Programs and providers, including medical professionals, serving babies, preschoolers and school-age children should assess language and reading development, and should regularly evaluate the quality and impact of their services.

Effective practice—whether educational or clinical—starts with comprehensive assessment. If we are to prevent reading difficulties, provide timely, successful intervention for those at-risk children, and raise the bar for reading success, ongoing assessment should be commonplace. It should guide our program designs, classroom practices, intervention goals and clinical services, including our mid-course corrections.

We recognize that a recommendation about assessments may be construed as problematic or inappropriate. There are legitimate reasons why assessing preschool children has been an unpopular idea. When assessment systems result in high-stress experiences for our children or purposeless additions to professionals' plates, we can all be concerned. However, by neglecting to regularly evaluate our young children's language and early reading skills, we have done more harm than good. We need to put our efforts into selecting multiple measures and interpreting their results in appropriate ways to promote student success. It is how assessments are used—and with whom and how the results are interpreted and used—that can be positive or negative, accurate or inaccurate. When used in accurate and ethical ways, assessments can be the critical difference between a child receiving the help he needs or struggling in reading.

Research shows that we can predict in early childhood who is at risk for later reading difficulties. For example, a child's vocabulary at age 4 is predictive of grade 3 reading comprehension.[37] Yet we often don't formally identify and support a student who is struggling academically until that child has failed the third grade test. By that point, a cycle of academic failure (and its ripple effects) is entrenched. In some cases, test prep interventions are provided just prior to the third grade MCAS for students perceived as having skills that will result in *just missing* a passing score. In turn, these students may in fact earn scores that are slightly above the *Needs Improvement* range, and for accountability purposes, the school has succeeded.

Nonetheless, the sources of their students' learning struggles are by no means remedied. Such late-in-the-game practices are neither preventive nor proven to have any meaningful, long-term impact on outcomes. Without formal assessment systems, educators and families too often remain in the dark about a child's learning needs until after MCAS scores return, and years of opportunities for intervention and support have been squandered. Even before preschool, infants and toddlers display language differences that could trigger prevention services towards building strong third-grade readers.[38] Effective supports, interventions, and programs to promote children's development are inextricably tied to assessment that begins from birth and carries forward into school. We need a comprehensive assessment system that is two-fold: It must focus on our children's reading and language development while also evaluating the learning environments, settings, and supports we are providing them with on a daily basis.

Built-in Opportunities to Focus on Children's Language: A Routine Part of the Routine Physical?

- In 2008, 82.1% of Massachusetts mothers received adequate prenatal care.
- In 2007, 84.7% of the state's children were immunized.[C]

It is important to note that some of our early education and care settings and schools have early literacy assessment systems in place to inform instructional change; they are to be applauded. However, this is most often a result of taking part in initiatives that have been implemented over the years, including *Reading Excellence Act, Early Reading First, Reading First, Bay State Readers, John Silber Reading Grants* and the state's ongoing *Early Literacy Intervention Program.* Save for the *Early Literacy Intervention Program,* these programs have been targeted toward low-performing settings and serve only a fraction of students in the state. *Reading First,* for example, was implemented in 89 of our public elementary schools—only 8 percent. And in all cases, they have been grant programs, which means that the children who benefit are only those in schools that are adept at navigating the application process and successful in the competition.

Statewide, we do not have any data on children's reading collected before grade 3. Yet results from many initiatives, including *Reading First* in Massachusetts, for example, reveal that improved student outcomes are related to an increased focus on assessment.[39]

The Road to Reading, Birth to Age 4: Talking with Parents

Does your...

5-MONTH-OLD	1-YEAR-OLD	2-YEAR-OLD	3-YEAR-OLD	4-YEAR-OLD
■ turn his head toward sounds he hears? ■ watch your face when you speak? ■ vocalize her feelings (laugh, giggle, cry, fuss)? ■ make noises when you talk to him?	■ attend to books or toys for several minutes? ■ answer simple questions non-verbally? ■ say two to three words to name a person or object? ■ try to imitate simple words?	■ have 250-350 words he can use when he talks? ■ point to pictures in a book? ■ use sentences that are 3 or 4 words long? ■ ask questions about the stories you read or things she sees?	■ have 800-1000 words she can use when she talks? ■ play imaginary games? ■ look through a story book and retell it? ■ scribble on paper and tell you what he wrote? ■ answer and ask questions?	■ hold a book right side up and turn the pages starting from the front? ■ recognize some letters, like the ones in her name? ■ pay attention to stories? ■ know how to rhyme? ■ start conversations?

ACTION STEP

Health care clinics and practices, and early education programs should implement initial screening and ongoing assessment of language and reading skills.

The appropriate alternative to our current assessment practices is to implement developmentally appropriate screening and ongoing monitoring of language and reading skills from the start, with all children. While elementary schools are, indeed, one setting where assessment is vital, the earliest years in our children's lives are a missed window of time in which assessment-driven support and intervention is needed to promote development. Several settings should, collectively, adopt proactive practices. First, all early education settings need formal assessments of language and early reading skills—assessments that provide an external benchmark of performance relative to same-aged peers across the state and/or nation, such that risks can be identified. In this way, targeted actions that focus on children's learning needs will begin at a time when prevention of deficiencies is still an option. In addition, visits to medical professionals provide an opportunity to ensure appropriate language development. A nurse, nurse practitioner or pediatrician could implement a simple checklist of language skills as part of well-baby and annual visits. While some pediatricians and other health care providers make useful referrals for toddlers who demonstrate striking language delays, and there are protocols in place for early identification of autism, a formal protocol that supports ongoing assessment of language skills as precursors to later reading success is lacking as part of well-baby visits. Ongoing assessments provide opportunities for vital conversations about creating language-rich learning opportunities across settings.

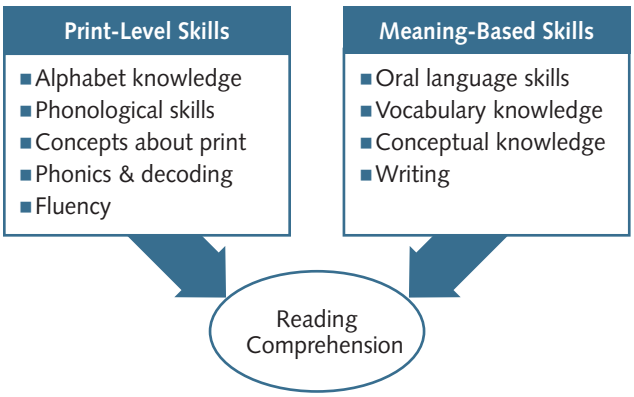
ACTION STEP

School districts must have a PK-3 early literacy assessment system that includes language measures.

While some schools do have early-literacy assessment systems in place, these tend to focus primarily on print-level skills (letter knowledge, the correspondence between letters and their sounds, and word reading); they generally do not include crucial language and meaning-based measures. The substance of these assessments consequently tips instructional balance, with the skills that are measured receiving priority for instructional time, planning, and professional development. In turn, students may appear to progress in reading based on the material assessed, particularly in the primary grades, only to demonstrate problems down the road because of the reading and language skills not included in the literacy battery.[40] Most concerning, a child's vocabulary and background knowledge more strongly predicts later reading comprehension ability.[41] Therefore, students deemed capable in print-level skills could still face subsequent difficulties understanding text. Since successful reading depends on a multitude of abilities and factors, as described at the outset of this report, a weakness in any of these realms can lead to a breakdown in the reading process. In the absence of comprehensive assessment, these breakdowns are not visible until it is too late and our students slip through the cracks. A balanced approach to assessment informs balanced instructional practices

that target the multi-faceted learning needs of our young readers; learning needs that include language and knowledge development.

Pre-K to Grade 3 Literacy Assessment



ACTION STEP

Programs, clinical settings, and schools should implement assessments of quality and impact on children's development.

Children's development and the environments and opportunities they encounter daily are inextricably linked. Yet, the great majority of the assessment data we have focuses only on the students themselves. In this paradigm, we can become overly focused on individual children's assessment scores—perpetuating a deficit model—without critically examining the quality of the settings and interactions those scores reflect. As program evaluation and setting-level measurement become more sophisticated, we should use these tools to gain a better understanding of the quality of the learning environments and relationships we provide for our children, and the impact on their outcomes. As a step forward, the Department of Early Education and Care is initiating a 2010 pilot of the *Quality Rating and Improvement System* (QRIS) to monitor and evaluate program outcomes and share information across early education settings. These results should then be tied to agendas for improvement, to advance the quality and impact of our settings and services, and ultimately, children's development. This process must be ongoing in nature so that a cycle of setting-level assessment and informed action becomes the norm.

ACTION STEP

Support the creation of a statewide database to track children's development and their program enrollment.

In Massachusetts, we lack a comprehensive database that will allow us to track, integrate, and share information about a child, from birth through their school years. Very often, when we do have assessment data on a child, the information often stays local; it does not necessarily travel with the child. Although laws are in place to ensure sharing of information collected as part of publicly-funded services, this applies only to a portion of the young children in the state.

Equally important, our lack of consistent use of assessment tools and shared knowledge in this regard makes it difficult for practitioners and clinicians to interpret and use shared

When Assessments Fail to Measure Up: An Incomplete Battery

Every fall, winter, and spring, teachers at the Rosa Parks* Elementary School would test their students' reading levels with a two-part assessment. In part one, teachers presented each student with a list of words and tallied the percentage of words the student read accurately. Part two assessed the student's ability to retell a story. Principal Mary Lansdowne took heart in her students' progress on these informal reading inventories. She was convinced that their gains on the school tests would be reflected in their MCAS scores. Unfortunately, like the results in so many other educational settings, growth on the Rosa Parks School's measures didn't translate into improvement on the standardized assessment.

Lansdowne had minimal formal training in choosing and interpreting reading and language assessments. She was not aware that, in addition to the data from tests used at Rosa Parks, her teachers would need test data that would compare her students with students at same-grade levels across the state and the nation. Without this comparable information, it was difficult for teachers to recognize that while students were, indeed, improving in reading, they were not meeting benchmarks. Mary and her teachers didn't realize that the vocabulary and reading instruction at Rosa Parks wasn't targeted or rigorous enough to help their children reach the level of their Massachusetts peers.

*Representative of schools/students the research team has studied.

information. This is not the first call for better information on our children; others have cited the need for such a comprehensive database, and progress has been made at the state level to put this in place. For example, in an effort to collect data on an early childhood population, the city of Springfield is currently piloting a program to assign every child with a unique identification number at birth. Statewide, once logistical obstacles, including issues of privacy and information sharing, have been worked through, and assessment of early language and reading skills using similar tools becomes standard, a comprehensive database is a potentially powerful instrument in our efforts toward promoting reading outcomes. However, to be sure that results are used ethically, multiple measures, careful interpretation, and careful discussion of the dynamic nature of development are necessary; any decision with data at its core should be made in concert with professional judgment. Ultimately, by tracking children's development beginning in infancy and assessing the quality of our settings and programs—and having these data available in a database—we will be able to develop a sufficiently nuanced and meaningful understanding of our population and of what works—for whom and under what conditions.

It is important to conclude this section of the report by noting that gathering information on our children and the quality of our settings are necessary-but-not-sufficient steps toward promoting reading development. Using these data to inform our practice is the critical next step to build into our professionals' knowledge base and routines, across care settings, schools and clinics, the subject of our next recommendation.

37 National Institute of Child Health and Human Development (2000). *Teaching Children to Read: An Evidence-Based Assessment of the Scientific Research Literature on Reading and Its Implications for Reading Instruction: Report of the National Reading Panel.* NIH Publication No. 00-4769. Washington: U.S. Government Printing Office.

38 Snow, C., Burns, S., & Griffin, P. (1998). *Preventing Reading Difficulties in Young Children.* Washington, D.C.: National Academy Press.

39 University of Massachusetts Donahue Institute Research and Evaluation Group. (2010). *Investigation into Effects and Impact of the Massachusetts Reading First Program: A Synthesis of Statewide Findings* UMass Donahue Institute. January, 2010.

40 Scarborough, H. (2005). Developmental relationships between language and reading: Reconciling a beautiful hypothesis with some ugly facts. In H. W. Catts & A. G. Kamhi (Eds.). *The connections between language and reading disabilities* (pp. 3-24). Mahwah, NJ: Erlbaum.

41 Storch, S. A., & Whitehurst, G.J. (2002). Oral language and code-related precursors to reading: Evidence from a longitudinal structural model. *Developmental Psychology,* 38, 934-947.