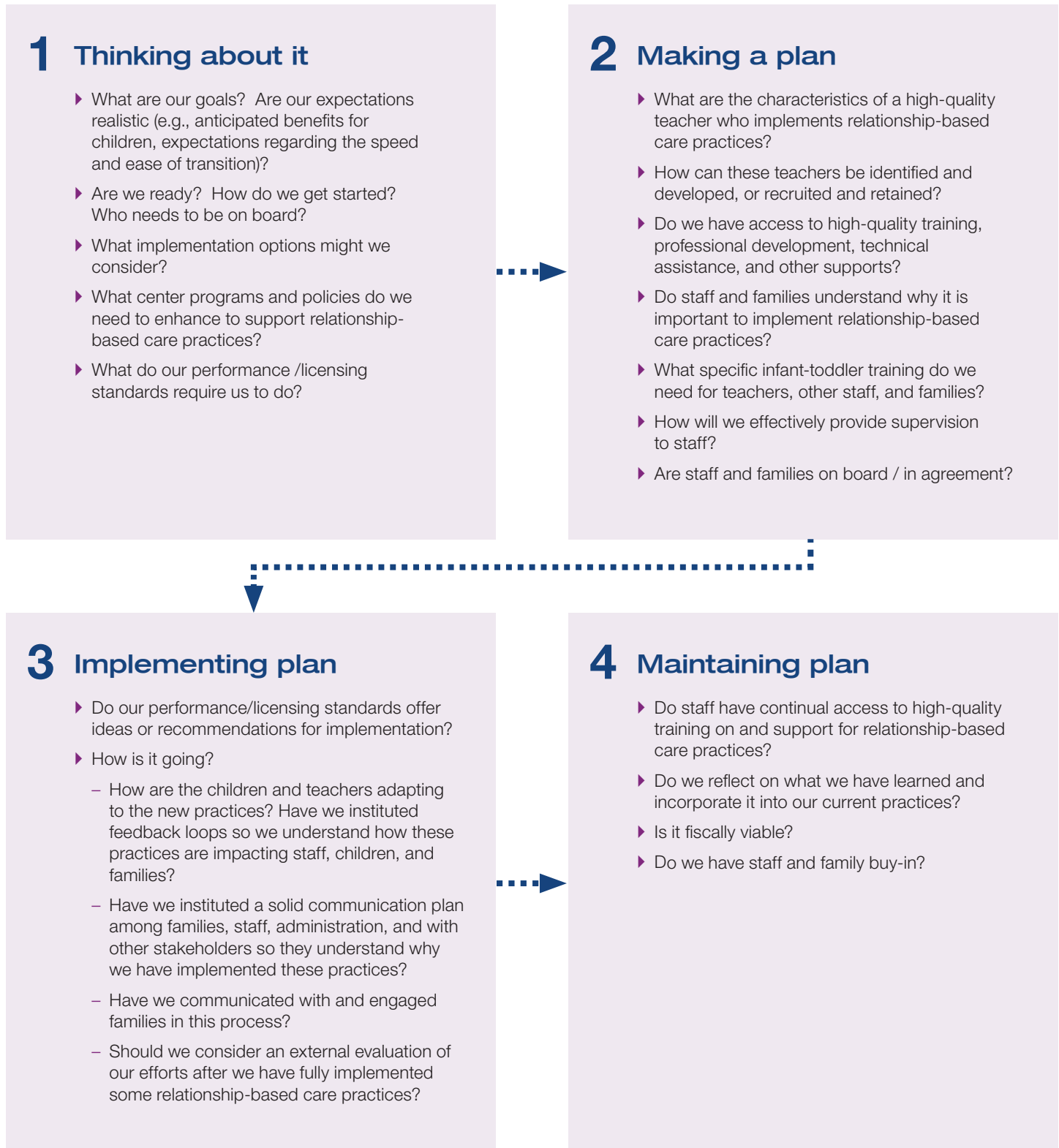
addressed again. Child care centers must thoughtfully and continually update their training, policies, procedures, and communication to parents and staff about the importance of these practices. Common questions and possible responses about implementing continuity of care are presented in Table 2. The center implementation tool (Figure 1) presents decision points depending on where a center is in the process of implementing relationship-based care practices, ranging from “thinking about it” through “maintaining it.”

Table 2. Common Center Questions about Implementation of Continuity of Care

QUESTION	RESPONSE
<p>We have such high staff and/or child turnover. How could we realistically implement relationship-based care practices?</p>	<p>Primary caregiving or continuity of care approaches are particularly difficult to implement with frequent staff turnover, but there is no research to suggest that <i>implementing</i> continuity of care will lead to staff turnover (Aguillard, Pierce, Benedict, & Burts, 2005; Cryer et al., 2000) Some research has suggested that a primary care or a continuity of care model might have a positive effect on center operations. By instituting careful hiring practices and professional development opportunities, center directors can address teacher’s ability and willingness to implement relationship-based care practices (Aguillard, et al., 2005). A focus on the importance of relationship-based care as the foundation upon which child development and learning are built could help professionalize the infant-toddler workforce by honoring their important and lasting contribution. This recognition could help reduce turnover by highlighting the value and critical role of their work.</p> <p>While child turnover may be an issue wholly out of the control of the program, some of this may be addressed with the same practices suggested above by thoughtful hiring practices for teaching staff. Families may be more willing to stay at their child care provider if they feel the teachers are in a partnership with them. However, because child care is parent choice, there is no way to fully control for child turnover—except to develop a strong program that shows deep care and respect to the children and families.</p>
<p>How long should we implement continuity?</p>	<p>Many centers may not be able to implement continuity for 3-year spans, and the research does not tell us how long is long enough for children and teachers to gain benefits. However, research does suggest children should experience minimal transitions in child care. The more transitions children experience, particularly between 18-24 months of age, the more likely they may show less competence in certain social emotional skills. While it is up to the center to make these decisions, it is important to consider what young children need in order to develop positive relationships with their teachers.</p>

QUESTION	RESPONSE
<p>What if I have staff resistance to primary caregiving or continuity of care?</p>	<p>Invite an infant/toddler specialist to talk about relationship-based care practices or visit a local center that has implemented these policies and practices. Talk to staff about <i>why</i> they are resistant to change. Directors will need to provide coaching and ongoing training for staff in order to implement these practices well. Teachers new to primary caregiving will need frequent and consistent training, and time for reflection on this practice.</p> <p>Center program policies and procedures can also help support relationship-based care practices. Staff and parent handbooks should use relationship-based care language. Use titles to shape identity by identifying teachers as “continuity teachers” or “birth-3 teachers” instead of singling out an age group.</p>
<p>How do I address parent concerns?</p> <p>For example, some parents may be concerned that a very young infant may not be safe in a mixed-age classroom that includes highly active 2-3 year olds.</p> <p>Or, some of my parents like that their child “graduates” to a new class.</p>	<p>Share information about why relationships are so important in early child care settings. Provide research and real-world examples on why primary caregiving and continuity of care practices are important to children’s development. Give examples of how relationships are important for adults and show how those relationships are even more critical to young children who do not have the language or motor skills to make choices.</p> <ul style="list-style-type: none"> ▶ In mixed-age settings, provide information on how children will be monitored and kept safe, and on the benefits of scaffolding learning and on similarities to family and home settings. ▶ Parents and teachers can still celebrate milestones together without having the child adjust to new teachers, children, and classrooms every 6-12 months. The celebration of milestones will become more meaningful when children share them with caregivers for whom they have relationships. New caregivers may not realize achieving a milestone may not only represent the next phase of the child’s development, but a significant achievement for the family-teacher partnership that may have worked hard to have a child achieve a goal, particularly if that child has developmental needs or if the parent had concerns about their child’s developmental progression.
<p>We are considering mixed-age groups, but have staff and parent concerns about meeting the developmental needs of all children in a classroom.</p>	<p>Mixed-age settings are one way to implement continuity of care, and this setting most closely mimics a family setting with siblings of different ages. Centers may want to think about if they want to offer classrooms that serve children birth-three or if they want to have classrooms that serve children who are 6 months or one year apart in age. If centers are considering mixed-age grouping, staff will need to have specific training on providing learning activities that involve all children and meet their developmental needs. Family child care settings offer models on how providers can successfully meet the needs of all ages of children. Mixed age settings also offer opportunities for older children to help scaffold younger children’s development over time.</p>
<p>As children get older, the cost of child care decreases. How do I address this issue if I am implementing small group sizes and continuity of care?</p>	<p>It is true that child care costs generally decrease as children get older. Some centers may not be able to decrease their costs if they are implementing relationship-based care practices. One way to address this issue may be the center charges the same rate for child care for children as long as they are in the continuity setting; i.e., the center has the same weekly or monthly rate regardless if the child is an infant or toddler.</p> <p>Additionally, new children can be added to the group as the group ages, with the new children being of similar ages as the children in the group. Recommended group sizes and ratios are higher for toddlers as compared to infants, and adding children to a primary care group still maintains the primary care and continuity experiences for the original children in the group.</p>

Figure 1. Center Decision Points: Is my program ready to incorporate or enhance relationship-based care practices?



Federal and State Policies Related to Adopting Relationship-Based Caregiving Practices

Relationship-based care practices intersect with federal and state policy through Early Head Start performance standards, licensing regulations, and state QRIS standards. In addition, federal and state programs can provide incentives, guidance, and strategies to encourage relationship-based care.¹ As discussed below, some regulations and policies present challenges to implementing relationship-based care practices and are important contexts to consider. The federal and state implementation tool (Figure 2) presents decision points for policymakers to consider in the process of promoting relationship-based care practices and policies, ranging from “thinking about it” through “maintaining plan.”

Early Head Start Performance Standards Related to Implementing Relationship-Based Care Practices

Early Head Start (EHS) performance standards (U.S. Department of Health and Human Services) include several elements that are consistent with relationship-based caregiving practices (see Appendix A1). Child-staff ratios are 4:1 with a maximum group size of 8 infants/toddlers with two teachers for the duration of the EHS program, which is from birth to 36 months of age. In addition, EHS programs must support the development of secure and trusting relationships between staff and young children by having consistent teachers and engaging in developmentally appropriate and culturally responsive practices.

¹ In 2012 the National Center on Child Care Professional Development Systems and Workforce Initiatives (PDW Center), jointly funded by ACF's Office of Child Care and Office of Head Start, published an assessment tool for State/Territory leaders to examine practices that support strong attachments among families, staff, and children, including subsidy policies, licensing regulations, Quality Rating and Improvement Systems, and Professional Development and workforce initiatives. https://childcareta.acf.hhs.gov/sites/default/files/public/201211_pdwcenter_infant_toddler_continuity_of_care_assessment_tool.pdf



As noted in Figure 1 on previous page, the revised performance standards in the Notice of Proposed Rulemaking issued in 2015 propose that, for EHS programs that operate a center-based option, “children in infant and toddler classrooms be assigned a consistent, primary teacher to promote continuity of care.” The NPRM further proposes that mixed-age classrooms be encouraged (NPRM; Head Start Program Performance Standards NPRM, 2015).

A new initiative announced in January 2014 extends EHS standards and resources to some partner child care providers. The Early Head Start – Child Care Partnerships (EHS-CCP) provide funds to EHS grantees who partner with child care providers to increase the number of infants and toddlers in high quality early learning programs (see Text Box 5). Child care program partners must meet the EHS performance standards.

TEXT BOX 5

Early Head Start – Child Care Partnerships

The Early Head Start – Child Care Partnerships (EHS-CCP) initiative is a competitive grant opportunity through the federal Office of Head Start and Office of Child Care in the Administration for Children and Families announced in January 2014 (Administration for Children and Families, 2014). The goal is to support the partnering of Early Head Start programs with child care providers to increase the number of infants and toddlers in high quality early learning programs.

By March 2015, \$500 million was awarded to grantees across the country (<http://www.acf.hhs.gov/programs/ecl/early-learning/ehs-cc-partnerships/grant-awardees>). Another competition will occur in the spring of 2016 for an additional \$150 million. EHS-CCP partners can leverage funds directly as well as partner on activities such as training and technical assistance, professional development, management, and the delivery of comprehensive services.

Under EHS-CCP, new or existing EHS grantees will partner with regulated center-based or family child care providers who agree to meet the Head Start Program Performance Standards. EHS standards may be higher than standards in a child care partner's own state (see Appendix A for EHS and state standards). For example, EHS requires ratios of 4:1 with a maximum group size of 8 infants/toddlers up to 36 months, and requires that teachers meet EHS standards for credentials, knowledge, and skills. EHS-CCP grantees can draw on EHS professional development and training/technical assistance resources when working with child care partners to meet EHS performance standards.

All children in a participating child care center will experience EHS standards regardless of whether each child is enrolled in EHS. Only enrolled EHS-CCP children will be eligible for direct family-specific benefits such as home visits, health tracking, and follow-up, and individualized family support services, but EHS-CCP programs must “ensure there is no segregation or stigmatization of EHS-CCP children due to the additional requirements or services” (Administration for Children and Families, 2015).

Implications of Licensing Standards for Implementing Relationship-Based Care Practices

State regulations vary and provide an important backdrop to implementing relationship-based care practices. Regulatable aspects of child care that help support these practices for infants and toddlers include lower child to staff ratios and smaller group sizes. Studies have found lower child to staff ratios are associated with important quality features that can lead to better developmental outcomes for children. For example, lower child to staff ratios were related to higher quality infant-toddler care (Phillipsen, Burchinal, Howes, & Cryer, 1997), and, in another study, were one of the strongest predictors of positive infant caregiving (NICHD Early Child Care Research Network, 1996).

Several states' child to staff ratio licensing requirements for infants are consistent with the staffing arrangements recommended to implement primary caregiving relationships, with ratios of 4:1 for 6- or 9-month-old infants. However, other states permit ratios that are 5:1 or 6:1 for infants nine months of age or younger. Furthermore, most states' child to staff ratio requirements increase as children get older; for children 27 months of age only a handful of states' ratios are 4:1. State licensing regulations are presented in Appendix A2 to illustrate the differences among states and the changes in licensing standards as children get older. States can provide incentives and supports to centers that wish to sustain lower child to staff ratios and smaller group sizes, which are expensive for centers to implement. For example, subsidy payments can be tiered with higher payments to child care providers that meet more stringent standards than minimal state ratio and group size regulations from birth to age three.

Of note, the 2014 reauthorization of the Child Care Development Block Grant (CCDBG) required legally unregulated child care facilities that serve children who receive Child Care Development Fund (CCDF) subsidies to follow their states' ratio and group size regulations. In some states, examples of legally unregulated center-based child care facilities may be programs operated by public schools, programs operated by some faith-based organizations, or part-time or part-year programs. This new federal regulation expands the reach of some of the standards regarding structural features needed as a foundation for strong relationship-based care practices for infants and toddlers.

Other aspects of state licensing are relevant to implementing relationship-based care practices. Nearly half of the states have requirements that licensed child centers assign a primary, consistent caregiver to each infant and toddler (see Appendix A3; National Association for Regulatory Administration, 2013; National Center on Child Care Quality Improvement, 2014). States that have not yet adopted primary caregiving in their child care regulations can look to other states to learn the best approach in adopting this language and guidance in child care regulations. In addition, some states limit mixed-age classrooms (e.g., mandate groupings based on chronological age or require centers to request special waivers to have mixed-aged groups of children up to 36 months) which presents a barrier to programs wishing to implement the continuity of care practice of operating a mixed-age classroom (Reidt-Parker & Chainski, 2015). States could add a primary caregiver requirement to state regulations and make it simpler for centers to implement mixed-age classrooms through policy revisions.

Implications of QRIS Standards for Implementing Relationship-Based Care Practices

Currently, 43 states have implemented either a statewide or regionally-based Quality Rating and Improvement System (QRIS) with the goal to improve the overall quality of child care available to children and families (QRIS National Learning Network, 2015). These systems are designed to assess, improve, and communicate to

parents and other stakeholders the level of quality in early care and education programs (Mitchell, 2005). A QRIS may be statewide or regionally based and generally includes (1) quality standards or indicators for programs and practitioners; (2) an infrastructure to meet such standards; (3) monitoring and accountability systems to ensure compliance with quality standards; (4) ongoing financial assistance that is linked to meeting quality standards, and (5) engagement and outreach strategies (Child Trends, 2009).

A 2011 review of existing statewide QRIS found that few states had incorporated indicators or standards addressing the quality of care specifically for infants and toddlers (NITCCI, 2011). This has been changing as many states recognize that policies and standards around infant and toddler care may need to be addressed further and have begun to incorporate infant and toddler characteristics and needs into their QRIS (National Center on Child Care Quality Improvement, 2014). As part of this process, QRIS standards and supports could be employed to encourage relationship-based practices for infants and toddlers.

Most states' QRIS standards use existing state licensing requirements as a foundation from which to build. While revising standards may represent a hurdle, state QRIS administrators could suggest enhancements to their state systems by implementing lower child to staff ratios at higher levels of their QRIS or by awarding additional points, providing incentives, and/or providing other supports to programs when they implement ratios lower than state regulations.

As of the fall of 2015, most QRIS do not emphasize relationship-based caregiving practices. For example, while primary caregiving is mentioned in 24 state licensing standards (see Appendix A), only one state - Montana - includes primary caregiving in both its QRIS and its licensing standards (National Center on Child Care Quality Improvement, 2014). Incorporating primary caregiving in state QRIS standards may be an easier method to support some relationship-based care practices because it is a method that can be implemented with minimal costs, mostly around training and coaching. Another way to incorporate primary caregiving is to implement the

specific practices and processes of primary caregiving into state QRIS standards, such as ensuring that a primary caregiver is responsible for intentionally and consistently addressing children's routine care needs, documenting the primary caregroup's development, and communicating with families (see pullout box Primary Caregiving Responsibilities; Ruprecht et al., 2015).

Similarly, continuity of care is not included in any state QRIS standards, though some states do include standards related to documenting primary caregiver assignments and including continuity of care practices in professional development and training activities. In some states, there are ongoing conversations among stakeholders regarding continuity of care as a component of QRIS. For example, the North Carolina QRIS Advisory Committee recommended that standards for high-quality infant and toddler care should be anchored in a relationship-based approach, and that standards for ratios and group sizes be improved to facilitate its implementation (NC QRIS Advisory Committee, 2012).

Additional Considerations Regarding Implementation of Relationship-Based Caregiving Practices in Federal Programs and State Early Childhood Systems

Ongoing general challenges in access to and delivery of high-quality early care and education provide an important backdrop to implementation of relationship-based care.

Subsidy eligibility re-determination

Subsidy eligibility re-determination periods that are short or influenced by temporary changes in family income or parent participation in work, training, or education may lead to frequent breaks in a child's receipt of care. These policies may have the effect of interrupting a child's access to consistent care which could interfere with the primary caregiving relationship or with longer-term continuity of care if the child care center was intentionally providing relationship-based care practices (Schumacher & Hoffman, 2008). Longer redetermination periods could support the *potential* for relationship-based caregiving by reducing one barrier to children's experience of

continuous care. Of note, the 2014 Child Care and Development Block Grant (CCDBG, 2014) establishes a 12-month eligibility re-determination period for Child Care and Development Fund families, regardless of changes in parent income or work, which may help address this issue (CCDBG provisions will become effective once state plans for 2016-2018 are submitted and approved; DHHS, January 9, 2015; Matthews et al., 2015). Extending the re-determination period to 12 months alone is not continuity of care as a *program practice*², which involves careful consideration and implementation efforts to sustain it as a relationship-based care practice. However, extending the re-determination period may help families sustain their child care arrangements.

It is important to note that children deemed eligible for EHS remain eligible for the duration of the program, up through 36 months of age. This policy suggests support for the potential of continuity of care, whereas each state has its own eligibility criteria for CCDF funding.

Staff turnover

High turnover of staff means that children experience more than one, and perhaps several, primary caregivers during infancy and toddlerhood. Turnover of high-quality staff is higher when pay is low, training is inadequate, and also when a center's climate has less stability of highly trained co-workers (Lally, 2009; Schumacher & Hoffman, 2008; Whitebook & Sakai, 2003). Not all departures are undesirable if particular staff are not engaged in or skilled at their jobs, though training or supervision may improve the quality of their work (Whitebook & Sakai, 2003). Efforts to reduce turnover, such as increasing compensation or bonuses, would also support relationship-based care practices (Schumacher & Hoffman, 2008).

² Some early childhood professionals include in the definition of continuity of care strategies to lengthen children's ability to continuously participate in a program (e.g., Reidt-Parker & Chainski, 2015), but we are limiting this brief to the specific relationship-based practice of keeping children with their caregiver for an extended period of time.

Training and professional development

Relationship-based care practices are gaining attention in the early childhood practice community, but they are not familiar to many teachers and caregivers, and may be met with resistance and lack of preparation. Directors in a small number of centers in Louisiana were likely to identify the attitudes and abilities of classroom staff as barriers to implementing continuity of care (Aguilard et al., 2005).

Pre-service and in-service professional development, education, and training efforts can be implemented to increase providers' familiarity with the reasons for and benefits of relationship-based care, and to support teachers and caregivers' abilities in regards to primary caregiving and working with children from birth to three. Professional development opportunities and support, including onsite coaching, can help teachers implement continuity of care practices successfully by focusing on the importance of effective interaction and communication skills to engage with infants and toddlers, helping teachers develop observational skills, and helping teachers increase understanding of the developmental abilities of different ages of very young children (Ackerman, 2008; Norris & Horn, 2015). Caregivers working in a center with a mixed-age continuity of care approach could benefit from specific training in regards to working with a small group of children of different ages, from infants to older toddlers. Center directors can also benefit from professional development and consultation regarding how to promote primary caregiving and continuity of care practices. Higher education can also play an important role by including more specialized courses on infant-toddler care and development in early childhood teacher preparation programs (Horn, Hyson, & Winton, 2013; Norris, 2010).

Early Head Start offers grantees access to training and technical assistance including practical professional development resources and approaches through the [Early Childhood National Centers for Training and Technical Assistance](#). In particular, the new National Center for Early Childhood Development, Teaching, & Learning ([NCECDTL](#))



offers professional development resources in a number of formats covering [topics including the unique features of caring for infants and toddlers](#) such as primary caregiving and continuity of care. For example, the Early Essentials online videos include continuity of care among the components of quality. Child care programs participating in EHS-CCP partnerships will have access to the professional development and T/TA systems as well. In addition, the State Capacity Building Center also has an established network of infant and toddler specialists who are available to assist states in implementing best practices for infants and toddlers.

Figure 2. EHS Grantee/State/QRIS Decision Points: Is my grantee/state ready to incorporate relationship-based care practices?



Conclusion

Incorporating relationship-based care practices into programs serving infants and toddlers and into federal and state standards can enhance the most important component of infant and toddler care—sensitive and responsive caregiving. Focusing on ways to strengthen relationships between infants and toddlers and their caregivers not only enhances the quality of care babies receive, but it also provides them with the foundation they need in order to be successful learners through preschool and beyond. It also highlights the important role of the infant and toddler caregiver, a segment of the early childhood workforce that has been undervalued.

Child care centers have a variety of options to implement practices consistent with relationship-based care. Programs can consider adjustments to staffing, organization, and space and facilities to support relationships between teachers and the infants and toddlers in their care. States can incentivize, encourage, or support relationship-based care practices through various mechanisms, such as giving higher subsidy payments to centers providing lower child to staff ratios or smaller group sizes, or awarding additional points or supports to providers implementing primary caregiving or continuity of care practices.

We know from research that infants and toddlers learn best in the context of relationships with caregivers who know them well. Using a relationship-based lens and focusing on what infants and toddlers need to be successful in the long-term may help us refocus on what matters most in terms of our practices and policies.



Appendix A. Federal Early Head Start Performance Standards and State Licensing Requirements Relevant to Relationship-Based Care Practices in Center-Based Settings Serving Infants and Toddlers

Federal EHS Performance Standards and state licensing regulations for center-based infant-toddler programs are presented in the tables below highlighting (a) child to staff ratios and group sizes and (b) primary caregiving. These tables illustrate the details, differences among states, and the changes in licensing standards as children get older.

Table A1. Early Head Start Performance Standards for Center-Based Settings

APPROACH	RATIO 0-35 MOS	GROUP SIZE 0-35 MOS	PRIMARY CAREGIVING
Early Head Start - current standards through 2015	4:1	8	Section 1304.22 <ul style="list-style-type: none"> ▶ In paragraph,,, (b) <i>Child development and education approach for infants and toddlers</i>. (1) Grantee and delegate agencies' program of services for infants and toddlers must encourage: ▶ (i) The development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time.
Proposed standards in the 2015 Notice of Proposed Rule Making	4:1	8	Section 1302.21 Center-Based Option <ul style="list-style-type: none"> ▶ ... in paragraph (b)(2), we propose children in infant and toddler classrooms be assigned a consistent, primary teacher to promote continuity of care.... Mixed age group classrooms, which can be structured to better support continuity of care for individual children and stronger bonds with primary caregivers, are encouraged.

Source: Head Start Program Performance Standards. 45 CFR Chapter XIII (Current through 2015)

<http://eclkc.ohs.acf.hhs.gov/hslc/standards/hspss/45-cfr-chapter-xiii/45-cfr-chap-xiii-eng.pdf>

Head Start Performance Standards Notice of Proposed Rule Making

<https://www.federalregister.gov/articles/2015/06/19/2015-14379/head-start-performance-standards#h-35>

Table A2. State Licensing Ratio and Group Size Requirements for Center-Based Settings Serving Infants and Toddlers

STATE	RATIO ¹				GROUP SIZE ^{1,2}			
	0-9 MOS	9-18 MOS	18-27 MOS	27-35 MOS	0-9 MOS	9-18 MOS	18-27 MOS	27-35 MOS
Alabama	5:1	5:1	7:1	8:1	not in regulations	not in regulations	not in regulations	not in regulations
Alaska³	5:1	5:1	5:1	6:1	10	10	10	12
Arizona⁴	5:1	5:1	6:1	8:1	not in regulations	not in regulations	not in regulations	not in regulations
Arkansas⁵	5:1	5:1	8:1	8:1	10	10	16	16
California	3:1	3:1	4:1	4:1	not in regulations	not in regulations	12	12
Colorado⁶	5:1	5:1	5:1	7:1	10	10	10	14
Connecticut	4:1	4:1	4:1	4:1	8	8	8	8
Delaware⁷	4:1	4:1	6:1	8:1	8	8	12	16
District of Columbia⁸	3:1	3:1	3:1	4:1	8	8	8	12
Florida	4:1	4:1	6:1	11:1	not in regulations	not in regulations	not in regulations	not in regulations
Georgia	6:1	6:1	8:1	10:1	12	12	16	20
Hawaii⁹	3:1	3:1	5:1	5:1	6	6	6	10
Idaho	6:1	6:1	6:1	8:1	not in regulations	not in regulations	not in regulations	not in regulations
Illinois¹⁰	4:1	4:1	5:1	8:1	12	12	15	16
Indiana¹¹	4:1	5:1	5:1	5:1	8	10	10	10
Iowa¹²	4:1	4:1	4:1	6:1	not in regulations	not in regulations	not in regulations	not in regulations
Kansas	3:1	3:1	5:1	7:1	9	9	10	14
Kentucky¹³	5:1	5:1	6:1	10:1	10	10	12	20
Louisiana	6:1	6:1	8:1	12:1	not in regulations	not in regulations	not in regulations	not in regulations
Maine¹⁴	4:1	4:1	5:1	5:1	8	8	10	10
Maryland	3:1	3:1	3:1	6:1	6	6	9	12
Massachusetts¹⁵	3:1	3:1	4:1	4:1	7	7	9	9
Michigan¹⁶	4:1	4:1	4:1	4:1	12	12	12	12
Minnesota	4:1	4:1	7:1	7:1	8	8	14	14
Mississippi¹⁷	5:1	5:1	9:1	12:1	10	10	10	14
Missouri¹⁸	4:1	4:1	4:1	8:1	8	8	8	16
Montana¹⁹	4:1	4:1	4:1	8:1	not in regulations	not in regulations	not in regulations	not in regulations
Nebraska²⁰	4:1	4:1	6:1	6:1	12	12	not in regulations	not in regulations

STATE	RATIO ¹				GROUP SIZE ^{1,2}			
	0-9 MOS	9-18 MOS	18-27 MOS	27-35 MOS	0-9 MOS	9-18 MOS	18-27 MOS	27-35 MOS
Nevada	4:1	6:1	8:1	8:1	not in regulations	not in regulations	not in regulations	not in regulations
New Hampshire²¹	4:1	4:1	5:1	6:1	12	12	15	18
New Jersey²²	4:1	4:1	6:1	6:1	12	12	20	20
New Mexico²³	6:1	6:1	6:1	10:1	not in regulations	not in regulations	not in regulations	not in regulations
New York²⁴	3:1	4:1	5:1	5:1	6	8	12	12
North Carolina²⁵	5:1	5:1	6:1	10:1	10	10	12	20
North Dakota²⁶	4:1	4:1	5:1	5:1	10	10	15	15
Ohio²⁷	5:1	5:1	7:1	7:1	10	10	14	14
Oklahoma²⁸	4:1	4:1	6:1	8:1	8	8	12	16
Oregon²⁹	4:1	4:1	4:1	5:1	8	8	8	10
Pennsylvania³⁰	4:1	4:1	5:1	6:1	8	8	10	12
Rhode Island	4:1	4:1	6:1	6:1	8	8	12	12
South Carolina³¹	5:1	5:1	6:1	7:1	not in regulations	not in regulations	not in regulations	not in regulations
South Dakota	5:1	5:1	5:1	5:1	20	20	20	20
Tennessee³²	4:1	4:1	6:1	7:1	8	8	12	14
Texas³³	4:1	4:1	9:1	11:1	10	10	18	22
Utah³⁴	4:1	4:1	4:1	7:1	8	8	8	14
Vermont³⁵	4:1	4:1	4:1	5:1	8	8	8	10
Virginia³⁶	4:1	4:1	5:1	8:1	not in regulations	not in regulations	not in regulations	not in regulations
Washington³⁷	4:1	4:1	7:1	7:1	8	8	14	14
West Virginia³⁸	4:1	4:1	4:1	8:1	8	8	12	16
Wisconsin³⁹	4:1	4:1	4:1	6:1	8	8	8	12
Wyoming⁴⁰	4:1	4:1	5:1	8:1	10	10	12	18

Sources: Individual state regulations via the National Resource Center for Health and Safety in Child Care and Early Education, State Licensing and Regulation Information, <https://childcareta.acf.hhs.gov/resource/state-and-territory-licensing-agencies-and-regulations>³
Indiana regulations from Interpretative Guidelines, 70 IAC 3-4.7-47 Child/staff ratio chart

³ Note: NRC funding ended 10/31/15. <http://nrckids.org/> The development and maintenance of the child care licensing regulations database has been transferred to National Center on Early Childhood Quality Assurance (NCECQA). They are working on a new version of that site, and it should be up later this year.

During this transition, a document has been created that includes direct Web links to all child care licensing regulations documents and the state agencies. It is available at <https://childcareta.acf.hhs.gov/resource/state-and-territory-licensing-agencies-and-regulations>.

1. Each state uses different age ranges. Data in the table reflect the higher number within a range, if the column range overlaps the state's range. Specific state data and language are included in footnotes where relevant.
2. "Not in regulations" indicates that maximum group size limits were not described explicitly in the state regulations.
3. Alaska: Through 18 mos.: 5:1; 10 max; 19 to 36 mos.: 6:1; 12 max
4. Arizona: Infants: 5:1; 1-year-old children: 6:1; 2-year-old children: 8:1
5. Arkansas: "Group size shall be limited to 2 times the number of children allowed with one staff member."
6. Colorado: 6 weeks to 18 mos. (infants): 1 staff member to 5 infants, max 10 infants; 12 mos. to 36 mos.: 1 staff member to 5 toddlers, max 12 toddlers; 24 mos. to 36 mos.: 1 staff member to 7 toddlers, max 14 toddlers; 2 1/2 years to 3 years: 1 staff member to 8 children, max 16 children
7. Delaware: Infant Under 12 mos. 1:4; max 8; Young toddler 12 through 23 mos. 1:6; max 12; Older toddler 24 through 35 mos. 1:8; max 16
8. District of Columbia: 0 – 12 mos.: 1:3; max 9; 0 – 12 mos.: 1:4; max 8; 12 – 24 mos.: 1:3; max 9; 12 – 24 mos.: 1:4; max 8; 24 – 30 mos.: 1:4; max 12; 30 mos. through 3 years: 1:8; max 16
9. Hawaii: 0 – 12mos: 3:1 or 4:1 - 12 – 24mos: 3:1 or 4:1 – 18 – 36 mos: 5:1 or 6:1
10. Illinois: Infants (6 weeks through 14 mos.): 1 to 4; max 12; Toddlers (15 through 23 mos.): 1 to 5; max 15; Two years: 1 to 8; max 16
11. Indiana: 0 – 9 mos.: 4:1, max 8; 9 – 18 mos: 4:1 until 13 mos, then 5:1, max 10; 18 – 27 mos: 5:1, max 10; 27 – 35 mos: 5:1, max 10
12. Iowa: 2 wks to 2 yrs: 4:1, 2 yrs: 6:1
13. Kentucky: Infant: 1 staff for 5 children; max 10; Toddler: 1 staff for 6 children; max 12; Preschool-age (2 to 3 years): 1 staff for 10 children; max 20
14. Maine: 6 weeks – 1 year: 1:4; max 8; 1 year – 2 1/2 years: 1:4 or 1:5; max 12 or 10; 2 1/2 years – 3 1/2 years: 1:7; max 21
15. Massachusetts: Up to 15 mos: 3:1; max 7 – 15 – 33 mos: 4:1; max 9
16. Michigan: Up to 30 mos.: 4:1
17. Mississippi: 0 – 12 mos: 5:1, max 10; 12 – 24 mos: 9:1, max 10; 24 – 36 mos: 12:1, max 14
18. Missouri: 0 – 24 mos: 4:1, max 8; 24 mos: 8:1, max 16
19. Montana: for children zero mos. through 23 mos.: 4:1; for children two years through three years: 8:1
20. Nebraska: At least two staff members must be on the premises at all times, except: a. When the number of children in care is 12 or fewer; or b. When all children in care are school-age and there are 15 or fewer. Rooms where infants are receiving care must be limited to the care of no more than 12 children at any one time
21. New Hampshire: 0 – 12 mos: 4:1; 13 – 24 mos: 5:1; 25 – 35 mos: 6:1
22. New Jersey: 0 – 18 mos: 4:1; 18 mos – 30 mos: 6:1; 30 mos – 48 mos: 10:1
23. New Mexico: 0 – 24 mos: 6:1; 24 – 36 mos: 10:1
24. New York: Under 6 weeks: 3:1, max 6; 6 weeks to 18 mos: 4:1, max 8; 18 – 36 mos: 5:1, max 12
25. North Carolina: 0 – 12 mos: 5:1, max 10; 12 – 24 mos: 6:1, max 12; 24 – 36 mos: 10:1, max 20
26. North Dakota: (1) For children less than eighteen mos. of age, one staff member may care for four children, a ratio of .25 in decimal form, with a maximum group size of ten children; (2) For children eighteen mos. of age to thirty-six mos. of age, one staff member may care for five children, a ratio of .20 in decimal form, with a maximum group size of fifteen children

27. Ohio: Infants (birth and under 12 mos.): 1 to 5 or 2 to 12 in same room; Infants (12 mos. and under 18 mos.): 1 to 6; Toddlers (18 mos. and under 2 1/2 years): 1 to 7; Toddlers (2 1/2 years and under 3 years): 1 to 8. Group size shall not exceed twice the maximum number of children allowed per child care staff member as required in the staff/child ratio section of this rule
28. Oklahoma: Infants (0 up to 12 mos.): 1:4; max 8; Toddlers (12 mos. through 23 mos.): 1:6; max 12; Two-year-olds: 1:8; max 16
29. Oregon: Six Weeks of Age through 23 Mos.: 1:4; max 8; 24 Mos. of Age through 35 Mos.: 1:5; max 10
30. Pennsylvania: Infant 1:4; max 8; Young toddler: 1:5; max 10; Older toddler: 1:6; max 12
31. South Carolina: Birth to one year 1:5; One to two years 1:6
32. Tennessee: Infants: Six (6) wks.–Fifteen (15) mos.: 1:4, max 8; Toddlers (Twelve (12) mos.–Thirty (30) mos.): 1:6, max 12; Two (2) years (Twenty-Four (24) mos. – Thirty-Five (35) mos.): 1:7, max 14
33. Texas: 0 – 11 mos.: 4:1, max 10; 12 – 17 mos.: 5:1, max 13; 18 – 23 mos.: 9:1, max 18; 2 years: 11:1, max 22
34. Utah: Birth – 23 mos. 1:4; max 8; 2 years old 1:7; max 14
35. Vermont: 6 weeks – 23 mos.: 4:1, max 8; 24 – 35 mos.: 5:1, max 10
36. Virginia: 1. For children from birth to the age of 16 mos.: one staff member for every four children; 2. For children 16 mos. old to two years: one staff member for every five children; 3. For two-year-old children: one staff member for every eight children
37. Washington: (a) One month, through 11 mos. (infant): 1:4; max 8; (b) Twelve mos. through 29 mos. (toddler): 1:7; max 14; (c) Thirty mos. through six years not attending kindergarten or elementary school (preschool age child): 1:10; max 20
38. West Virginia: 6 weeks – 12 mos.: 4:1; max 8; 13 mos. – 24 mos.: 4:1; max 12; 25 – 35 mos.: 8:1; 16 max
39. Wisconsin: Birth to 2 Years: 1:4; max 8; 2 years to 2½ Years: 1:6; max 12; 2½ Years to 3 Years: 1:8; max 16
40. Wyoming: Birth to 12 mos.: 1:4; max 10; 12 mos. – 24 mos.: 1:5; max 12; 24 mos. – 36 mos.: 1:8; max 18

Table A3. State Licensing Primary Caregiving Requirements for Center-Based Settings Serving Infants and Toddlers

STATE		PRIMARY CAREGIVING
Alabama	Y	“Each staff person giving care to infants and toddlers shall be assigned the responsibility of caring for the same infants/toddlers daily, except in the absence of the regularly assigned child care worker.”
Alaska	Y	“One or two primary caregivers to each child”
Arizona	N	
Arkansas	N	
California	N	
Colorado	N	
Connecticut	N	
Delaware	Y	“A licensee shall maintain the full staff/child ratio for infants at all times and a staff member shall be assigned to care for specific infants and toddlers within their group.”
District of Columbia	N	
Florida	Y	“Child care personnel at a facility must be assigned to provide direct supervision to a specific group of children, and be present with that group of children at all times.”
Georgia	Y	“Assignment of Caregiving Staff. Employees shall be assigned so that in so far as possible children receive care from the same employee each day.”
Hawaii	Y	“Assignment of each infant or toddler to a primary caregiver who shall be responsible for care the majority of the time”
Idaho	N	
Illinois	Y	“Early childhood assistants shall be assigned to infant, toddler and preschool groups and work under the direct supervision of an early childhood teacher.”
Indiana	Y	“Primary caregiver” means a caregiver is assigned to be primarily responsible for meeting the needs of specific children, especially for feeding, diapering, and periods when the child is falling to sleep or awakening.
Iowa	Y	“The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.”
Kansas	N	
Kentucky	Y	“In a Type I child-care center, a group size shall: 1. Be separately maintained in a defined area unique to the group; and 2. Have specific staff assigned to, and responsible for, the group.”
Louisiana	Y	“A staff person shall be assigned to supervise specific children whose names and whereabouts that staff person shall know and with whom the staff person shall be physically present. Staff shall be able to state how many children are in their care at all times.”
Maine	Y	“The maximum number of children to be assigned to one adult.”
Maryland	Y	“Assignment of Staff. One or more child care teachers shall be assigned to each group of children as needed to meet the requirements for group size and staffing set forth at §§C—G of this regulation.”
Massachusetts	N	
Michigan	Y	“The center shall implement a primary care system so that each infant and toddler has a primary caregiver.”
Minnesota	N	
Mississippi	Y	“During all hours of operation, including arrival and departure of children, a child care facility employee shall be present to whom administrative and supervisory responsibilities have been assigned.”

STATE	PRIMARY CAREGIVING	
Missouri	N	
Montana	Y	“Each infant shall be assigned a caregiver who is routinely responsible for that infant. There shall be sufficient staff so that an adult is always present and directly supervising infants.”
Nebraska	Y	“Staff assigned to infants must be identified in writing and assigned to the same infants whenever possible.”
Nevada	Y	“A caregiver must be assigned to a specific group of infants on a continuing basis.”
New Hampshire	Y	“Programs shall assign a staff person as primary caregiver to each group of children between 6 weeks and 18 mos. of age.”
New Jersey	Y	“A particular staff member shall be assigned as the primary caregiver to each specific group of children”
New Mexico	N	
New York	Y	“The continuity of care model requires that the center make every effort to establish and maintain a primary relationship between teachers and children and their respective families over a period of years. In the continuity of care model, infants/toddlers and their teachers stay together until all children in the group are thirty-six (36) mos. of age.”
North Carolina	Y	“A caregiver or team of caregivers shall be assigned to each infant or toddler as the primary caregiver(s) who is responsible for care the majority of the time.”
North Dakota	Y	“Two-day, onsite orientation to the child care program must include: Any special health or nutrition problems of the children assigned to the staff member; Any special needs of the children assigned to the staff member”
Ohio	Y	“Child care staff members shall be assigned to a group of children and shall have regularly assigned working hours to give continuity of care and supervision to children.”
Oklahoma	Y	“Each child is assigned a staff person responsible for him or her who is aware of the details of the child's habits, interests, and special problems, if any. Staff have access to each child's records at all times.”
Oregon	N	
Pennsylvania	Y	“Each staff person shall be assigned the responsibility for supervision of specific children. The staff person shall know the names and whereabouts of the children in his assigned group. The staff person shall be physically present with the children in his group on the facility premises and on facility excursions off the facility premises.”
Rhode Island	N	
South Carolina	N	
South Dakota	Y	“Children must be given attention on a one-to-one basis by staff members.”
Tennessee	Y	“Each child must be on roll in a defined group and assigned to that group with a specific caregiver(s)”
Texas	Y	“A group of children is defined by the number of children assigned to a specific caregiver or group of caregivers, occupying an individual classroom or well-defined physical space within a larger room. Each child in any group has two things in common with every other child in his group: the same caregiver(s) responsible for the child’s basic needs and the same classroom or activity space.”
Utah	Y	“The provider shall ensure that caregivers provide and maintain direct supervision of all children at all times.” ““Direct Supervision” for infants, toddlers, and preschoolers means the caregiver can see and hear all of the children in his or her assigned group, and is near enough to intervene when necessary.”
Vermont	Y	“Each child shall be assigned a primary staff person”
Virginia	N	

STATE		PRIMARY CAREGIVING
Washington	Y	“You may assign an assistant who is age eighteen or older to care for a child or a group of children under direct supervision of a lead staff person. This person may have sole responsibility for a group of children without direct supervision by a superior for a brief period of time.”
West Virginia	Y	“Have responsibility for the supervision, care and education of children and be regularly assigned to a group of children;”
Wisconsin	Y	“Each infant and toddler shall be cared for by a regularly assigned child care worker in a specific self-contained room or area.”
Wyoming	N	

Sources: Individual state regulations via the National Resource Center for Health and Safety in Child Care and Early Education, State Licensing and Regulation Information, <http://nrckids.org/index.cfm/resources/state-licensing-and-regulation-information/>⁴

⁴Note: NRC funding ended 10/31/15. <http://nrckids.org/> The development and maintenance of the child care licensing regulations database has been transferred to National Center on Early Childhood Quality Assurance (NCECQA). They are working on a new version of that site, and it should be up later this year.

During this transition, a document has been created that includes direct Web links to all child care licensing regulations documents and the state agencies. It is available at <https://childcareta.acf.hhs.gov/resource/state-and-territory-licensing-agencies-and-regulations>.

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PREPARED FOR:

Office of Planning, Research and Evaluation
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This brief was developed as a collaboration between
members of the Network of Infant/ Toddler Researchers
(NITR) and the Quality Initiatives Research and Evaluation
Consortium (INQUIRE). NITR is a consortium of leading
researchers studying the first 3 years of life. INQUIRE is
designed to facilitate the identification of issues and the
development and exchange of information and resources
related to the research and evaluation of quality rating and
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SUGGESTED CITATION:

Sosinsky, L, Ruprecht, K., Horm, D., Kriener-Althen,
K., Vogel, C., & Halle, T. (2016). Including Relationship-
Based Care Practices in Infant-Toddler Care: Implications
for Practice and Policy. Brief prepared for the Office of
Planning, Research and Evaluation, Administration for
Children and Families, U.S. Department of Health and
Human Services.

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represent the views or policies of the Office of Planning,
Research and Evaluation (OPRE); Administration for
Children and Families; or the U.S. Department of Health
and Human Services.

