Purpose

The purpose of this policy statement is to set a new vision for monitoring and oversight policy and practice within states that (a) improves the efficiency and cost-effectiveness of oversight with regard to early care and education programs; (b) creates a culture of health and safety that better supports the healthy development of children; and (c) enables states to be successful in meeting the goals of the Child Care and Development Block Grant (CCDBG) Act of 2014, (P.L. 113-186), which includes monitoring many more child care providers.

This joint HHS and USDA policy statement aims to:

- Encourage states to align monitoring policies and procedures across funding streams where appropriate rather than monitoring exclusively by funding stream;
- Recommend efficiencies that could be achieved through coordination, collaboration, cross-training, differential monitoring, data sharing, and greater use of technology;
- Shift the current focus of monitoring from one of “compliance only” to “continuous quality improvement”;
- Increase access to the Child and Adult Care Food Program (CACFP) to promote nutritious meals and snacks for children in early care and education settings;
- Recommend a universal set of core health and safety standards that apply across programs to support the alignment of monitoring policies and procedures;
- Share examples of best practices and resources to support states in creating a culture of safe, healthy and developmentally appropriate early childhood settings; and
- Ensure that results of monitoring visits are used to target technical assistance and other supports to ensure changes in behavior and improve overall quality of service.

Target Audience

- State Advisory Councils on Early Childhood Education and Care
- State/Tribal/Territory Child Care Administrators, Licensing Agencies, Subsidy Agencies, and Departments of Health
- State/Tribal/Territory CACFP Administrators
- State Head Start Collaboration Offices

Overview

Promoting the safety and healthy development of children in early care and education settings is the overarching goal of monitoring. However, today’s monitoring policies are often disconnected efforts based on the individual funding streams or program type that can lead to duplication and conflict. The various funding streams, including the Child Care and Development Fund (CCDF), CACFP, and Head Start have different legislative requirements, but all have the same overarching goals – to ensure that our
nation’s most disadvantaged children have access to what they need to promote their optimal development.

Although the goals of each funding stream may be shared, there is often little sharing of monitoring requirements, schedules, data and findings across programs. As a result, trends can go undetected and technical assistance efforts are not targeted to the areas of greatest need. In addition, while some early care and education (ECE) programs receive numerous monitoring visits every year (one or more for each funding stream), other programs receive few or none.

Monitoring has long been a challenge within states, in part, because of the many factors that affect monitoring such as funding related to staffing, monitor and provider training and support, enforcement, and provider and parent communication. With the passage of the CCDBG Act of 2014, new basic health and safety requirements, training requirements and monitoring apply to more ECE programs. Until reauthorization, states were not required to inspect child care centers annually and family child care homes were monitored even less frequently. In addition, many states exempted certain categories of care from licensing and monitoring requirements despite the fact that they were receiving CCDF and other public support. Under the new CCDBG Act, states are required to conduct annual inspections of all licensed programs and unlicensed providers (except relatives) that care for children receiving CCDF subsidy.\(^1\)

The Act also requires an inspection to be conducted before a license is granted, contains new minimum training requirements for the inspector workforce, and requires the ratio of licensing inspectors to child care programs be maintained in a manner that promotes timely and effective inspections.\(^2\) If current monitoring systems involving the various state and federal programs were better coordinated and, where appropriate, better integrated, more programs could be reached with existing resources and any new investments could be used more efficiently.

This provides states with an unprecedented opportunity to review their overall approach to monitoring and implement a new vision. Through use of technology, data sharing and aligned monitoring, we believe states can serve more ECE programs and improve the quality of these programs at the same time. It is the purpose of this policy statement to recommend that states use this opportunity to re-think their monitoring policies and practices to create a more effective monitoring system across programs that would improve program quality, allow for more efficient use of resources, operate in a more effective manner, and better serve children and families.

**Section I – Background**

Throughout the United States, more than 266,000 child care programs (centers and homes) are licensed\(^3\) with a capacity for 9.8 million children.\(^4\) More than 177,000 programs (centers and homes) participate in CACFP with an average daily attendance of 4.1 million children.\(^5\) About 57,685 license-exempt providers currently serve children whose care is paid for through a CCDF subsidy and will now be required to have at least an annual inspection.

Funding to states through CCDF and CACFP represent the two largest federal funding streams that require monitoring visits to early care and education settings. Depending on the ECE program and services provided, other types of monitoring visits may also occur. These include State Quality Rating and Improvement Systems (QRIS), State-funded preschool, national accreditation, fire safety, sanitation, health, Early Head Start or Head Start, and potentially reviews related to children with special needs. Table 1 shows early care and education programs subject to monitoring throughout the states.
Although the content and frequency of monitoring visits required by the funding sources may vary based on legislative requirements, they have similar goals and basic programmatic requirements such as staff qualifications, background clearances, enrollment eligibility, attendance requirements, and certain health and safety requirements. It is within these common areas where there may be opportunities for greater efficiency.

Table 1. Child Care and Related Programs Subject to Onsite Monitoring Visits

<table>
<thead>
<tr>
<th>Licensed Child Care</th>
<th>Number of Licensed Programs</th>
<th>Child Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Licensed Programs</strong>⁶</td>
<td>266,017</td>
<td>9,853,135</td>
</tr>
<tr>
<td>Child Care Centers</td>
<td>110,309</td>
<td>8,362,036</td>
</tr>
<tr>
<td>Family Child Care Homes</td>
<td>129,862</td>
<td>1,151,432</td>
</tr>
<tr>
<td>Group Child Care Homes</td>
<td>25,846</td>
<td>339,667</td>
</tr>
<tr>
<td><strong>Quality Rating and Improvement Systems (QRIS) Participating Programs</strong>⁷</td>
<td>87,077</td>
<td>QRIS systems in 38 states</td>
</tr>
<tr>
<td>NAEYC Accredited Programs⁸</td>
<td>7,136</td>
<td>50 states</td>
</tr>
<tr>
<td>NAFCC Accredited Programs⁹</td>
<td>1,400</td>
<td>50 states</td>
</tr>
<tr>
<td><strong>Unlicensed Care</strong></td>
<td>Number of Programs</td>
<td></td>
</tr>
<tr>
<td>Unlicensed non-relative family child care home providers caring for children receiving CCDF subsidies¹⁰</td>
<td>50,330</td>
<td></td>
</tr>
<tr>
<td>License-Exempt child care centers caring for children receiving CCDF subsidies¹¹</td>
<td>7,355</td>
<td></td>
</tr>
<tr>
<td>Non-relative caregivers receiving CCDF subsidies to care for children in the child’s home¹²</td>
<td>27,739</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adult Care Food Program</strong></td>
<td>Licensed/Approved Participating Programs</td>
<td>Average Daily Attendance</td>
</tr>
<tr>
<td>Total Programs¹³</td>
<td>177,825</td>
<td>4,057,714</td>
</tr>
<tr>
<td>Number of Centers</td>
<td>63,976</td>
<td>3,280,046</td>
</tr>
<tr>
<td>Number of Homes</td>
<td>113,849</td>
<td>777,668</td>
</tr>
<tr>
<td><strong>Other Related Early Care and Education Programs</strong></td>
<td>Enrollment</td>
<td>Location</td>
</tr>
<tr>
<td>State funded preschool¹⁴</td>
<td>1,383,450</td>
<td>57 programs in 42 states and DC</td>
</tr>
<tr>
<td><strong>Head Start</strong>¹⁵</td>
<td>944,581</td>
<td>2,932 programs</td>
</tr>
<tr>
<td>Head Start</td>
<td></td>
<td>1,613 programs</td>
</tr>
<tr>
<td>Early Head Start (EHS)</td>
<td></td>
<td>1,061 programs</td>
</tr>
<tr>
<td>Migrant and Seasonal Head Start</td>
<td></td>
<td>37 programs</td>
</tr>
<tr>
<td>Migrant and Seasonal EHS</td>
<td></td>
<td>15 programs</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIAN) Head Start</td>
<td></td>
<td>148 programs</td>
</tr>
<tr>
<td>AIAN Early Head Start</td>
<td></td>
<td>58 programs</td>
</tr>
</tbody>
</table>

Over the last several decades, effective monitoring policies and practices have been an elusive goal. There are a combination of factors that have challenged states: the largest source of federal child care funding, the Child Care and Development Block Grant, had no requirement for inspections, states faced with budget challenges underfunded or cut funds for monitoring, and state policies were not strong as
agencies sought to draft policy without sufficient resources to undertake monitoring in a more effective manner. One trend is clear. Past reports of poor monitoring practices have not necessarily led to improvements. For example, a 2009 report in Connecticut, “Ensuring Health and Safety in Connecticut’s Early Care and Education Programs,” an analysis of the Department of Public Health Child Care Licensing Specialists’ reports of unannounced inspections was a comprehensive study reviewing 676 child day centers (41% of the state’s supply) and 746 homes (28% of the supply). Among the violations that the report identified in child care centers:

- 48% of the centers had playground hazards,
- 41% administered medicine without a written order,
- 38% had indoor safety hazards,
- 28% had toxic chemicals accessible to children,
- 23% had fire code violations,
- 19% had bathroom sanitation issues,
- 12% didn’t have CPR certified staff, and
- 11% had high chairs without safety straps.

Despite the findings of this report and the potential harm for children attending these programs, a similar report was issued in 2014 by the HHS Office of Inspector General (OIG) that showed many of the same violations occurring in child care centers and family child care homes in Connecticut.

Office of HHS Inspector General Reports on State Monitoring of Child Care Programs

Between 2013 and 2016, the OIG issued reports from nine states and Puerto Rico. The OIG found that 96% of providers that they inspected had numerous potentially hazardous conditions that failed to comply with state licensing requirements. The providers served subsidy children and had a history of compliance violations (i.e., they were not random). Nevertheless, despite having hazardous conditions that could potentially place children at-risk, these programs were (a) licensed and (b) serving CCDF subsidy children.

Weakness in state monitoring and enforcement of licensed child care programs is not new. In 1992, the Government Accountability Office (GAO) issued a report, “Child Care: States Face Difficulties Enforcing Standards and Promoting Quality.”16 In 1993 and 1994, HHS’ Inspector General issued reports related to inspections/safety compliance in North Carolina17 and Nevada18 that found many violations similar to those the OIG has found during the past 3 years. Violations involved: fire code safety, unsanitary conditions, playground hazards, incomplete employee records, incomplete children’s records, and toxic chemicals accessible to children.19 The Nevada report noted inconsistencies among county monitoring and recommended that “the state provide more specific and definitive guidelines to the jurisdictions to ensure uniformity and consistency.”20

A nationwide 1994 OIG report about state child care monitoring across multiple states found similar weaknesses in state monitoring.21 For example, among 169 programs that were reviewed, the OIG found multiple types of violations including: fire code violations (94), toxic chemicals (84), playground hazards (134), unsanitary conditions (394), missing or erroneous employee records, including a lack of background checks (236), missing or erroneous children’s records (191), and other facility hazards (499).22

The 2013-2016 series of OIG reports involving licensed child care centers and family child care homes in Arizona,23,24 Connecticut,25,26 Florida,27,28 Louisiana29,30 Maine,31,32 Michigan,33,34 Minnesota,35,36 Pennsylvania,37,38 Puerto Rico39 and South Carolina,40,41 shows that there are systemic weaknesses in
monitoring practices that include the same types of violations first identified 20 years ago. Therefore, it is not just about the number of inspections that are conducted but it is also about the effectiveness of how monitoring is conducted – including follow up steps taken after an initial visit where violations are found.

**Stakeholder Listening Sessions**

In 2016, the U.S. Departments of Health and Human Services and Agriculture held eight joint listening sessions with key stakeholders to better understand challenges with the current early care and education monitoring efforts. Included were child care center directors, family child care home providers, grantees operating Head Start, Migrant and Tribal grantees, child care resource & referral agencies, state agencies and sponsoring organizations administering CACFP, state licensing officials and representatives from national associations reflecting various ECE sectors. Nearly 100 people provided input on their experiences with the current monitoring system across the country.

In general, some center directors and FCC providers report between 8 to 14 different types of monitoring visits to the same site annually while others reported no monitoring visits or infrequent monitoring with sometimes several years lapsing without a monitoring review.

**Stakeholder Feedback**

The following is a brief summary (in no particular order) of what we learned during the listening sessions:

- Regulations should be more user-friendly, written in plain language, easy to understand, and supplemented by interpretive guidelines.
- Inspectors should be supportive, fostering a culture of mutual respect.
- Monitoring should be more seamless across ECE programs with a shared core purpose (e.g., providers recommended using a common set of health and safety requirements across programs to reduce confusion).
- Inspectors should have sufficient training so that inspections are conducted in a more uniform/consistent manner and by staff knowledgeable about differing requirements between centers and homes.
- Common forms should be developed where possible to avoid conflicting requirements (e.g., conflicting requirements between CACFP and child care licensing or subsidy such as approved attendance sheets or allowable foods. States could review their nutrition requirements to determine areas of conflict with CACFP and use CACFP allowable foods as a base to reduce conflicts).
- Monitoring should be coordinated with duplication reduced (or eliminated).
- Monitoring checklists should be posted on the internet so that providers understand what is expected and are not surprised during an onsite visit.
- Data and documents/previous inspections should be shared among agencies where appropriate.
- Communication among agencies or among departments within agencies should be improved.

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**Perspective from a Provider Operating in Multiple States**

“A big problem that we see across states is that licensors have different interpretations of rules. We understand human factors, but need some type of way to promote more uniformity. Some states’ fire department requirements are in conflict with licensing departments. Who do we follow? Last in the door…”

April 2016 ACF-USDA Listening Session
Monitoring conducted by CACFP and Head Start were viewed as overwhelmingly positive and supportive, while child care licensing inspections were not. What participants told us made the difference in CACFP and Head Start monitoring approaches was:

- Providers felt supported;
- Although the reviews were for compliance, the monitoring visits did not feel adversarial;
- They knew the expectations in advance and they understood the requirements; and
- Providers felt valued and the reviewers offered strategies to promote quality.

State licensing administrators discussed challenges that occur when various programs are overseen by different agencies and departments within state government. They described efforts to integrate departments or divisions to better align monitoring and administration while maintaining the important purposes and focus of the underlying programs. Some states have aligned program standards and have cross-walked monitoring needs and strategies. Some states are increasing the use of technology to increase efficiency, better target technical assistance/support, and identify trends or challenges to be addressed. Some states have revamped their qualifications in hiring and training inspectors. More detail on state innovative practices is described under the best practices sections of this policy statement.

Our stakeholder calls also revealed a frustration beyond challenges related to alignment. For example, licensing agencies are often understaffed which causes a backlog as well as stress among monitors. While licensing administrators agreed that there could be opportunities for greater coordination and efficiency, they also said that they need support from within their administration and state legislature to place a greater priority on monitoring and oversight.

State administrators of the CACFP program stressed the need to improve communication and coordination among monitoring agencies. In discussion with CACFP agencies, some issues arose that require attention and closer coordination between agencies.

- **Responding to Reports of Imminent Danger.** While there may be written protocols within states with regard to cases where one agency contacts another to report a potential case of imminent harm for a child, CACFP agencies report that follow up by some licensing offices (or other appropriate agencies) can be delayed by a week or longer. This delayed response places children at risk and suggests that clear protocols are needed – not just on paper, but also in practice, for all responses to reports of imminent harm.

- **Protection of Children during Investigations.** CACFP agencies report that in some cases when CACFP participation is suspended for imminent threat to children, the children still attend the program (although the food program has been suspended). State licensing agencies should review such cases and determine appropriate next steps (e.g., whether parents should be notified, whether the program should be reviewed for appropriate enforcement actions, etc.).

- **Inspection Delays and Backlog.** CACFP agencies report delays in fire, safety, and health inspections that are needed for CACFP at-risk afterschool programs to operate (i.e., public or private nonprofit organizations eligible to offer afterschool meals and snacks). Inspection backlogs inhibit access to healthy meals and snacks for children. In one state, delays are reported of up to 2 years for a non-school site to obtain the required inspections they need.
Section II – Federal and State Monitoring Models

HHS has released several reports recommending efficiencies for monitoring policy and practice across early care and education programs. In 2015, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in partnership with the Administration for Children and Families (ACF) published, “Innovation in Monitoring in Early Care and Education: Options for States”44 and the Administration for Children and Families published, “Caring for Our Children Basics: Health and Safety Foundations for Early Care and Education.”45 In 2016, the Office of Planning, Research and Evaluation (OPRE) in coordination with ACF published, “Coordinated Monitoring Systems for Early Care and Education.”46 These reports offer recommendations for more efficient monitoring systems.

In addition, the National Center on Early Childhood Quality Assurance (NCECQA) has published numerous policy briefs and provides technical assistance on best practices and research to assist states in developing more effective monitoring systems.47

For ECE, there are four primary federal funding streams that have statutory monitoring requirements. These include Head Start, CCDF, the Military Child Care Program, and CACFP. All share one goal – to improve the quality of ECE programs under their jurisdiction. While CCDF monitoring is described below, for a description of each of the other programs, see Appendix I.

Prior to the CCDBG Act of 2014, states were given broader latitude in assuring that health and safety requirements and enforcement mechanisms were in place to protect children. Under prior law, 4% of funding was required to be spent on activities related to improving the quality of care but activities related to quality were not defined. The new law increases accountability for the receipt and expenditure of child care funding by states and increases the quality set-aside to 12% by FY2020. It requires provider background checks and minimum training, new health and safety requirements and annual monitoring of non-relative providers. CCDF is still a flexible funding stream for states; within federal regulation, states will need to determine how they can best meet the new minimum requirements. The challenge for states varies depending upon individual state policies compared to the minimum requirements to protect the health and safety of children under the new law.

State Governance Models:

As described above, states have considerable flexibility in designing their monitoring systems. And, as described, the new requirements in the CCDBG Act of 2014 have caused many states to re-examine and expand their monitoring systems.

These new requirements have also led several states to rethink their governing structures. Although not a specific purpose of this policy statement, state governance is a major factor in the state’s ability to reduce overlap and align with other statewide efforts such as the Quality Rating and Improvement Systems. According to a BUILD Initiative policy statement, “A Framework for Choosing a State-Level Early Childhood Governance System,” “Governance refers to how (often multiple) entities are managed to promote efficiency, excellence, and equity. It comprises the traditions, institutions and processes that determine how power is exercised, how constituents are given voice, and how decisions are made on issues of mutual concern.”48, 49 Current state ECE governance structures are frequently disconnected. Recognizing this fragmentation, in the 2007 Head Start reauthorization, Congress created the State Advisory Councils on Early Childhood Education and Care (SACs) in an effort to prompt states to coordinate activities and thereby reduce fragmentation, uneven quality, and inequity in programs and
In the BUILD Initiative ECE Governance policy statement, three models are described for states to consider. These include:

- **Coordinated Governance.** Coordinated governance places authority and accountability for early childhood programs and services across multiple public agencies. In states where this is the model, the SACs (or their equivalent) seek to improve coordination and collaboration among the agencies. Some have formal agreements or even State legislative guidance to support their work. For example, Pennsylvania’s Office of Child Development and Early Learning (OCDEL) is a collaborative venture between the State Department of Education and the Department of Human Services.

- **Consolidated Governance.** Consolidated governance places authority and accountability for the early childhood system in one executive branch agency – for example, the state education agency – for development, implementation, and oversight of multiple early childhood programs and services. One state that has done this is Maryland.

- **Creation of a new Agency.** In this model, a state might create a new executive branch agency or entity within an agency that has the authority and accountability for the early childhood system. The governing entity might be an independent state agency with a single mission focused on early childhood. Georgia, Massachusetts, and Washington have created stand-alone ECE agencies.

**Examples of Recent State Monitoring Alignment Efforts**

The following are examples of states that have made recent changes to improve their State monitoring structures to better align their efforts:

**Rhode Island – Aligning among Agencies.** In Rhode Island, multiple agencies are responsible for administering early learning settings: licensing regulations (Department of Children, Youth, and Families), QRIS- BrightStars (Department of Human Services), and Comprehensive Early Childhood Education (CECE) standards for preschool (Rhode Island Department of Education or RIDE). The three agencies worked to compare and align standards to produce a continuum of quality that includes a similar set of components across all three sets of standards for a better integrated monitoring system. Rhode Island’s work included developing:

- A common application for licensing, BrightStars and CECE approval to reduce the need for programs to complete three separate applications.
- Job description and assessor reliability policies for ERS and CLASS© assessors to use across both agencies and to ensure that monitoring is coordinated using the same instruments.
- An integrated data system that will allow data to be shared across the Departments of Human Services, Education, and Children, Youth and Families.
- Training for all front line staff from the three agencies, focusing on topics such as curriculum, health, safety, and family engagement.

**Georgia – Linking Compliance with Technical Assistance.** The Department of Early Care and Learning (DECAL) changed the title of the state’s “licensing monitors” to “child care consultants” to better reflect responsibilities related to regulation and support in improving Georgia’s child care system. When hired, child care consultants complete standardized on-boarding [orientation] and then mentoring by
seasoned veteran staff for at least three months. Thereafter, DECAL conducts or contracts for relevant, appropriate professional development to ensure that licensing consultants are adequately equipped to maintain the balance of monitoring and technical assistance.

In 2014, DECAL convened a task force comprised of child care providers and other stakeholders to revamp the agency’s approach to monitoring. The goal of the task force was to recommend an enforcement model that would be:

- Consistent (easily applied equally to all providers)
- Transparent (easy to understand)
- Fair (providers not excessively penalized, especially for violations that they immediately correct), and
- Predictable (providers know what to expect when rules are violated).

The task force recommended a progressive continuum of enforcement designed to better connect or link regulation and support for providers. The task force’s review resulted in an enforcement chart, which is based on a point system, and classifies enforcement actions as prevention (P), intermediate (I), or closure (C). Examples of prevention include technical assistance and/or citations. Intermediate enforcement options include fines and restrictions. Closures encompass both license suspension and revocation. The overall goal is to better support provider needs in attaining and sustaining compliance.

Use of the model began July 1, 2016 and is automated within the licensing database; a program’s compliance zone designation and enforcement action, if applicable, automatically computes at each visit. A program’s compliance zone (good standing, support, or deficient) is based on a summary measure of the program’s 12 month monitoring history with child care licensing rules.

### Section III: Moving Toward More Effective Monitoring Strategies

**Recommendations & Discussion**

The complex array of early learning programs within today’s environment calls for states to consider a new integrated approach to monitoring. This policy statement offers recommendations to improve the efficiency, cost-effectiveness, and long-term outcomes of monitoring across early learning programs.

**RECOMMENDATION ONE:** Using the Congressionally mandated SACs (or their equivalent), examine the governance structure of early care and education programs to foster greater coordination, collaboration, and policy alignment.

- Utilize SACs (or their equivalent) to:
  - Review any structural barriers that impede communication, coordination, and alignment among the various entities responsible for ECE programs and related funding support.
  - Identify the purpose, function, and expected outcomes of early care and education programs.
  - Determine options that could assist in building a more cohesive early childhood system, which could involve consolidating the governance of related early learning programs within one agency, within a collaborative venture between two agencies, or creating a new agency to house early childhood programs.
DISCUSSION: Many states and localities have worked to better coordinate programs and system infrastructure, accelerated by the Race to the Top Early Learning Challenge Fund and federal promotion of coordination in the 2014 CCDBG Act as well as Head Start policies.

Yet, in many cases, policies, goals, and oversight strategies are not aligned. Fragmentation in governance structure and authority can impede the ability to coordinate and share information across programs. There is no single model that is likely to work for every state, however, the Administration for Children & Families (ACF) recommends that every state review any structural barriers that impede communication, coordination, and alignment. How best to structure governance begins with identifying the purpose, function, and expected outcomes of early care and education programs. While it is not easy to re-align state governance structures, coordination, collaboration, alignment and accountability may be easier for related programs when they are housed under one roof. Interviews with agency, department and division directors engaged in governance reform recommend that the exact form of governance should follow intended function and that “these functions are present and linked in ways that encourage the system’s coordination, coherence, sustainability, efficiency, and accountability at all levels of service delivery.”

Examples of State Governance Models that Promote Alignment

- Georgia has consolidated governance of child care, preschool, and CACFP in the Department of Early Care and Learning (DECAL), a stand-alone agency.  
- Maryland has consolidated governance of child care and preschool into the state education agency. 
- Massachusetts has consolidated governance of child care and preschool into the Department of Early Education and Care, a stand-alone agency.  
- Michigan has consolidated governance of child care, preschool, and early intervention in the Office of Great Start within the Department of Education.  
- North Carolina has consolidated governance of child care and preschool into the Division of Child Development and Early Education within the Department of Health and Human Services.  
- Pennsylvania has consolidated governance of child care, preschool, and early intervention programs within the Office of Child Development and Early Learning (OCDEL), a collaborative venture between the state Department of Education and Department of Human Services.  
- Vermont has consolidated governance of child care, preschool, and early intervention into the Department of Children and Families.  
- Washington has consolidated governance of child care, preschool, and early intervention within the Department of Early Learning, a stand-alone agency.

RECOMMENDATION TWO: Design, implement, and evaluate consistent approaches, including differential monitoring systems to target resources to providers at the greatest risk of providing unsafe settings and to promote greater monitoring efficiencies.

- Consider differential monitoring systems to:
  - More cost-effectively determine the depth of monitoring needed as well as the frequency;
  - Better target technical assistance and training to support providers who could benefit from assistance.

Discussion: ACF’s Office of Child Care and the National Association for Regulatory Administration (NARA), published “Best Practices for Human Care Regulation” in 2015, which helps states define key system characteristics of high-performing regulatory organizations. This document outlines best
practices, provides guidance to implement the best practices, and includes a self-study assessment tool\textsuperscript{65} to help organizations score their performance and facilitate process recognition and improvements. Among best practices that are recommended are three types of assessments: for monitors, providers, and process to ensure that monitoring systems are working as intended.\textsuperscript{66}

According to NARA, “\textit{most performance problems are system-driven problems rather than people-driven problems because the overwhelming majority of people want to do a good job. Individuals flourish when they can see themselves as knowledgeable contributors in a sharp, high-performing organization.}”\textsuperscript{67} NARA’s best practices document lays the foundation for an organization to focus on and assess its resources and processes across the board.

In “\textit{Contemporary Issues in Licensing, Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators},”\textsuperscript{68} full and abbreviated monitoring strategies are reviewed. A differential monitoring system can be used to recognize a provider’s strong record of licensing compliance with abbreviated or less frequent inspections if there have been no serious violations for a period of time. For providers with rule violations and compliance issues, licensing agencies can use differential monitoring to focus more attention on those facilities with additional monitoring visits, targeting visits on problem areas, and providing technical assistance.\textsuperscript{69}

With the requirement in the CCDBG Act of 2014 to ensure that non-relative providers serving children whose care is paid for through a CCDF subsidy receive at least one annual inspection, a “one-size-fits-all” approach may not be the most cost-effective strategy to broaden the base of providers who need an annual inspection (at a minimum).

As of 2014, 37 states used abbreviated compliance forms during routine inspections and 13 states reported using differential monitoring.\textsuperscript{70} It’s not about whether to conduct monitoring visits or not, but rather, it is about the type of monitoring visit to promote efficiencies and greater effectiveness, continuous quality improvement, and accountability. Continuous quality improvement applies to both internal monitoring protocols and practices as well as external provider improvement. Using information collected throughout monitoring visits can assist states in targeting support and resources (i.e., technical assistance) to providers moving the system from determining whether a provider complies on specific standards to helping providers understand why it is important to the health and safety of children that specific standards be met. Quality improvement and compliance are not mutually exclusive but rather components of a more seamless monitoring approach.
Washington’s monitoring system is based on the 13 key indicators developed by Dr. Richard Fiene for the U.S. Department of Health and Human Services. The indicators are used across all programs (centers, FCC homes, and school-age programs). Providers with non-expiring full licenses are monitored using an abbreviated checklist when the site has demonstrated a high level of compliance since the prior visit. This includes, but is not limited to, no valid complaints, compliance agreements, or other information demonstrating noncompliance with licensing regulations. Licensors are required to move to a full checklist in cases where providers are not in compliance with any of the key indicators.

Washington also posts abbreviated checklists online to inform providers:

RECOMMENDATION THREE: Align monitoring policies and procedures across funding streams to promote more effective practice, reduce confusion within ECE programs, and realize cost efficiencies.

- Conduct an organizational assessment to identify:
  - Who is monitoring providers,
  - The role of each monitor,
  - The frequency of monitoring,
  - Tools that are used in monitoring,
  - Staff competencies (qualifications, training, and oversight), and
  - Data systems used in monitoring.

- Review all standards used to monitor ECE programs and determine where there are inconsistencies, duplicative requirements or conflicts.

- Review whether the data and monitoring reports are shared or, could be shared between agencies to reduce duplication and maximize efficiency.

- Identify policies that stem from statute or regulations, cite specific requirements, corrective action requirements, remedies and penalties.

DISCUSSION: ACF recommends that states use “Mapping the Early Care and Education Monitoring Landscape,” tool to assist in identifying how to begin developing a more efficient monitoring system. A coordinated approach could not only produce systemic efficiencies but also help evolve the culture of monitoring from compliance to continuous quality improvement. An aligned system with cross-training could assist monitors in better understanding how the pieces fit together and how fostering a culture of improvement could assist providers with the support they need to be successful.

Many state quality rating and improvement systems are separate from child care licensing and from child care subsidy systems. They operate independently, but are not integrated to promote provider participation and parent awareness. The majority of state QRIS are voluntary and in only 12 states is participation mandatory for providers caring for children on a CCDF subsidy. In some states, quality rating systems do not require programs to be licensed in order to participate. Parallel systems create layers of monitoring that could be more efficient if the system components were better integrated.

State Best Practices:
North Carolina Integration of Licensing, QRIS, and Subsidy

In North Carolina, the state’s Star Rated License System is part of the Division of Child Development and Early Education and is based on the total number of points earned. Licensing is embedded in the state’s quality rating system with level 1 representing licensed care. A facility receives one point for meeting minimum licensing requirements and will be issued a One Star License if that is the extent of that facility’s achievement. To earn more than one point, a facility must meet higher voluntary standards that are based on two components: program standards and education levels of staff. There is also an opportunity for a facility to earn one additional point for meeting a programmatic or education quality point option. A facility can earn up to fifteen (15) points total. For providers to serve children whose care is paid for through CCDF, programs must achieve a 3 to 5 star license.


The monitoring of home-based programs is a particular concern because the number of licensed homes has been declining. Since 2011, the number of licensed homes has declined by 22,489 (14.7%). The capacity within licensed homes has declined by spaces for 165,581 children (12.5%). Home-based care
is an important choice for many families -- not just for its smaller environment but also because home-based providers may offer more flexible hours (including nontraditional hours). As states consider monitoring strategies, intentional approaches to better support home providers, including those with low literacy levels and also those who may not speak English as a first language, should be considered to ensure that the supply of child care homes does not continue to decline. Particularly in rural areas where home-based care may be the only option, it is concerning that the number of licensed homes is declining.

**RECOMMENDATION FOUR:** Wherever possible, adopt a universal set of health, safety and performance standards to be used across programs.

- Consider using ACF’s *“Caring for Our Children Basics: Health & Safety Foundations for Early Care and Education,”*\(^76\) which represents the **minimum** health and safety standards experts believe should be in place for center-based or home-based child care. Standards on the following topics are included:
  - Staffing
  - Program Activities for Healthy Development
  - Health Promotion and Protection
  - Nutrition and Food Service
  - Facilities, Supplies, Equipment, and Environmental Health
  - Play Areas/Playgrounds and Transportation
  - Infectious Disease
  - Policies

**DISCUSSION:** In June of 2015, the Administration for Children and Families published, *“Caring for Our Children Basics: Health & Safety Foundations for Early Care and Education,”*\(^77\) to reduce conflicts and redundancies found in program standards linked to multiple funding streams. *Caring for our Children Basics* should not be construed to represent all standards that would need to be present to achieve the highest quality of care and early learning just a minimum to serve as a floor across early care and learning programs. ACF recommends adoption of the standards contained in Caring for our Children Basics to improve health and safety standards in licensing, quality rating and improvement systems and to promote efficiency in monitoring systems for ECE settings.

By using a core set of health and safety standards across ECE programs, states can implement a more seamless monitoring system. As the new Head Start Performance Standards and the CCDBG regulations were developed, ACF aligned basic requirements wherever possible. In areas such as background screening, basic training requirements and health and safety, the two regulations, if not completely aligned, are not in conflict. In addition, the new Head Start Performance Standards offer specific requirements around state licensing and QRIS to reduce overlapping or duplicative requirements. The new Head Start Performance Standards also defer to the nutrition requirements of CACFP.

Along with the adoption of core health and safety standards, Child Care Health Consultants (CCHCs) can be important resources to: support local programs in meeting state licensing requirements, help create a culture of health and safety, and support for continuous quality improvement.

CCHCs are licensed health professionals with education and experience in child and community health as well as early care and education settings. While CCHCs do not provide clinical services, they do offer technical assistance and consultation to early care and education programs in a variety of areas including but not limited to national health and safety standards for out-of-home child care; state child
care licensing and public health requirements; indicators of quality early care and education related to health and safety; recognition and reporting requirements for infectious diseases; Early and Periodic Screening, Diagnosis, and Treatment screening recommendations and immunization schedules for children; importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children’s Health Insurance Programs; development and implementation of health and safety policies and practices including poison awareness and poison prevention; health literacy on a variety of topics; and disaster planning resources and collaborations within child care communities (CCHCs also link programs with community resources for child, family, and staff health and mental health).

In Pennsylvania, initial evaluation of the Early Childhood Education Linkage System (ECELS) “Infant/Toddler Quality Improvement Project” clearly demonstrates the efficacy of utilizing a CCHC mentoring approach to improve compliance with selected Caring for Our Children Basics standards such as safe sleep practices and SIDS risk reduction, diaper changing procedures, training related to medication administration, hand hygiene, physical activity, and child abuse reporting. The evaluation also showed improvements in meeting the needs of children with disabilities.

RECOMMENDATION FIVE: Based on a statewide assessment of need, establish caseload requirements that take into account the type of ECE program being monitored and the varying levels of quality, different locations (rural vs. urban), and type of setting (center vs. homes).

- Set reasonable caseloads for inspectors
  - NARA recommends 50-60 programs per inspector and two inspections annually.
- Rebalance the caseload based on geography, type of program and setting, and program quality.

DISCUSSION: The average child care licensing inspector caseload includes 97 centers. The average licensing inspector caseload for home monitoring is 103. Monitoring caseloads range by state from 25-300. In some states, monitors inspect both centers and homes. For CACFP, federal regulations require sponsoring organizations to have one full time staff person for each 50 to 150 child care homes it sponsors and a sponsoring organization of centers must document one full-time staff person for each 25 to 150 centers it sponsors. However, within the above ranges, it is the State CACFP agency’s responsibility to determine the appropriate level of monitoring staff for each sponsoring organization.

In “Best Practices for Human Care Regulation,” a document produced by ACF (the Office of Child Care) and NARA, workload assessments are recommended every 3 years or sooner. Effective caseload assessments use historical data to identify types of programs, types of activities, and time to conduct each activity (e.g., a person monitoring across funding streams may require a lower caseload compared to a person monitoring only one type of program). They also use geographic service areas and deployment patterns for efficient and effective monitoring visits, which includes travel time. NARA also recommends that workload calculations should include time for professional development activities.

RECOMMENDATION SIX: Create policies and monitoring approaches across agencies that encourage and support cross-training of personnel to support a coordinated system.

- Consider maximizing CACFP monitoring to support quality care as well as to increase access to CACFP.
- Consider developing a Memorandum of Understanding (MOU) with the CACFP agency to potentially:
  - Develop cross-training initiatives based on key indicators;
Provide reciprocity of certain monitoring items to reduce duplication and conflict;
Develop common forms (e.g., attendance forms acceptable for both CACFP and CCDF subsidy);
and,
Promote efficiencies among and between systems.

DISCUSSION: Currently, in many states, CACFP monitoring and child care program monitoring occurs through separate efforts. Within states, CACFP is administered by the state health agency, the state education agency, the state human services agency, or the state agriculture department. Child care programs are administered by the human resources agency, the education agency, the economic development agency, the labor/workforce agency, or the social services agency. In some states, components of child care programs are spread across different agencies or departments (e.g., child care subsidy, child care licensing, and state quality rating and improvement systems may be administered by different agencies or different departments or divisions).

Given the frequency of CACFP sponsor monitoring, in rethinking an aligned integrated state monitoring system, it makes sense to review how to better maximize CACFP monitoring to support quality care as well as to increase access to CACFP.

State agencies administering CACFP and state child care licensing agencies could develop a Memorandum of Understanding (MOU) to potentially develop agreements about how to undertake monitoring that would allow for sharing resources for better coordination. For example, a state with a key indicators system or differential monitoring system could potentially develop a cross-training initiative where CACFP monitors could be trained on a small subset of key indicators identified by the child care licensing agency. The MOU could consider a scaffolding approach to maximize resources among agencies. Where appropriate, States could use Caring for Our Children Basics as a core set of health and safety requirements across programs, which would provide consistency that has been lacking and a floor to quality from which all states could operate. States could provide reciprocity of certain monitoring items to reduce duplication and promote uniformity across program standards where applicable (e.g., CACFP nutrition standards and food safety could be adopted by child care licensing agencies instead of each agency having separate (and sometimes conflicting) requirements). Head Start already requires CACFP participation.

An MOU could also include an agreement to use a uniform attendance form or other forms that could be shared to reduce administrative burdens for programs. These types of actions can be undertaken by states without approval from HHS or USDA. For example, as long as federal requirements are met, states can create their own integrated attendance forms or monitoring forms. If helpful, HHS and USDA could support states as conveners and disseminate information about state level best practices.

With MOUs, monitoring policies could be constructed and undertaken in a more efficient manner which not only promotes systemic coordination and effectiveness but also avoids the number of times providers are disrupted in the provision of services for children.

RECOMMENDATION SEVEN: Develop uniform personnel requirements for all monitors that include a description of the knowledge, skills and abilities (KSA) necessary to meet the goals of the monitoring policies and training that supports continuous quality improvement and a culture of support for providers and inspectors.

ACF recommends the following to promote a more supportive approach to monitoring that fosters efficiency and mutual respect:
Ensure all monitors are provided systematic comprehensive training before they begin work and routine in-service training throughout the year. This should include training on all standards, rationale for why the standards are important, and examples of what they should review to determine compliance.

Ensure all monitors are trained in balancing compliance and continuous quality improvement.

Ensure job descriptions reflect shared components of monitoring processes.

Share monitoring checklists, along with the rationale for the requirements with the ECE providers and general public including parents to remove the element of surprise and to enable providers to fully understand standards for which they will be held responsible.

Include mentoring and coaching for all newly hired monitors by experienced staff during a probationary period.

Ensure that those who monitor family child care home providers have specialized training to fully understand child care home regulations and the operation of home-based programs.

Determine appropriate caseloads for the various program types and ensure monitors are not overwhelmed. If warranted, adjust caseloads for monitors who have difficult programs or other unique circumstances.

Support a shared vision among agencies and divisions to avoid unintended consequences when issues are identified during monitoring visits.

Include inspection checklists in the materials providers receive during trainings, upon licensure and licensure renewal, and that providers can easily access online; and

Conduct regular, systematic surveys of ECE providers in order to allow those monitored to provide feedback and to promote continuous quality improvement among providers and inspectors.

DISCUSSION: Currently, multiple agencies share responsibility for monitoring the same or similar standards across settings. Aligning monitoring strategies is part of implementing a coordinated process, however, it begins with cross-training and basic competencies of monitors. As of 2014, 39 states required child care inspectors to have at least a Bachelor’s degree. In 24 states, the content or major of the degree must be in early childhood education, child development, or a related field. Twenty-one states also required experience working in a setting with children. In addition, 28 states required licensing staff to complete additional training each year. It is not known how many states engage in cross-training to promote monitoring across programs and funding streams. Only 6 states use inter-rater reliability studies to help promote consistency in monitoring. Inter-rater reliability is a critical issue that needs to be addressed by states; it is as important as the issue of validity. With regard to CACFP personnel requirements, federal regulations require that each sponsoring organization provide adequate supervisory and operational personnel for the effective management and monitoring of the program at all facilities it sponsors.

It is not easy to change the culture of monitoring from a framework of compliance to support for continuous quality improvement. Specific training on balancing compliance and continuous quality improvement is needed so that both inspectors and providers are supported. The listening sessions revealed challenges with licensing inspector knowledge of state regulations and too often the attitude of monitors in conducting inspections. The key to changing the culture of the monitoring framework is to have an underlying quality assurance program. This is a major paradigm shift in seeing the glass as half full rather than as half empty. NARA’s “Best Practices for Human Care Regulation,” includes a number of recommendations related to quality assurance programs such as monitor training, coaching, workload, and provider feedback. While each state may define quality assurance differently, at the core is the ability to have feedback on the system and how each of the components of the system is working. Florida, Georgia, Oklahoma and Texas have a formal quality assurance program with written policies designed to increase consistency across the state.
**State Best Practices:**
**Training of Licensing Staff**

**Florida’s** staff undergo inspector led pre-service training, 38 hours of nine online child care training courses (e.g., family child care home licensing and center licensing, identifying and reporting child abuse and neglect, child growth and development, record-keeping, etc.). Supplemental training includes shadowing an experienced licensing specialist in conducting a child care center inspection, family day home inspections, assisting in opening a new facility, and ongoing professional development and in-service training. With a year of on-the-ground experience, inspectors (referred to as family services counselors) can complete the National Certified Investigator/Inspector Training (NCIT) certification offered by the Council on Licensure, Enforcement, and Regulation (CLEAR). Upon successful completion of the NCIT Basic certification, licensing staff can complete the NCIT Advanced certification. Currently, about 90% of Florida’s licensing staff have obtained the NCIT Basic certification and 25% have obtained the Advanced certification. Beginning this year, for staff who have completed the NCIT Basic program, the Department of Children and Families will pay for costs related to completing the NARA National Regulatory Professional Credential (NRPC).

**Washington’s** staff complete the NARA curriculum on regulatory enforcement and human care regulation and some staff have completed the NARA National Regulatory Professional Credential (NRPC). New licensors complete the NARA online curriculum as they come on board. Washington uses a variety of professional training techniques, including agency specific courses offered both online and in person. The Department of Early Learning is currently developing cross agency trainings between licensing, the state’s preschool, and the quality rating and improvement system (Early Achievers) staff. Also under development is a parallel training track for both licensing staff and early learning providers, focusing on the new standards as well as increasing the quality in child care.

**Quality Assurance & Consumer Feedback**

**Oklahoma** conducts annual regional audits of each supervisory area, during which a team of licensing staff from around the state reviews cases to determine if licensing requirements, policies and procedures are being consistently implemented. Policies governing the audit process are publicly posted. Oklahoma also solicits feedback about inspections through biannual provider satisfaction surveys and community forums.

**Florida’s** regional program analysts conduct annual quality assurance monitoring visits to determine if policies are followed by each licensing counselor for each provider type in each region.

**Georgia’s** regional directors evaluate field staff by conducting quality assurance visits at least once per year for all consultants. Lead consultants also conduct joint visits with field staff throughout the year in a more informal quality assurance process. The purpose of the joint visits is to evaluate staff on:
- Professional practice
- Consistent and accurate evaluation and application of rules and regulations
- Principles of documentation; and
- Conducting an appropriate exit conference during the inspection.

**Utah** evaluates its program by having managers conduct onsite observations of licensing inspections 4 times per year. Child care providers are given inspection feedback forms after each inspection. The program administrator reviews and records the feedback, and licensors receive a monthly report that includes all comments received from providers. Program managers meet with licensors as needed to discuss any concerns or clarifications.

RECOMMENDATION EIGHT: Develop cross-agency protocols that ensure agencies are responsive when monitoring reveals a situation where children may be at risk.

- Develop written guidelines and timeframes for conducting complaint investigations and allegations of illegal operations.
  - Ensure clear protocols are in place.
  - Prioritize investigations by levels of risk.
  - Include timeframes ranging from immediate to no longer than 5 days.
  - Integrate timeframes into automated data systems.

DISCUSSION: ACF and NARA’s “Best Practices for Human Care Regulation,”94 recommends that licensing agencies have written guidelines that include timeframes for conducting complaint investigations and allegations of illegal operations, that the guidelines take into consideration the severity of the complaint and assign timelines based on severity. Because the health and safety of children may be at risk, NARA recommends that complaints received by any individual or organization should be treated with the same level of response. When multiple agencies are involved in a complaint, there should be written protocols in place to clarify timelines and a lead agency. Communication, collaboration, and timeliness are each important to ensure the safety of children.

In addition to protocols for complaint investigations, NARA recommends that corrective action plans be based on cause and monitored systematically for compliance. Such plans should include corrective action expectations, templates, required signatures, and expected follow-up by both the provider and the regulatory program. The plan should require corrective action completion within an appropriate time frame, which at a minimum should be the next licensing inspection or at another time consistent with the level, frequency, and type of violation.95 Any timeframes developed through the policy process should be integrated into a state’s automated data system.

RECOMMENDATION NINE: Ensure that all requirements are publicly available, written in plain language with clear rationale and indicators about how the requirements will be assessed. Publish interpretive guidelines to promote clarity, transparency, and greater utility among the provider community and the monitoring workforce.

- Ensure regulations are user-friendly, written in plain language, easy to understand, and supplemented by interpretive guidelines.
- Ensure regulations take into account cultural competence and respect community diversity.

DISCUSSION: Interpretive guidelines provide a practical guide to how an agency will apply, measure, and enforce a rule. They can help child care licensing staff and providers better understand the purpose of each rule and how it is to be measured to assess a facility’s compliance with licensing regulations.96 According to NARA’s 2011 survey, about half (24) of states in 2011 had developed interpretive guidelines in some manner.

State Best Practices: Oregon Equity Lens

Oregon’s Equity Lens aids in recognizing institutional and systemic barriers and discriminatory practices that have limited access for many children because of their race, ethnicity, English language proficiency, socioeconomic status, gender, sexual orientation, special health care needs, and geographic location. By utilizing an equity lens, Oregon aims to provide a common vocabulary and protocol for resource allocation, policy development and evaluating strategic investments.

Oregon Equity Lens:
http://www.ode.state.or.us/superintendent/priorities/final-equity-lens-draft-adopted.pdf
The benefit of interpretive guidelines is that both providers and monitoring staff can use them as a tool to more easily understand state policies and meet state expectations.

**State Best Practices: Virginia and Washington Interpretive Guidelines**

**In Virginia,** the Department of Social Services (VDSS) has published “interpretive guidelines” for licensed family day homes. These guidelines are written in plain language and assist providers and licensing inspectors in better understanding the state’s regulations. VDSS has also published a technical assistance manual for centers, in a Q&A format that is a form of interpretive guidelines written in an easy to understand manner with concrete examples to improve compliance with state regulations.

**Standards for Licensed Family Day Homes with Interpretation Guidelines**

**Standards for Licensed Child Day Centers, Technical Assistance**

**In Washington,** guidebooks for both centers and family child care homes have been published with the community college and align with the state’s current rules. The guidebooks are in electronic format with links on the state agency web site. They provide guidance on every phase of the licensing process and best practices in child care for meeting the child care rules. The guidebooks are used to assist providers, assist licensing preservice and ongoing training, and also by the community college in conducting provider training.

**Child Care Center Licensing Guidebook**

**Family Home Child Care Licensing Guide**


**RECOMMENDATION TEN:** Utilize technology to both increase efficiency and better target training and technical assistance resources to monitors and providers. Develop policies that support the sharing of data between agencies.

- Utilize technology to increase accountability, efficiency, and transparency.
- Use data to better understand training needs for both monitoring staff and providers.
- Share data and information among and between agencies and programs where appropriate.

**DISCUSSION:** According to the National Center on Early Childhood Quality Assurance, 34 states report using portable devices to help staff more efficiently inspect and monitor licensed programs such as through laptops, tablets or other digital means. Some of the benefits include:

- Monitoring data are recorded once during the inspection visit and do not have to be reentered upon return to the office.
- Pre-population of forms with program information can reduce the time spent on paperwork and allow more time for observing care.
Software that performs spell-check, provides an alert when something has been overlooked, and allows for the selection of standardized text makes reports more consistent, quicker and more accurate.

Licensors can access relevant monitoring information such as prior history, requirements and the licensing statute while in the field.

Licensors can produce an inspection report on site.

Posting the report onsite or on the internet is more efficient.

Some states work internally within their agency and others contract with private vendors. Greater use of technology can not only make the monitoring system more efficient (and cost-effective) but also can be used for strategic purposes. For example, states that can integrate compliance issues can better target training for providers and monitors to better address identified challenges. In Georgia, software enables the state to track programs, trainers, and monitoring consultants, to track types of violations, and to address them regionally by trend such as if there is an uptick in playground problems, trainings can be specifically targeted based on identified need.

Indiana Family and Social Services Administration

Indiana uses wireless webforms software. Licensors are provided with a tablet computer with a USB camera, field case, docking station, blue-tooth enabled portable printer, and a wireless card to transmit data. Forms are automatically populated with program information. A plan of correction form is populated with any noncompliance information. The following benefits were reported:

Cost Reductions
- Reduction in costs for consultants, saving 26% ($316,605 annualized)
- Reduction in clerical effort by 82% ($30,360 annualized)
- Potential savings by reducing the risk of making errors in subsidy payments
- Savings in travel expenses by eliminating trips into the office to submit and pick up forms
- Elimination of costs associated with preprinting of paper inspection forms

Productivity Increases
- Reduction in licensing application processing time from a 35 day average to less than 2 days
- Increase in the number of inspections that can be completed from 6,849 to 9,288 (annualized)
- Increase in accurate reporting and data-driven management decisions with more timely data
- Implementation of standardized workflow processes

Source: Use of Technology to Enhance Licensing Administration. National Center on Child Care Quality Improvement (2014).

In addition to a greater use of technology is the critical need for data and information sharing. A coordinated monitoring strategy depends on the ability to share data and information among and between agencies. In too many states, there is no sharing of data and no sharing of information (e.g., monitors do not have access across programs to previous inspection reports to reduce duplication or to promote follow-up). Monitors should know across settings the spectrum of programs in which providers participate (e.g., licensing, CACFP, Head Start, QRIS, State Pre-K, etc.) to promote efficiencies in monitoring approaches. Head Start data could be shared for community birth-to-five planning purposes as well as CLASS© results where appropriate for use in quality rating systems (e.g., 15 states use CLASS© observations as part of state QRIS ratings).
With the requirement under the CCDBG Act of 2014 to post inspection reports on the internet, some of the information sharing will be facilitated. However, the challenge with data and information sharing goes beyond the posting of licensing reports. For example, although allowed, in most states, CACFP participation data and disqualification actions are not shared with the state licensing office. Conversely, the state licensing data is not shared with the state CACFP administering agency.

In Florida, Georgia, and North Carolina, CACFP state agencies link with child care licensing agencies or divisions to promote tracking of licensing activities (e.g., new issuances, denials, suspensions, revocations, etc.). This type of data sharing enables both agencies to be better informed about the status of programs and to protect children.

### State Best Practices: CACFP Agency and Child Care Licensing Data Sharing

**In Florida**, each month the Department of Children and Families (DCF) sends to the Division of Community Health Promotion, the CACFP state agency, an excel spreadsheet that includes an updated listing of all licensed centers and homes. In addition, a list of revoked licenses is sent each quarter. If during a routine inspection, child care licensing staff discover an egregious situation (e.g., imminent threat to children), it is reported immediately to both the field staff assigned to the area and the central office in Tallahassee via a phone call and a follow up email.

**In Georgia**, both the licensing agency and the CACFP administering agency are part of the Department of Early Care and Learning which administers Georgia’s Pre-K Program, licenses child care centers and home-based child care, administers Georgia’s Childcare and Parent Services (CAPS) program, federal nutrition programs, and manages Quality Rated, Georgia’s community powered child care rating system. Staff from both agencies participate in regular meetings to review issues related to licensing and CACFP so that each agency is kept abreast of issues and concerns as soon as they are discovered.

**In North Carolina**, whenever the child care licensing agency takes any adverse action (e.g., a warning, revocation, suspension, etc.), the CACFP state agency receives a copy of the action as soon as it is issued.

These partnerships promote agency coordination, the health and safety of children, and accountability for public funding.

Source: USDA email exchanges with HHS staff, Florida, Georgia and North Carolina CACFP state agencies. (August 2016).

For efficiency and cost-effectiveness, it is recommended that states and CCDF tribal grantees develop policies to enable data and information sharing between agencies to promote more coordination, collaboration, and efficiencies throughout state monitoring initiatives.

In addition, there should be more information sharing with the public, particularly families. While posting inspection reports on the internet is required under the CCDBG Act of 2014, the content of those reports should be easy to understand and prioritized related to severity. Merely posting reports on the internet may not be helpful to parents depending upon the format a state uses. The concept behind posting reports is to enable families in a user-friendly manner to become educated consumers. Reports that are dense, hard to understand, and not prioritized undermine that goal. Whether it is the format used in posting inspection reports or the new requirement under CCDBG to post provider quality indicators, the information needs to be easy for the public to access and digest.

Data sharing among state agencies and Tribes where applicable can also help promote state outreach strategies (e.g., strategies related to assisting more providers to become licensed or to participate in CACFP). Data sharing when combined with data visualization (e.g., geocoding licensed program data and
CACFP participation data) can help both agencies identify areas within a state where there is an imbalance between supply and demand leading to proactive strategies to better serve children.

**State Best Practices: CACFP and Child Care Data Sharing in Virginia**

In Virginia, the Department of Health, the Virginia Early Childhood Foundation, and Child Care Aware of Virginia held a CACFP summit in June of 2016 to support quality child care through increasing CACFP participation. Through data visualization, a data-driven strategy is being developed to better target outreach for both CACFP participation and licensing. Data sharing has enabled partners to work together in a more coordinated and strategic manner to ensure that more children have access to safe settings as well as nutritious meals and snacks.

![CACFP Throughout Virginia](image)

Source: Child Care Aware of Virginia; Virginia Department of Health

**Section IV. CONCLUSION**

The reauthorization of CCDBG and the revisions to the Head Start Performance Standards offer an opportunity to review current state (and federal) monitoring systems to better align standards and promote greater efficiencies to ensure a more effective, uniform, and cost-effective approach to monitoring. The final CCDF regulations include CACFP agencies as a required partner for the CCDF Lead Agency, which can help promote more coordination, collaboration, and policy alignment.

Coordinated monitoring begins with mapping the number of inspections within the early care and education community, who conducts them, what the purpose of each is, what programs receive monitoring visits, the frequency of such visits, the tools used to measure compliance or performance, applicable statutory and regulatory requirements, and how a systemic monitoring approach can be better designed. Considering the use of differential monitoring systems can bring about efficiencies that enable more resources to be allocated to programs that need additional attention, including those currently not subject to inspection but that will be under the new CCDBG law.

Using **Caring for our Children Basics** across programs will ensure that there is a core set of health and safety standards regardless of early learning setting. Developing MOUs between state agencies or departments with reciprocity or agreement on common standards (e.g., CACFP meal and food safety rules, attendance forms, etc.) can help promote more effective and efficient monitoring approaches. Promoting continuous quality improvement and compliance will lead to a culture of support bolstered
by monitor training, the use of interpretative guidelines, customer feedback, and reasonable monitoring workloads. Utilizing today’s technology and greater sharing of data and information will not only make monitoring systems more efficient but will also enable greater resource targeting that is data-driven. With cross-training and MOUs, it is possible to achieve greater efficiencies across agencies.

Early care and education programs are more complicated today than they were decades ago yet the system to monitor ECE programs has changed very little. It is possible to design a more efficient and cost-effective monitoring system for early learning programs. The recommendations in this policy statement are meant to foster discussion, share some innovative state practices, and help states design the next generation of monitoring policy and practice.
Appendix I:

Head Start’s Aligned Monitoring System

Following enactment of "the Improving Head Start for School Readiness Act," (P.L. 110-134), the HHS Office of Head Start (OHS) revamped its Head Start program monitoring system. Head Start has implemented some data-driven reforms that are recommended in this statement.

Prior to the Head Start reauthorization in 2007, Head Start grantees operated under an indefinite grant period with an intensive review once every three years to ensure compliance with the Head Start Performance Standards. The new monitoring system involves program reviews conducted across the five-year grant cycle focused on a specific content area:

- Environmental Health & Safety
- Leadership, Governance, & Management Systems
- Fiscal Integrity/Enrollment, Recruitment, Selection, Eligibility, and Attendance (ERSEA)
- Comprehensive Services & School Readiness
- Teacher-Child Interactions, as addressed through the Classroom Assessment Scoring System (CLASS©) observation instrument

The new Aligned Monitoring System (AMS) takes into account compliance and quality by using a program’s track record to determine the intensity of monitoring. The AMS provides two different approaches to monitoring based on a grantee’s history: the Comprehensive Monitoring Process and the Differential Monitoring Process.

The Comprehensive Review involves the five content-focused assessments in the first three years of the grant. The Differential Monitoring process focuses on a shorter list of key indicators selected from the Comprehensive Monitoring tool. Grantees with a strong track record of compliance receive the shorter, key indicator review. If they are in compliance, the Office of Head Start will only monitor the Environmental Health and Safety and CLASS© during the grant cycle. If they are not compliant, they will receive a Comprehensive Monitoring review. For grantees with findings or deficiencies, a corrective action plan is put into place and OHS staff work with grantees to come into compliance. Targeted technical assistance is provided. A follow up review is conducted to ensure that identified findings have been addressed.
Finally, the Office of Head Start has increased transparency and partnership with grantees, which has helped transform the culture from one of compliance anxiety to continuous quality improvement. To assist grantees in better understanding the areas that will be monitored, OHS has developed an online “Aligned Monitoring Virtual Expo.” The on-line expo describes specific content areas that will be reviewed, allows grantees to access videos and supporting information, and offers grantees an opportunity to ask questions. The transparency of the information has helped reduce the anxiety and mystery associated with the monitoring process so that grantees can be successful. Revamping the monitoring process and creating greater transparency with regard to standards and monitoring tools has helped transform the culture and helped to promote a link between monitoring and quality practices (rather than a focus on the negative).

While Head Start programs are federally funded, they are required to be licensed by states (or meet comparable standards) and participate in CACFP. In addition, many Head Start programs participate in state quality rating and improvement systems. Therefore, in addition to the federal aligned monitoring system, programs are also subject to other inspections. With greater sharing of information, duplication in monitoring could be avoided.

The Child and Adult Care Food Program (CACFP) Monitoring System

Through USDA, CACFP provides reimbursement for meals and snacks in child care, Head Start, and other early childhood settings serving low income children. Child care home providers and affiliated and unaffiliated centers are required to operate under a sponsoring organization. Independent centers are not required to participate under a sponsoring organization. Instead, they can conduct their own administrative tasks and participate directly under a state agency.

State agencies must annually review at least 33.3 percent of all programs. Independent centers and sponsoring organizations with 1 -100 facilities must be reviewed at least once every 3 years. Such reviews must include reviews of 10 percent of the sponsoring organization’s programs. Sponsoring organizations with more than 100 facilities must be reviewed at least once every 2 years. Such reviews must include at least 5 percent of the first 1,000 facilities and 2.5% of the remainder in excess of 1,000. Sponsoring organizations of homes or centers must visit programs at least 3 times per year. Programs participating in CACFP must be licensed. If licensing is not required by state agencies, USDA offers some flexibility on alternative approval, including a minimum set of standards for health and safety that are part of CACFP regulations for use when licensing and alternative approval is not available. The state agency requires submission of health/sanitation and fire/safety permits or certificates for all independent centers and programs seeking alternate child care standards approval.
Child and Adult Care Food Program (CACFP) Monitoring
State Agency Reviews & Sponsoring Organization Reviews

State Agency Monitoring
Large Sponsors (100+)
- Sponsoring organizations with more than 100 facilities: Must be reviewed at least once every 2 years. The review of the sponsoring organization must include reviews of 5% of the first 1,000 facilities and 2.5% of the facilities in excess of 1,000.
- New sponsoring organizations of 5 or more facilities must be reviewed within the first 90 days of operation.

State Agency Monitoring
Small Sponsors (1-100) & Independent Centers
- Independent Centers & Sponsoring Organizations of 1-100 facilities: Must be reviewed once every 3 years. The review of the sponsoring organization must include reviews of 10% of the sponsoring organization’s facilities.

Sponsoring Organizations
100+ facilities
- Family Child Care Homes
- Child Care Centers

Sponsoring Organizations
1-100 facilities
- Family Child Care Homes
- Child Care Centers

The Department of Defense operates the nation’s largest employer-sponsored child care system assisting 200,000 children of military families every day. At the core of the military’s support for child care: high quality standards and enforcement of those standards, workforce preparation, parent engagement, and affordable access. However, the military child care system was not always the model it is today.

A 1982 U.S. General Accounting Office (GAO) study found that many military child care programs “currently in use are neither safe nor suitable places for child care programs.” The majority of the Army child care facilities did not meet fire and safety codes. The majority of Navy facilities needed upgrading to comply with fire, safety, and sanitation standards. One-fifth of Air Force programs needed improvements and additional facilities were needed to meet Marine Corps demand. A 1989 GAO study found extensive and growing demand for child care and deemed child care services to military families as an “essential service” and “mission critical.”

The GAO reports, a series of public scandals involving military care, and parent demand fueled Congressional hearings and ultimately enactment of the Military Child Care Act of 1989 (P.L. 101-189), which called for the military to establish a comprehensive cross-system (i.e., Army, Navy, Marine Corps, and Air Force) of health and safety regulations, training for the workforce, and an enforcement system including quarterly unannounced inspections as well as tough sanctions for noncompliance.

The military monitoring system was developed as a monitoring system of checks and balances with each level responsible for ensuring that monitoring is completed as required, objective, and comprehensive.

- At the installation or community level, each installation is required to conduct quarterly inspections of its’ Child Development Programs.
- Each Major Command (a group of installations with common missions) then must conduct at least one unannounced monitoring visit to each installation within its’ command per year.
- Each Military Service (Army, Navy, Marine Corps and Air Force) must then conduct at least one unannounced inspection of one installation within each command.
- Finally, the Department of Defense (DoD) selects one installation within each Military Service to conduct an unannounced inspection with the goal of ensuring appropriate oversight within each service.

The system is designed to ensure comprehensive, objective monitoring that is conducted at each level within the system.

At the installation level, the quarterly inspections include health and sanitation, fire and safety, program quality and overall compliance against standards by a multidisciplinary team. Each team includes a parent representative. Each service branch’s headquarters also conducts an annual inspection.

Although DoD has its own child care system, it depends on state policies and practice to meet the needs of military families who cannot access on installation care.
ACF’s National Center on Early Childhood Quality Assurance (ECQA) supports state and community leaders in devising innovative models to promote more effective monitoring systems among quality initiatives. The ECQA Center’s priorities include advancing strong health, safety, and quality standards and licensing regulations within states and territories. ECQA Center staff have developed resources and tools that address two main areas of child care licensing: policies and practices (e.g., monitoring, enforcement, and licensing staff development), and program requirements.

The Health and Safety and Licensing topic page on the Early Childhood Training and Technical Assistance System website includes issue briefs, research reports, and other resources. The page is available at https://childcareta.acf.hhs.gov/topics/health-and-safety-and-licensing. Highlights include three series of briefs:

- Nine topical briefs about health and safety requirements
- Three research briefs about national trends in child care licensing
- Eight issue briefs about contemporary issues in licensing

Technical assistance tools include the following:

- **The National Database of Child Care Licensing Regulations** is a repository of State and Territory licensing regulations and agency contact information. It is organized by State/Territory and allows users to access child care licensing regulations that apply to child care centers, family child care homes, school-age programs, infant care programs, and other specialized programs. In addition, website links are provided for other early childhood programs standards, such as quality rating and improvements system (QRIS) standards, prekindergarten program requirements, and state health and safety requirements for child care providers receiving payment from the federal Child Care and Development Fund. https://childcareta.acf.hhs.gov/licensing

- **The CCDF Data Explorer** contains State-level data about licensing requirements and is available on the ECTTA website. Child Care and Development Fund (CCDF) data include child-staff ratios and group sizes, criminal background checks, minimum preservice qualifications, ongoing training hours, and types and frequency of routine licensing inspections. https://childcareta.acf.hhs.gov/data

- **The National Program Standards Crosswalk Tool** is prepopulated with national early childhood program standards (such as Head Start, accreditation, Caring for Our Children). It is designed to help States that are developing and aligning program standards for licensing, QRIS, or prekindergarten programs to search and compare the content of several sets of national standards. https://occqrisguide.icfwebservices.com/index.cfm?do=crosswalk

Additional information and resources from the ECQA Center are available at https://childcareta.acf.hhs.gov/quality-improvement.
2 Ibid.
4 Ibid.
7 BUILD Initiative, QRIS Compendium, Create a Report, 87,077 programs in 38 states. (2016). http://griscompendium.org/create-a-report; There are additional states such as Alaska, Alabama, New Jersey, and Texas that have begun implementing a statewide QRIS but were not included in the most recent BUILD Compendium. Refer to the Compendium web site for updated reports expected in the fall of 2016.
8 NAEYC Accreditation as of June 2016
9 NAFCC Accreditation as of June 2016
11 Ibid.
12 Ibid.
16 GAO: “Child Care, States Face Difficulties Enforcing Standards and Promoting Quality,” November 1992 (GA/HRD-93-13). “In most cases, budget cutbacks and the resulting lack of staff in addition to increased numbers of providers were the major reasons states cited for difficulties in conducting on-site monitoring.” Page 7. http://www.gao.gov/assets/220/217095.pdf
19 Ibid.
20 Ibid. Page i
42 April 14, 2016 Early Care and Education Consortium (multi-site child care centers)
43 April 14, 2016 National Head Start Association (grantees and delegate agencies)
44 April 15, 2016 Child Care Aware of America (Child Care Resource & Referral Agencies)
45 April 18, 2016 National Association of Family Child Care (family child care homes)
46 April 28, 2016 USDA Food & Nutrition Service/State Agencies (State agencies administering CACFP)
47 May 2, 2016 USDA Food & Nutrition Service/Sponsors (Sponsoring agencies for CACFP)
48 May 23, 2016 National Association for Regulatory Administration (state licensing officials)
49 May 23, 2016 Migrant and Tribal Head Start Programs (grantees)


http://decal.ga.gov/

http://earlychildhood.marylandpublicschools.org/


http://www.michigan.gov/mdr/0,4615,7-140-63533---,00.html

http://ncchildcare.dhhs.state.nc.us/general/mb_ncprek.asp

http://www.education.pa.gov/Early%20Learning/Pages/default.aspx#tab-1

http://dcf.vermont.gov/cdd

https://www.del.wa.gov/


Ibid.


FY2015 CCDF QRIS Performance Data and FY2016-FY2018 CCDF State Plans


Initial Evaluation results reported by the Early Childhood Education Linkage System (ECELS), on Grant Number: H25MC26235, the Infant/Toddler Quality Improvement Project.


Kansas, New York, Florida and Texas developed their data systems internally. Other states have contracted with SansWrite or TCC Software Solutions.


Ibid.


Innovation in monitoring in early care and education

Options for states
An ASPE White Paper, in partnership with ACF

U.S. Department of Health and Human Services
Pamala Trivedi, Office of the Assistant Secretary for Planning and Evaluation (HHS/ASPE), in partnership with the Administration for Children and Families (ACF)
Innovation in monitoring in early care and education:
Options for states

An ASPE White Paper

April 2015

Pamala A. Trivedi

Office of the Assistant Secretary for Planning and Evaluation (ASPE),
in partnership with the Administration for Children and Families (ACF)

U.S. Department of Health and Human Services


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Many people worked hard in supporting the completion of this white paper. This paper contains a great deal of information about local practice in states, and I am greatly appreciative of the time and openness of state administrators across agencies who have been working on behalf of the health and safety of children for many years. This paper has also greatly benefitted from the advice and careful thinking of a number of colleagues at the U.S. Department of Health and Human Services. Linda Smith from the Administration of Children and Families, and her team members Katherine Beckman and Richard Gonzalez have helped shaped this paper from its inception. Adia Brown from the Office of Head Start also provided substantial support in developing the content of this paper. Several colleagues at ASPE provided thoughtful feedback at various stages of this work, including Jennifer Burnszynski, Laura Radel, Lindsey Hutchison, Sharon Wolfe, Kimberly Burgess, Nina Chien, and Kirby Chow. This paper also benefitted considerably from the conscientious reviews of Taryn Morrissey and Richard Fiene.
Executive Summary

Ensuring children are in safe environments that promote health and development is a top priority of families, state regulators, the federal government, and national organizations that accredit early care and education programs (ECE). This paper examines monitoring across ECE settings and considers lessons learned from the analogous sectors of child welfare and health. Although professional organizations in partnership with federal agencies developed national guidelines for health and safety, there is wide variation in state and local regulations around the minimum health and safety requirements for children in care. Areas of regulatory variation include: 1) thresholds for the number of children in licensed care at ECE facilities located in family child care homes (FCCs); 2) the comprehensiveness of background checks for ECE provider staff and individuals residing at FCCs; and 3) the frequency of monitoring visits.

ECE providers may receive funding from one or more public sources including, the Child Care and Development Fund (CCDF), Head Start/Early Head Start (HS/EHS), State Pre-Kindergarten (State Pre-K), Child and Adult Care Food Program (CACFP), Early Intervention and Special Education, and the Department of Defense Child Care. Providers funded by more than one public source are subject to multiple accountability systems that are not always aligned. ECE providers seeking national accreditation engage in yet another layer of accountability and quality improvement. Some states that are building or reforming Quality Rating and Improvement Systems (QRIS) are attempting to create unified early learning standards and consistent ECE program ratings across funding streams and provider types.

Many states use differential monitoring to improve the efficiency of monitoring systems and technical assistance (TA) systems. As opposed to “one size fits all” systems of monitoring, differential monitoring determines the frequency and comprehensiveness of provider monitoring based on the provider’s history of compliance with standards and regulations. Providers that maintain strong records of compliance are inspected less frequently, while those with a history of non-compliance may be subject to more announced and unannounced inspections. This paper includes case studies from states involved in various stages of implementing differential monitoring approaches.

Implementation of the Child Care and Development Block Grant Act of 2014 (CCDBG), which was signed into law in November 2014, will likely result in more uniformity in state practice in some of the components of monitoring. Using examples from states reforming their child care licensing systems, this paper outlines the challenges and possibilities of building accountability systems that support positive child and family outcomes while reducing the burden on individual providers within multiple funding streams. This paper provides a general overview of the current monitoring system, and highlights several examples of promising state practices that are already underway. It offers a vision for accountability that addresses compliance with a minimum floor of health and safety standards, and promising strategies for continuous quality improvement. The goal of this paper is to inform upcoming changes in licensing and monitoring systems that will take place in the context of the reauthorized CCDBG implementation.
Options for states that could improve monitoring practice:

1. Monitoring policies and procedures could be aligned across funding streams, and grounded in a universal set of health, safety, and performance standards that are research-based and endorsed by professional organizations.
2. After further validation by the research community, differential monitoring could be piloted and implemented to help states target technical assistance and monitoring resources to the ECE providers most at-risk for providing unsafe learning environments.
3. Third party accreditation and credentialing by national organizations could be expanded. This strategy is widely used in analogous sectors.
4. For ECE programs that are also federal grantees subject to monitoring, federal and state agencies could share any negative findings, or instances of non-compliance.
5. Federal and state agencies could partner to increase understanding among the community of providers that the larger purpose of monitoring is to keep children, families, and staff safe.

Background, Issues and Challenges

Ensuring children are in safe environments that promote health and development is a top priority of families, state regulators, the federal government, and national organizations that accredit early care and education programs (ECE). This paper examines monitoring across ECE settings and considers lessons learned from the analogous sectors of child welfare and health. Although professional organizations in partnership with federal agencies developed national guidelines for health and safety, there is wide variation in state and local regulations around the minimum health and safety requirements for children in care. Areas of regulatory variation include: 1) thresholds for the number of children in licensed care at ECE facilities located in family child care homes (FCCs); 2) the comprehensiveness of background checks for ECE provider staff and individuals residing at FCCs; and 3) the frequency of monitoring visits.

This white paper outlines the goals and purposes of monitoring in ECE settings and provides policy options for accomplishing these goals. It describes the current state of monitoring in ECE and in two analogous fields. In doing so, it provides examples of best practices and advances that have been achieved in monitoring across ECE settings, and it provides research-based policy options that federal, state, and local governments can employ to encourage states to imbue monitoring systems with innovative, evidence-based practices; foster greater consistency across states; and move away from a culture of compliance and accountability toward a culture of continuous quality improvement.

This paper addresses several questions about monitoring in ECE settings, including:

- What is the current purpose of monitoring in ECE?
- What federal regulations for ECE monitoring currently exist?
- What is the evidence base for effective monitoring strategies in ECE or analogous sectors?
• What ongoing monitoring work in states is linked to quality improvement?
• Are technical assistance resources directed to the ECE programs that are identified as having compliance issues through monitoring? If so, how?
• How can we reduce the overlap between federal or state monitoring and other systems of quality assurance in ECE, such as accreditation, licensing, inspection, and Quality Rating and Improvement Systems (QRIS)?

In addressing these questions, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in conjunction with the Administration for Children and Families (ACF), conducted a literature review and interviews with federal and state officials, researchers, and advocates. ASPE’s work on this paper builds on a foundation of background research and discussions with expert researchers, practitioners, and stakeholders initiated by ACF in 2012.

The Current State of Monitoring in Early Care and Education (ECE)

<table>
<thead>
<tr>
<th>Table 1: Types of Child Care and Early Care and Education (ECE) Settings¹</th>
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<tr>
<td><strong>Child care center</strong></td>
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<tr>
<td><strong>Family child care home (FCC)</strong></td>
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<td><strong>Group child care home</strong></td>
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<td><strong>Relative care²</strong></td>
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<td><strong>In-home care</strong></td>
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<td><strong>Head Start/Early Head Start (HS/EHS)</strong></td>
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<td><strong>Pre-Kindergarten (Pre-K)</strong></td>
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</table>

¹ Many of these definitions are according to the Child Care and Development Fund (CCDF) Final Rule (1998). Care is usually specified as fewer than 24 hours per day per child, unless care in excess of 24 hours is due to the nature of parent(s)’ work.
² Relative and in-home care are usually excluded from state regulations.
Licensing, monitoring, accreditation, and national standards: The need for reform

Licensing, accreditation, and monitoring systems have been independently designed and implemented. Licensing in ECE settings is under the provision of the state and subject to local statutes. In contrast, ECE providers may choose to seek accreditation by a private organization. The National Association for the Education of Young Children (NAEYC) and the National Association for Family Child Care Homes (NAFCC) are two of the major national professional organizations that provide accreditation. Accreditation typically involves a provider self-study followed by an on-site review by trained professionals associated with accrediting bodies.

Monitoring is performed in conjunction with state child care licensing and is typically accomplished through an on-site visit of ECE provider facilities. Its purpose is to determine whether the providers and setting meet applicable regulatory standards. Several challenges are associated with monitoring systems that currently exist in states, including:

- States may legally exempt certain types of ECE sites from licensing, such as those associated with established religious organizations or congregations. In some states, family child care homes that care for only one or two unrelated children are not regulated. It is important to note that the safety of children in license-exempt programs is unknown, even if these programs receive federal funds.
- Part-time child care settings operating for fewer than four consecutive hours are not regulated across states.
- Not all states regulate programs for children age 4 years and older that operate as part of private, accredited, independent elementary or K-12 schools.
- Some states accept provider self-reports to meet licensing requirements. Providers attest to whether or not they have met listed requirements for licensing through checklists.
- Some ECE sites also receive federal funds and are subject to federal monitoring procedures that may not directly correspond with state monitoring requirements, contributing to an administrative burden for ECE sites.

A lack of coordination across systems. Federal and state governments have implemented systems for monitoring in response to national and local statutes in different ECE sectors. These sectors range from the state-administered Child Care and National Health and Safety Standards. Ensuring the health and safety of children across ECE settings is a foundational element of quality care, a major concern of families, and a top federal priority. The National Resource Center for Health and Safety in Child Care and Early Education (NRC) partnered with the American Academy of Pediatrics (AAP) and the American Public Health Association (APHA) to develop a set of recommended national health and safety standards with the publication of Caring for Our Children and Stepping Stones (3rd edition, 2011) with funding from the HHS’ Health Resource Services Administration (HRSA), Maternal Child Health Bureau (MCHB). These standards are not required but provide research-based best practices that minimize adverse incidents for children in ECE settings. Although the licensing administration field has embraced these two documents, the guidance is not regulatory and may be more aspirational than immediately practical in some early care and education settings. The Administration for Children and Families (ACF) and HRSA have also created an additional companion document to Caring for our Children called Caring for Our Children Basics that will serve as a voluntary tool for states to create a floor of minimum health and safety standards across Head Start and child care settings. This document was released for public comment in 2014.
Development Fund (CCDF), Head Start and Early Head Start (HS/EHS) grantees that receive federal funds, the expanding state-administered Pre-Kindergarten programs, state-administered Early Intervention and Special Education, the federally funded Child and Adult Care Food Program (CACFP), and the federally administered Department of Defense (DOD) child care programs on military installations. A common result of varying statutes is inefficiency and a high administrative burden for grantees and programs that are subject to different monitoring requirements due to support from multiple funding streams.

For example, a large number of private and public ECE providers—including many HS/EHS grantees—participate in CACFP, a federal program administered by the U.S. Department of Agriculture (USDA) that offers assistance to ECE centers and family child care homes in providing nutritious foods. Many children who participate in ECE with the assistance of federal subsidies attend programs that are part of the CACFP program. Additionally, the training and inspection requirements for CCDF across states and CACFP are very similar. Program and monitoring requirements are also similar across CACFP and CCDF, and USDA has issued guidance encouraging streamlining of these requirements. However, a lack of coordination among state agencies that administer these programs often results in duplicative inspections across these federal programs, and results of monitoring visits are not shared or used in concert in efficient ways.

Charlotte Brantley, who led the Child Care Bureau from 1999-2001 and is now director of an ECE program in Colorado underscored this frustration during a Senate Subcommittee hearing that informed the reauthorization of the Child Care and Development Block Grant (CCDBG):

> The program that I run, it's a licensed child care facility, so it's inspected by child care licensing, it's inspected by the food program, it's inspected actually by the local arm of the State health department, it's inspected by Head Start, and it's inspected separately by Early Head Start...and it's inspected by the HIPPY USA because we use the HIPPY curriculum, and it's inspected by Denver Public Schools because we are a Denver Public Schools Colorado preschool program provider, and now we're being also inspected by the Denver Preschool Program. So we are inspected by funding stream, if you will. We are an incredibly high-quality program. We have all the stars you can get. We'd have more stars if there were more stars in Colorado's QRIS. We have incredibly clean [monitoring reports] every 3 years Head Start and Early Head Start. There are never any findings in this program, and yet I am monitored by everybody and their brother.

As the quote demonstrates, grantees are often at a loss about why there are different requirements across funding streams. Even if there are similarities in inspection and

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4 Home Instruction for Parents of Preschool Youngsters
5 Quality Rating and Improvement Systems
enforcement from different federal and state regulatory agencies, concerns and non-compliances may be handled differently by each entity. Current monitoring practices often overlap in ways that are not efficient and are potentially burdensome to ECE programs subject to multiple and duplicative regulations. The inefficiencies and increased costs are passed along to taxpayers, monitors, and regulators.

The need for more effective oversight. Unfortunately, while there are cases of high-quality programs that are frequently monitored by parallel systems, there are also egregious instances of serious injury or deaths in ECE programs. In part, these instances can be attributed to a lack of effective oversight or resources needed to meet regulatory requirements. In 2011, the U.S. Department of Health and Human Services’ Office of the Inspector General (OIG) reviewed open-source information from the previous decade and found several cases across states of individuals convicted of serious sexual offense who gained access to child care facilities as maintenance workers, cooks, or spouses or friends of providers. OIG found that providers either knowingly hired these offenders or did not perform the necessary pre-employment background checks intended to detect such convictions.

To further identify health and safety risks at child care providers receiving federal funds, in 2014 OIG audited licensed child care centers and family child care homes across states. OIG found that although states were largely conducting inspections that their licensing rules mandated, the monitoring did not ensure that providers complied with state health and safety licensing requirements. Noted violations existed that were often related to physical conditions of the center or family home, and required criminal background and child protection checks. To ensure more adequate state oversight, OIG recommended that monitoring staff have smaller caseloads. States also provided feedback about undertaking analyses of inspection protocols in order to increase efficiency for existing monitoring staff. Recently, Crowley and her colleagues undertook an analysis of routine, unannounced reports of child care centers collected by the Connecticut Department of Public Health. The study found that outdoor safety was the largest area of non-compliance. Notably, there was a positive association between compliance with health and safety regulations and continuing professional development and education for staff, another Connecticut requirement. Inconsistency in reporting among inspection staff also threatened to undermine a standardized and fair licensing experience for

Connecticut ECE providers. These findings across studies are indicative of the lack of a strong regulatory and enforcement infrastructure in some state child care systems. The findings also suggest those providers who comply with health and safety regulations are often those who are more committed to training and professional development or advancing quality in other ways.

Thanks to decades of research, a great deal is known about healthy brain development, the impact of toxic stress, and how ECE settings can be responsive to the needs of highly vulnerable children and families. However, not enough is known about the specific characteristics of a comprehensive, high-quality monitoring system that identifies whether programs adequately support healthy child development. To improve the way monitoring is performed, systems should focus both on applying a compliance framework in a fair, consistent, and non-duplicative way and focus on improving quality through program supports. With many young children receiving care in settings outside their homes, the ECE community is re-focusing attention on the dual purposes of work support for families and ensuring that children are in safe settings that promote health and development across domains.

**Monitoring in Child Care Settings**

**Current regulations, variations in state practice, and upcoming reforms**

The Administration for Children and Families (ACF) administers the Child Care and Development Fund (CCDF), providing child care subsidies for 1.5 million children every month. Based on data reported to ACF by States, in fiscal year 2012, an estimated that 89 percent of children who received CCDF subsidies were served in either family homes or centers. Prior to the passage of the Child Care and Development Block Grant Act of 2014 (CCDBG), there were no specific federal health and safety requirements defined in statute. Current federal regulations require states to certify that procedures are in place to ensure compliance with all applicable state and local health and safety requirements. Some states allow providers to self-certify, yet current CCDF regulations do not require monitoring. States are required to have health and safety regulations related to 1) preventing and controlling infectious disease; 2) building and physical premises safety; and 3) minimum health and safety training. However, states have considerable flexibility in how they meet these requirements. For example, because it had not been in federal statute or regulation, not all states have requirements for criminal background checks, training on first aid and CPR, or safe sleep.

**Exemptions, unlicensed care, and serious injuries and fatalities in child care.** Although state child care licensing regulations provide a baseline of protection for the health and safety of children, the types of providers who are required to meet licensing standards vary

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14 Section 658E of The Child Care and Development Block Grant Act of 1990 (CCDBG)

tremendously. As mentioned previously, most states have exemptions for licensing, including facilities with parents on the premises; facilities operated by religious organizations; recreational programs or instructional classes; facilities with a small number of hours per day or week; and before- and after- school programs. Family child care providers are often excluded from licensing in some states and not regulated by other public agencies. Reports of child injury and death occur most frequently in homes and facilities that are not monitored by states. In one of the few national studies of child mortality rates in early care and education, Dreby and colleagues documented variation in fatality rates by the strength of licensing requirements. This study also suggested that licensing serves as an important mechanism for identifying high-risk facilities that pose the greatest threats to child safety. It is important to note that there is a lack of comprehensive, national data on deaths and injuries in child care, and many states do not require reporting on deaths or serious injuries. In FY 2012, ACF began requiring states to include a Quality Performance Report (QPR) as an appendix to biannual State Plan submissions, and currently, states have the option to list and describe the annual number of injuries and fatalities in child care. However, not all states review the context and circumstances of injuries and fatalities in child care in ways that provide opportunities to improve regulations and enforcement. The discussion below delves further into variations in state practices of implementing health and safety standards. Following this discussion, prominent case studies are presented of states mobilizing efforts across public and private sectors to learn from tragedies in child care by putting in place safeguards to prevent children from being harmed. Recent state data and examples from the media underscore the need for more uniform requirements across states.

**State licensing thresholds.** Using data collected in 2011, the Office of Child Care’s National Center on Child Care Quality Improvement (NCCCQI) in conjunction with the National Association for Regulatory Administration (NARA) analyzed child care licensing and monitoring practices in states. All states regulate child care centers. However, state variation is even more pronounced among family child care homes, group child care homes, and certain types of religiously affiliated child care facilities. Forty-two states license family child care homes, and nine of these states (21 percent) require licensure when there is even one unrelated child in care (AL, CT, DE, DC, MA, MD, MI, OK and WA). Most other States set their licensing threshold to three children (19 percent) or four children (26 percent). Thirty-eight states license group child care homes, which are defined as two or more adults taking care of a group of children, with states (42 percent) most frequently setting the threshold at seven

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children. Thirteen states do not have a separate designation for group child care family homes, but several of these include group child care family homes under the category of family child care homes, with the associated thresholds.

**Monitoring frequency in states.** The NCCQI-NARA analysis also examined frequency of inspections (see Table 2). Although the frequency of inspections has improved since 2007, monitoring practices still range widely. Only 14 states (28 percent) inspect centers two or more times per year, the recommended frequency by *Caring for our Children* (see Table 2). Only nine of the states (21 percent) that license family child care homes, and 13 (34 percent) of those that license group child care homes visit these sites twice a year. States more commonly conduct only one annual monitoring visit, with 24 states (48 percent) visiting centers once a year. Fourteen of the states (33 percent) that license family child care homes require visits once per year, and 14 of the states (37 percent) that license group child care homes do so.

<table>
<thead>
<tr>
<th>Table 2: Frequency of Licensing Inspections in States in 2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Care Centers</strong> (N=50 states)**</td>
</tr>
<tr>
<td>More than three times per year</td>
</tr>
<tr>
<td>Three times per year</td>
</tr>
<tr>
<td>Twice a year</td>
</tr>
<tr>
<td>Once a year</td>
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<tr>
<td>Once every two years</td>
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<tr>
<td>Once every three years</td>
</tr>
<tr>
<td>Less than once every three years</td>
</tr>
<tr>
<td>No inspection</td>
</tr>
<tr>
<td>Other frequency**</td>
</tr>
</tbody>
</table>

*Note 1* Please see footnotes 10-12 for the National Center on Child Care Quality Improvement (NCCQI) Research Briefs that are the source of data for this table

*Note 2**For the purposes of this study, DC was treated as a state. ID has child care licensing at the city/county level and was not included in this study.

*Note 3***Not all states license family child care homes or group child care homes

*Note 4**** Other frequencies could be based on compliance history or facility size

**Comprehensive background checks.** In terms of setting a minimum floor of health and safety standards for children in out-of-home care, the issue of comprehensive background checks is closely related to monitoring. In 201120, ACF provided guidance to states about criminal background checks in the form of an information memorandum (IM), recommending that comprehensive criminal background checks for all child care providers be performed. ACF

recommended that all paid staff in ECE settings undergo comprehensive background checks, regardless of whether they are legally exempt from licensing as determined by a state. The recommended practices align with what is required in Head Start/Early Head Start settings. ACF cites the lack of a unified, national system for checking criminal history and child abuse records, and recommended that background checks include:

- Using fingerprints for state checks of criminal history records;
- Using fingerprints for checks of FBI criminal history records;
- Checking the child abuse and neglect registry; and
- Checking sex offender registries.

Although all states and territories require some type of background check for ECE providers, the types of providers and staff members who must undergo background checks vary, as does the kind of background check that is required, which combination of state and federal databases are used, and whether fingerprinting is involved. An organization focused on research, advocacy, and resources for families and practitioners, Child Care Aware of America described background checks that are not based on fingerprints as “of limited value,” presumably because a name search alone can be misleading. NCCQI-NARA found that in 2011, 12 states required comprehensive checks of federal and state criminal history checks for both center-based staff and family child care home staff; the process used fingerprinting and checks of child abuse and neglect registries. Many of the states that have implemented comprehensive background checks are also working on other aspects of health and safety. Table 3 below summarizes state practices on different aspects of criminal background checks.

<table>
<thead>
<tr>
<th></th>
<th>Child Care Centers (N=50 states)</th>
<th>Family Child Care Homes (N=42 states)</th>
<th>Group Child Care Homes (N=38 states)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal history records</td>
<td>48</td>
<td>41</td>
<td>35</td>
</tr>
<tr>
<td>Federal fingerprints</td>
<td>32</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>State fingerprints</td>
<td>26</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Child abuse and neglect registry</td>
<td>44</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td>Sex offender registry</td>
<td>24</td>
<td>13</td>
<td>20</td>
</tr>
</tbody>
</table>

Note 1* Please see footnotes 10-12 for data sources and notes

Despite variation in state practices surrounding basic health and safety standards, national surveys demonstrate that parents are under the reasonable assumption that their child care providers have undergone all necessary background checks, completed health and safety trainings and are regularly monitored.22 The current system must strengthen health and safety

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standards, assist parents in making informed choices about care, reduce the administrative burden on ECE providers, and support state efforts to improve the quality of early care and education settings families can access. The Child Care and Development Block Grant of 2014 (CCDBG) that was signed into law in November of 2014 goes a long way to advance the field in these specific areas.

**New legislation and regulations.** Following up on guidance issued in 2011, ACF filed a Notice of Proposed Rulemaking (NPRM) on May 20, 2013, to amend the CCDF regulations. Simultaneous to and consistent with ACF’s efforts to reform the existing statute, legislators from both parties worked on historical reauthorizing legislation. The Child Care and Development Block Grant Act of 2014 passed in both chambers of Congress and was signed into law by the President on November 19, 2014 (PL 113-186). The much-anticipated CCDBG Act reauthorizes the program for the first time in 18 years and establishes minimum health and safety requirements for child care providers who receive CCDF subsidies. It also requires that states monitor providers to ensure the requirements are met. States must also provide more information to parents about child care quality, extend eligibility periods for families to at least 12 months, and establish other reforms to improve the quality of child care.

The CCDBG Act encodes into law many of the requirements ACF had proposed through rulemaking but had not yet implemented when the reauthorization passed. In addition to reiterating ACF’s 2011 guidance about comprehensive background checks, the new legislation requires all providers receiving CCDF subsidies (excluding relatives and providers caring for children in the child’s own home) to have pre-licensure inspections and at least one unannounced monitoring visit per year.

Notably, based on more than 500 comments submitted during the public comment period of the NPRM, state officials, foundations, professional organizations and advocacy organizations generally support a minimum floor of health and safety requirements and efforts to raise the overall quality of ECE settings. However, commenters expressed concerns about the costs states may incur. Some argued for significantly increasing the federal investment in the CCDF program to offset potential costs to states, while other organizations advocated for a better balance between federal and state shared expenses for licensing and administration. These issues will continue to be worked out as the CCDBG Act is implemented.

After reviewing the NPRM—which anticipated reforms in the CCDBG Act—several moved forward with the state legislative changes to expand health and safety provisions that will be required under the act. Policymakers, researchers, advocates, practitioners, families, and other stakeholders agree that the CCDBG Act takes important steps to improve the health, safety, and quality of care, which children need to thrive. Following the passage of the new legislation, ACF embarked on a multi-pronged plan to provide interim guidance and TA to states about implementation, and develop a new rule by 2016.
Health and Safety Provisions of the CCDBG Act of 2014

The CCDBG Act includes the following provisions:

- **States must provide pre-service and ongoing health and safety training to all CCDF providers.** Topic areas include: 1) prevention of shaken baby syndrome and abusive head trauma; 2) prevention and control of infectious diseases, including immunization; 3) hand washing and self-care; 4) medication administration; 5) management of food allergies; 6) safe sleep and prevention of Sudden Infant Death Syndrome (SIDS); 7) sanitary food handling; 8) building and physical premises safety; 9) emergency preparedness; 10) handling of hazardous materials; and 11) first aid and CPR.

- **Trainings on social-emotional development, positive behavioral support, and other strategies to prevent preschool expulsion were suggested as activities associated with improving quality.**

- **States must establish age-appropriate child-to-staff ratios.**

- **States must develop health and safety standards related to first aid and CPR, prevention of Sudden Infant Death Syndrome (SIDS), and child abuse prevention.**

- **States can no longer rely solely on provider self-certification of health and safety requirements.**

- **States must perform at least one annual inspection and at least one pre-licensure inspection of CCDF providers and one annual fire, health, and safety inspection of license-exempt CCDF providers.**

- **All individuals who provide care for children and accept CCDF subsidies must undergo comprehensive background checks.**

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**Case Study: The experience of reform in Georgia**

Georgia has been reforming its ECE licensing administration, housed in Bright from the Start: The Department of Early Care and Learning (DECAL). Bobby Cagle led these efforts as DECAL commissioner from 2011-2014. In 2013, researchers at the Frank Porter Graham Institute conducted an evaluation of the state’s licensing and monitoring practices in overseeing 6,000 providers. Prior to Commissioner Cagle’s tenure, health and safety violations were predominately handled through technical assistance (TA), though the infrastructure and staffing were not in place to follow-up with ECE providers on their areas of non-compliance. Cagle’s approach, which garnered public support, combined increased enforcement action with TA.

*Public and legislative support.* Reform was facilitated in part through public outcry, after a series of articles in the local paper, *The Atlanta-Journal Constitution* on the safety of children in child care. One of DECAL’s first responses to the increased scrutiny was commissioned studies investigating the statewide prevalence of serious injuries in child care.

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An analysis of state administrative data indicated that young children were much safer in center-based care than other ECE settings. The study also highlighted concerns over safe sleep practices. As is the case in a select number of other states, public attention and advocacy involving the families of young children who died in child care was crucial in enacting legislative changes to support health and safety. Following the death of a four month old child placed on his stomach to sleep, Jace’s Law was passed unanimously by the Georgia legislature, granting DECAL the authority to immediately close a family child care home in which a minor dies. In 2011, the legislature further granted DECAL emergency closure authority when there is any immediate risk to children—a significant improvement from the 90-day formal revocation process.

Transportation safety involving children being left unattended in vehicles has been another area highlighted in the media. Reforms now focus on issuing fines for transportation violations in such cases, as well as instituting new training requirements for providers and the child care consultants who monitor providers.

DECAL’s overall goal is to visit each facility twice a year, a goal they met in 80 percent of family child care homes and 67 percent of child care centers in 2012.

To address the number of children in unregulated care in Georgia, DECAL is advocating for a legislative change that would require regulation of family child care homes to begin when a provider cares for two, rather than three unrelated children.

By featuring current licensing reports on the DECAL homepage, parents, guardians, and other members of the public can access the information about how ECE facilities function, including how health and safety violations are addressed, and announcements of license revocations.

**Change in staffing practices.** Many states struggle with a high turnover rate for regulatory and support staff. This problem is compounded in Georgia because in the rural parts of the state, travel times are extensive for child care consultants who conduct monitoring visits. Since DECAL increased its enforcement authority in terms of the number of follow-up visits required when there is an adverse event at a facility, more demands have been placed on staff. DECAL has tried to address turnover and the additional burden it places on remaining staff by significantly expanding the number of child care consultants on staff. To address vacancies with minimal burden, new staff members are also cross-trained to handle “blended caseloads” that include different types of ECE facilities, and initial licensing visits as well as complaints. The DECAL management team considers reallocating staff resources an integral part of building a more sustainable infrastructure.

**Infrastructure to support increased enforcement.** In addition to providing technical assistance to ECE providers attempting to correct problems, DECAL has made concerted effort to ensure that

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26 See Lexie’s Law in Kansas (2010), which required the Kansas Department of Health and Environment to create a database of licensed child care facilities that includes information about complaints that parents can access.

27 Bryant & Kelly, 2013

28 Bryant & Kelly, 2013
enforcement procedures are applied quickly, equitably, firmly, and predictably. DECAL is building an information technology system to support increased enforcement in a more timely manner. For example, whereas transportation violations could take up to 62 days to process manually, DECAL’s new data system will automatically generate legal action for repeat non-compliances in this area. DECAL has also taken a research-based approach to strengthening Georgia’s child care rules and regulations.

DECAL has developed an inter-rater reliability process in which multiple child care consultants conduct monitoring visits to the same facilities, and results of compliance determinations are compared by DECAL’s in-house research staff. DECAL also focuses monitoring visits around a set of 74 “core rules” that were deemed the most crucial to ensuring children’s health and safety. In 2014, Richard Fiene, a university-based investigator, determined that Georgia’s core rules moderately correlated with key indicators of compliance that emerged from licensing data from 2008-2012. Based on these findings, DECAL is considering changes to its compliance determination protocol to more closely align the core rules with compliance indicators.

Interagency communication and collaboration. Effective communication between the divisions within DECAL that handle child care regulation and Pre-K was reported, particularly about child care centers that are applying for a grant to house Georgia’s Pre-K classes. In these cases, the licensing and compliance status of the applicant must be available to make determinations about awarding Pre-K grants. The Pre-K delivery system in Georgia is a mix of public and private providers, and challenges have emerged over jurisdiction when Pre-K classes are housed in K-12 public schools that are regulated by independent school boards set up by the statutes of the state. Although licensing staff do not monitor Pre-K that is housed in public schools for licensing compliance, DECAL staff conduct other visits related to the implementation of learning guidelines and classroom quality. If concerns over health and safety emerge during these visits, they can be reported to the school system, which has a different enforcement system. Some of the health and safety concerns that have been raised about Pre-K in K-12 settings involve playgrounds and equipment designed for older children. DECAL is still working on several performance goals related to the visiting of all ECE providers more frequently, improving automation in data systems so enforcement can occur more quickly, advocating for legislative changes that will bring more informal providers under state regulation, and improving collaboration with other state agencies, including public schools.

29 Fiene, R. (2014). Georgia Child Care Licensing Study: Validating the Core Rule Differential Monitoring System. Middletown, PA: Research Institute for Key Indicators.
Case Study: The experience of reform in Kansas

Kansas is another state that has implemented more stringent health and safety regulations, in part in response to advocacy and media attention that surrounded fatalities in child care. State administrators reported that a history of legislative interest in reducing oversight and licensing requirements overlapped with an alarming rise in serious injuries and fatalities which peaked during the 2007 calendar year. The high incidence of fatalities prompted the Kansas Department of Health and the Environment, which houses Child Care Licensing, to implement new procedures to guide investigations of serious injury or sudden, possibly unexplained deaths in child care that were not required in existing statute.

The trend for infant mortality in Kansas was also higher than other states at the time, with Kansas ranked 40th out of all states in 2011.\(^{30}\) The Governor’s Blue Ribbon Panel on Infant Mortality highlighted these statistics, as well as the need to collect more robust and geographically specific data. In addition, in 2010, Kansas was ranked 46 out of all states in the annual report by Child Care Aware\(^{31}\) on state standards and oversight for family child care homes. At the time, one third of all child care providers were ‘registered family day care homes,’ which could serve up to six children without being subject to pre-inspection, or any ongoing monitoring or regulation, except in the event of a complaint.

The family of Lexie Engelman advocated for change after the 13-month old suffered fatal injuries in a family day care home in 2004 due to lack of supervision. The family day care home Lexie died in had been licensed. However, another family, the Patricks, lost their 18-month old Ava on her first day at an overcrowded, registered—but not licensed—family day care home in 2009. After learning of the problems with oversight, the Engelman and Patrick families organized a grassroots campaign focused on reform. As a result of partnerships in and out of government, public awareness that was raised through advocacy, and publicizing data about death and serious injury in child care, Lexie’s Law was enacted in 2010. The law strengthened inspection and health and safety requirements for child care providers and marked the first major change to the state’s child care standards in three decades.

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Lexie’s Law required that by the end of June, 2011, all registered providers transition to licensed providers. New health and safety regulations were effective by February 2012 that included regular inspection, training for providers, and the minimum requirement that new providers applying for a license have at least a high school diploma. New rules for the competent supervision of children in child care came into effect, as well as additional requirements for the protection of children. Lexie’s Law also established an online database with information about complaints and violations that families can access. The implementation of Lexie’s Law has boosted Kansas from 46th, to 3rd in Child Care Aware’s 32 annual ranking, and state officials have used new data collected electronically from providers to target regulatory action and provide information to the public in a much more timely way. State officials report that more stringent regulations have greatly enhanced state capacity to protect children, in part by supporting providers.

Lessons learned from reform efforts in states

- Partnerships between state agencies and advocacy efforts that include families and practitioners can facilitate public and legislative support for reform.
- It is important to consider staff capacity, caseload and professional development needs when major changes in regulatory practice are being implemented.
- A robust data infrastructure is needed to support the collection of data on complaints and violations, as well as serious child injuries and deaths. This information could also be communicated to the public in a seamless and timely fashion.
- State-level statutory barriers in monitoring across settings can remain even if there is extensive cooperation between the agencies that regulate settings where children are served.

Monitoring across ECE sectors

This section provides an overview of monitoring in other ECE sectors related to child care. Please see appendices for a comparison of factors significant to monitoring, such as statutes, monitoring goals, types of monitoring performed, data collection methods and federal and program level feedback. It is noteworthy that across sectors, reforms are being considered and implemented in ways that can be mutually informative to researchers and policymakers focused on specific program areas.

Head Start/Early Head Start. A federal program established in 1965, Head Start (HS) promotes school readiness for children from low-income families by offering comprehensive services. Early Head Start has served infants, toddlers, young children, and expectant parents since 1994. In fiscal year 2013, HS/EHS was funded to serve nearly one million children. Currently, the Office of Head Start (OHS) uses the Office of Head Start Monitoring System, which is aligned with five-year grant oversight to assess program services and quality.

The Designation Renewal System (DRS), which went into effect in 2011, introduced major changes to the Head Start monitoring system. The DRS uses monitoring outcomes to make designation determinations that increased accountability by specifying conditions about whether high-quality, comprehensive services are being offered to children and families. The new system informs decisions about whether a grantee needs to re-apply for funding, and effectively transformed all HS grants from indefinite funding to five-year grant periods. To date, four cohorts of Head Start grantees—including nearly 400 individual grantees—have been designated to compete for continued funding.

One of the seven conditions that will spark re-competition for a grantee is scores on the Classroom Assessment and Scoring Instrument (CLASS-Pre-K) falling below a minimum threshold, or in the lowest 10 percent of all grantees assessed in the three areas the instrument evaluates the quality of adult-child interactions in: emotional support, classroom organization or instructional support. Although changing teacher behavior and practice at the ground level that the CLASS evaluates is a daunting task, OHS leadership reports that they have implemented a wide range of TA supports, including adapting a case consultation approach to targeted technical assistance. This has been a successful strategy piloted with Tribal grantees, particularly in improving instructional support.

DRS implementation also created the opportunity for OHS to offer Birth-to-Five pilot awards to new grantees. The awards create the flexibility for grantees to design programs based on the current needs in their communities for serving children and families as they proceed on a continuum of care through the many transitions from expecting a child to the beginning of a child’s formal schooling. OHS is currently implementing a risk-based assessment model that will

allow TA and monitoring resources to be further targeted to programs that are at the greatest risk of failing to maintain safe and healthy ECE environments.

**State funded Pre-Kindergarten Programs.** State-funded prekindergarten programs have grown in recent years and are an important part of the President’s Early Learning Initiative. However, systematic implementation or monitoring of these programs by the states that operate them is currently limited. To date, there are more than 54 different public Pre-K initiatives in 40 states and territories which serve more than one million children. In most states, Pre-K is a mixed delivery system. Some providers are part of the K-12 public school system, monitored by State Departments of Education. Others are HS grantees subject to federal monitoring. Still others are private entities that receive state grants to administer services and are subject to regulation by state licensing agencies.

Monitoring often consists of evaluating or tracking the implementation of early learning standards for Pre-K, yet in many states that offer these services, programs are not required to adhere to standards. The frequency of monitoring visits to state Pre-K programs varies widely across states, and Pre-K stakeholders—including philanthropists, advocates, business leaders, and elected officials—may not be well versed in assessment methods or health and safety standards. Monitoring data may include classroom quality, teacher efforts to support student learning, information about the quality of teacher-child interactions, and facility and safety practices.

Documenting children’s learning outcomes is an increasingly common way to assess State Pre-K providers and make determinations about funding. As states curtailed their budgets during from 2008-2012, they eliminated monitoring requirements that were put in place in the early 2000s. Tension remains between the number of slots available for students and the budget for monitoring and quality improvement. The Preschool Development Grant funding opportunities first made available in 2014, required states to describe the system they intended to put in place for monitoring subgrantees that will be providing high-quality Pre-K services. This requirement was put in place despite a lack of standardization and mandate for monitoring protocols in existing Pre-K systems. It is likely that states that receive this funding either through a development or expansion track will put in place more sophisticated monitoring and evaluation systems, and are offered flexibility in designing these systems.

**Early Intervention and Special Education (Parts B & C of IDEA).** US Department of Education’s Office of Special Education (OSEP) monitors compliance with the Individuals with Disabilities with Education Act (IDEA). Part C of IDEA covers infants and toddlers with disabilities who are typically served in their homes, child care settings, or other naturalistic, least restrictive

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38 Ackerman & Coley, 2014.

39 Barnett et al., 2012.

settings. Part B includes preschoolers with disabilities. State programs are monitored to ensure program compliance with federal requirements for services. From 2003-2012, federal monitoring teams conducted site visits. The visits involved interviews with stakeholders and record reviews. Historically, the focus of OSEP’s monitoring has been on compliance with regulations. However, OSEP is now moving toward a Results Driven Accountability (RDA) process that will focus on child and family outcomes.41

In June 2014, the US Department of Education (ED) announced42 that it was making a formal shift in the way it oversees the effectiveness of state special education programs by adapting the RDA process. The new system will no longer focus exclusively on procedural requirements, such as the timeliness of evaluations and service delivery. It will now also include educational outcomes, and assessments of proficiency gaps between students involved in special education and general education. These reforms will allow federal policymakers and program staff to consider data on how students are actually performing, rather than just compliance issues, which states have made great strides in improving.

The Department of Defense (DOD) child care programs. The U.S. military has invested heavily in high-quality child care and in the past two decades has transformed its system from one of the most poorly rated systems in the country to a model for the nation.43,44 The DOD runs the largest employer-sponsored child care system, serving 200,000 children domestically and internationally, and considers high-quality, affordable care a major component of combat readiness for military families.

Monitoring in military child care is grounded in certification by the military, accreditation by national organizations, and frequent inspections (four times per year). At least one of these monitoring visits must include an interdisciplinary team with an ECE expert. ECE settings certified by the military include family and group child care homes, centers, and Pre-K programs. Military child care programs are certified for one-year, and serious violations uncovered during monitoring visits result in immediate closure. Information about violations is publicly reported.

Waiting lists for military child care are common, and since 2000, it has also been possible to receive subsidies for off-installation civilian ECE providers that are state licensed. In an ongoing effort to understand the extent to which there are comparable levels of quality in non-military child care in states, the DOD is currently analyzing state efforts on quality improvement, which includes state Quality Rating and Improvement Systems (QRIS).

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As is the case in other ECE sectors, the DOD programs are currently in the midst of reform. For the first time since 1996, the DOD in August of 2014 issued new guidance and instructions\(^45\) for providing care. Some of these reforms were to standardize inspections across branches of the military. The service branches have reached consensus on a common framework for inspection criteria that groups them into three main categories of 1) general management; 2) facility, health, safety and risk management; and 3) programming. Each service branch compared current criteria to ensure they inspect the same items. Further standardization is currently underway that will involve the number of classrooms observed and the number of files reviewed during inspections. Software is being developed to support the inspection visit and report writing. These efforts will ensure that regardless of how a military family enters the child care system, the family has access to the same high level of quality.

Across ECE programs described above, feedback from monitoring is used to target technical assistance resources, and by individual programs for the purposes of quality improvement. OSEP and the DOD post monitoring reports publically. Several types of programs are subject to monitoring by multiple regulatory systems with little collaboration across federal and state agencies. Almost all of these parallel systems are engaged in reform that would require greater consideration of child and family outcomes.

**Third party accreditation and Quality Rating and Improvement Systems (QRIS)**

Quality in ECE settings has multiple dimensions. It has been defined as the aspects of the environment and children’s experiences that nurture child development.\(^46\) High-quality ECE settings have been associated with better language development, math, and reading skills at kindergarten entry.\(^47,48\) Burchinal and colleagues\(^49\) identified structural components of quality as class size, teacher-child ratios, staff turnover, salaries, training, and curriculum. These structural components of quality are related to what has been identified as process-level components, including teacher beliefs, and teacher-child interactions.\(^50\) There is no single method of evaluating quality, and the definitions of quality could vary from different stakeholder perspectives.\(^51\) Some states have additional goals for their regulatory systems, including using licensing as a foundation for building quality improvement systems.

As has been discussed in other sections of this paper, licensing generally focuses on basic issues of health and safety, while QRIS and national accreditation move ECE programs to higher levels.

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of quality. A widely promoted strategy to improve quality in ECE is voluntary accreditation through a national organization, such as NAEYC and NAFCC. NAEYC offers a five-year accreditation to school and center-based providers and NAFCC offers a three-year accreditation to family child care providers. Both organizations begin the accreditation process with a self-study. In addition to an on-site observation, accreditation by both organizations involves a commitment to upholding research-based standards, meeting credential and training requirements for providers, program administrators, and teaching staff, and meeting the requirements for the highest level of regulation to operate a facility by the authorized regulatory agency—the state licensing agency, state board of education, or military. Maintaining each kind of accreditation involves annual reporting, updates and agreeing to announced and/or unannounced (in the case of NAEYC) visits before each renewal. Whitebook\textsuperscript{52} noted that public funds, including CCDF funds, are increasingly directed to accredited programs as a way to supplement what is sometimes limited quality assurance provided by compliance with state licensing systems.

**Health and safety in accredited programs.** Research is limited on the relationship between state child care regulations and accreditation. However, the presumption in the field is that accredited programs exceed the floor of minimum health and safety standards regulated by state licensing agencies. Apple\textsuperscript{53} used descriptive statistics to examine the relation between quality indicators found in state regulations and the number of NAEYC accredited programs in states. Apple found that as maximum staff-child ratios decrease and minimum pre-service teacher education qualifications increase in state child care regulations, the number of ECE programs that have obtained or are seeking accreditation increases. Winterbottom and Jones\textsuperscript{54} studied the relationship between accreditation and licensing violations in the state of Florida. Comparing licensing data on the 23 percent of ECE centers that were accredited from 2007-2010 with non-accredited child care centers, Winterbottom and Jones determined that children were more at-risk for both imminent and less serious health and safety violations if they attended a non-accredited ECE center. Although the number of statewide health and safety violations increased over time among all facilities, presumably because of increased enforcement, accredited facilities experienced a lower rate of increase.

Accredited facilities have demonstrated that they are meeting standards in the structural areas of small class size, teacher-child ratios, turnover, staff salaries, training, curriculum, and the education level of the teacher. Because there is considerable variability in state licensing, accreditation offers an alternative means to ensure that children are in safe environments that are meeting their developmental needs.

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\textsuperscript{54} Winterbottom & Jones, 2014
Lessons learned from the Race to the Top—Early Learning Challenge (RTT—ELC)

The Race to the Top—Early Learning Challenge (RTT—ELC) is a discretionary grant program jointly administered by the U.S. Department of Education and Health and Human Services, and is an important part of the President’s early learning agenda.\(^{55}\) RTT—ELC focuses on improving early learning and development by supporting states in coordinating across agencies and programs that serve young children and their families from vulnerable communities. Goals of the program include raising the quality of ECE programs and increasing access to high-quality programs for young children who are disadvantaged, so that all children enter kindergarten ready to learn.

The five key areas of reform are:\(^{56}\)

- Successful state systems based on broad stakeholder support and effective governance.
- High-quality, accountable programs aligned across Head Start, child care, state Pre-K, and Early Intervention and Special Education.
- Promoting early learning and development outcomes through the implementation of statewide standards, and implementing comprehensive assessments aligned to standards.
- Building a well-trained early childhood workforce through professional development, and incentives to improve knowledge, skills, and abilities to promote children’s learning and development.
- Measuring outcomes and progress through evaluation that will address children’s outcomes across domains. Building robust data systems that will support quality improvement.

Quality Rating and Improvement Systems (QRIS). There are three cohorts encompassing 20 states that were awarded RTT—ELC grants from 2011-2013, with a total investment of over $1 billion. The one absolute priority of the RTT—ELC program is the alignment of resources to create a common, statewide tiered quality rating and improvement systems (QRIS) that is inclusive of all ECE programs. QRIS is an approach intended to assess, improve, and communicate levels of quality in ECE programs. QRIS awards quality ratings to ECE programs that meet a set of defined program standards, and are designed to help families understand the quality of ECE programs available for their children. Even prior to RTT—ELC, nearly half of all states and the District of Columbia were operating statewide QRIS, and almost all other states were planning or piloting them.\(^{57}\) Oklahoma instituted the first system in 1998, and North Carolina followed in 1999. QRIS that existed in RTT—ELC grantee states prior to reform was typically focused on licensed child care and family and group child care homes. Existing QRIS in many states has historically been tied to a tiered reimbursement rate; ECE providers that were designated at higher levels of quality could obtain a higher rate of CCDF subsidies. QRIS also

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traditionally offered a pathway for credentialed programs to enter at a higher quality level, in part through a policy strategy that has become increasingly common in states known as tiered reimbursement. Through tiered reimbursement, child care providers that are offering higher quality care are eligible to receive a reimbursement rate that is higher than the maximum rate set by the state when they care for a child who is receiving CCDF subsidies. NAEYC noted in 2012 that 27 states and the District of Columbia had tiered CCDF reimbursement rates for center and family and group child care homes linked to accreditation. 

QRIS systems had not been traditionally designed to include funding streams, standards, or requirements for ECE providers who were Head Start grantees, state Pre-K, or special education providers. However, RTT—ELC encouraged states to include all ECE programs, and grantees had to re-conceptualize their approach in order to create an integrated QRIS. In 2012, ECE financing and policy expert Louise Stoney reviewed the QRIS sections of the first round of applications to the program, which consisted of 35 states and the District of Columbia. Stoney noted that several states also envisioned QRIS as an opportunity to align monitoring and technical assistance. North Carolina and Oregon made this the cornerstone of their ECE reform plan. Illinois, Kentucky, and New Mexico also focused on creating an integrated process so ECE providers with different funding streams only have to be monitored once.

At the third annual RTT—ELC grantee meeting in April 2014, the 20 grantees shared more of their views about the implementation challenges of building and validating a QRIS. RTT—ELC states have also been making decisions about how to include licensing in their QRIS. Acting on feedback from providers that regulation and quality improvement should be separate goals, Washington State did not initially include state licensing agencies in their QRIS planning and outreach. Because Washington envisions its QRIS as a cornerstone that grounds different funding streams, the state team is currently re-envisioning their licensing system to align all standards with QRIS. In Illinois, outreach has been targeted to child care consultants (monitoring staff) from the state licensing agency. The QRIS team is currently making regional visits to child care consultants to provide information about QRIS, research, and validation. The Illinois QRIS team received positive feedback from child care consultants, some even asking to participate in trainings available to providers through QRIS. Maryland has gone even farther in aligning efforts with state licensing staff. Part of the training for quality assurance specialists that are members of Maryland’s QRIS is accompanying state licensing consultants on monitoring visits.

There is still some tension between the minimum health and safety standards that are coded in licensing regulations and higher levels of quality QRIS incentivizes by publicly rating programs and offering financial resources for attaining different levels of quality. The tension is apparent in the decision of several states, including Illinois and Wisconsin, to remove personal care

routines, such as hygiene, and sanitation requirements from QRIS, since this is viewed as within the realm of licensing. Other states expressed that their licensing agencies had not been involved in the RTT-ELC or other ECE reform plans, and are not always amenable to the kind of systems change that these reforms require. Representatives from Massachusetts expressed that in their experience co-location of child care licensing and QRIS staff matters in obtaining the buy-in of licensing staff. In Massachusetts, the licensing division is subsumed under the Executive Office of Education, Early Learning Division, and Georgia has a similar governance structure. In Illinois and several other states, the licensing division is in a different agency than QRIS and there are limited opportunities for collaboration or shared planning.

A benefit of aligning ECE systems in quality improvement is to encourage the participation of State Pre-K and Head Start providers in QRIS. States have various strategies for attracting these providers to the system. Several states offer incentives to adopt QRIS, such as Washington’s grants for Head Start Centers to become local, regional, or state resource centers that provide technical assistance or training to other ECE providers. Washington has partnered with the Bill & Melinda Gates Foundation in funding these awards, and some of the grants to Head Start providers can be substantial, depending on how extensively a Head Start provider can offer training and support. Almost all RTT—ELC grantees have reciprocity programs in place for Head Start and Pre-K providers to enter the QRIS at a higher level or rating, but many states also require that providers supply evidence from their own federal or state reviews that they have met minimum thresholds in areas such as quality of classroom environments (based on environmental rating scales), the curriculum, child assessment, inclusion of children with or at-risk for disabilities, and program administration.

Several states have identified pathways for providers joining QRIS. Illinois has mapped the standards for different kinds of providers in their state to attain each QRIS level. To further reduce the burden on ECE programs that have already committed to quality improvement, some RTT—ELC grantees also have tracts for nationally accredited programs to join QRIS. However, several states struggled with alignment between newly reformed and ambitious QRIS and national accreditation standards. Massachusetts recently partnered with NAHYC to conduct a comparison between national accreditation standards and their QRIS. The study found an 80 percent overlap, making it difficult to simply offer entry at a particular level of quality to accredited ECE providers. Massachusetts is still considering these results in terms of how to reduce the number of initial and ongoing quality visits to accredited ECE programs.

Some RTT—ELC states have mandated that participation of Universal Pre-K programs be included in QRIS. In other states, Pre-K participation is voluntary. However, even in states with mandatory participation, it has been difficult to apply all the QRIS standards, particularly to Pre-K programs in K-12 facilities. Many of the RTT—ELC teams include state Pre-K directors in efforts to address these issues. Just as there is collaboration and cross-training between QRIS and state licensing staff, there are opportunities to work closely together and conduct joint monitoring visits with education staff. For example, Ohio and Georgia reported a high level of collaboration.
In summary, the lessons learned from the QRIS features in RTT—ELC are instructive in thinking about larger ECE policy about the layering of funding streams, collaboration between agencies, and how to develop early learning standards of quality that are applicable to different kinds of ECE providers. As the RTT—ELC states continue to grapple with reducing the burden of licensing, quality, monitoring, and federal visits, the solutions and compromises they arrive at by engaging stakeholders throughout ECE systems will undoubtedly be instructive to all states.

**Brief overview of monitoring in other sectors (child welfare and health care)**

This section summarizes the purposes and goals of monitoring in child welfare and health care, analogous sectors that have reformed their inspection and monitoring systems in recent years.

**Monitoring and reform in the child welfare systems**

Monitoring in child welfare had historically been compliance driven. In 2000, regulatory changes involved a federal mandate for state accountability in achieving quantifiable outcomes for children and families involved in the child welfare system. Increased federal oversight occurred through the rulemaking process for the Adoption and Safe Families Act of 1997 (ASFA, PL 105-89).\(^60\) The new federal outcomes represented a major shift in focus of child welfare thinking towards children’s health and safety concerns, and state performance in operating child welfare and child protection programs is now assessed through the Child and Family Services Reviews (CFSRs). According to a Children’s Bureau factsheet, CFSRs enable the Bureau:

1. To ensure conformity with federal child welfare requirements;
2. Determine what is actually happening to children and families as they are engaged in child welfare services; and
3. Assist states to enhance their capacity to help children and families achieve positive outcomes.\(^61\)

More specifically, CFSRs measure seven child and family outcomes in the areas of safety, permanency, and well-being and seven systematic factors. The systematic factors include the effectiveness of the state’s systems for child welfare information, case review, and quality assurance; training of child welfare staff, parents, and other stakeholders; the services that support children and families; the agency’s responsiveness to the community; and foster and adoptive parent licensing, recruitment, and retention. CFSRs are conducted in partnership with State child welfare agency staff and are structured to help states identify strengths and weaknesses. Part of the CSFR involves a self-assessment by states with respect to national performance measures, determined by the Children’s Bureau, a federal agency. Performance standards focus on child safety, permanency of living situations, and family and child well-being. The Statewide Assessment is followed by a weeklong, labor intensive onsite review conducted by a federal-state team and involving an administrative record review and

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interviews with children and families served by the child welfare system and community stakeholders. Ninety percent of cases reviewed must be judged to have substantially achieved the outcomes and systematic factors being assessed. States determined not to be in “substantial conformity” in all required areas must develop a Program Improvement Plan (PIP), for which TA and additional monitoring is provided. Financial penalties are levied against states that do not achieve required improvements. State PIPs must be developed in collaboration with community stakeholders, including representatives from the judicial system, mental health practitioners, and state legislators.

The first round of CFSRs took place between 2000 and 2004, and the second round was from 2007 to 2010. The Children’s Bureau set very high standards of performance for the CFSR, and no states achieved substantial conformity on child and family outcomes. Therefore, the Children’s Bureau took a step back to consider how to improve the CFSR process, and in the summer of 2014 issued new guidance for states on the next rounds of CFSRs, to be conducted between 2015-2018. The Children’s Bureau is also currently encouraging States to strengthen their own self-monitoring tools using the principles of continuous quality improvement (CQI).

Despite performance gaps, there are instances of states engaging in the CSFR and PIP process to move forward on self-evaluation and quality improvement. The National Conference of State Legislatures documented several instances of child welfare administrators partnering with state legislators and other community stakeholders over CFSR results in ways that were productive in moving state systems reform efforts forward, as well as building the infrastructure to finance these changes. In the recent history of child welfare reform, states have expressed concerns about being held accountable for child well-being largely because child outcomes are dependent on other, related systems. Although state officials, advocates, and researchers have been critical about the measures used in the reviews, there is consensus among stakeholders that the focus on child and family outcomes is appropriate and constituted a much-needed shift in child welfare monitoring. As the capacity of states to routinely collect and use data to examine their work and make data-driven decisions is built through CQI frameworks, the role of federal monitoring is being re-configured.

Monitoring of patient safety and quality in health care delivery settings

Health care delivery is another sector that prioritizes the safety and quality of care. Health care monitoring and quality improvement systems have gone through significant reform in the past several years, which could be instructive to how federal and state governments are considering re-envisioning and improving monitoring in ECE settings.

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63 http://www.acf.hhs.gov/programs/cb/monitoring/child-family-services-reviews/round3
The modern culture of patient safety in U.S. hospitals coalesced after the Institute of Medicine (IOM) released a report in 1999 entitled, To Err is Human: Building a Safer Health System. The report highlighted the tens of thousands of deaths each year attributable to preventable medical errors, and called for comprehensive efforts across sectors to improve patient safety. Problematic areas cited by the report include: a fragmented health care delivery system, a lack of attention to preventable medical errors in the systems that license health care providers, flaws in the medical liability system, and the lack of financial incentive for health care organizations to improve safety and quality of care.

Regulatory groups have instituted major patient-safety initiatives that have been undertaken in the years since the IOM report, through professional organizations, and private, for-profit companies. The IOM report noted that licensing and accreditation standards were the main accountability drivers for health care organizations and professionals; yet, at the time, neither focused on patient health and safety. An influential party in health and safety monitoring of health care organizations is the third party credentialing organization, the Joint Commission (TJC), formerly known as the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The Joint Commission has been classified as a quasi-regulatory entity, and it is an independent, not-for-profit organization that accredits and certifies more than 20,000 hospitals across the country. Hospitals that participate in Medicare and Medicaid are required to undergo a regulatory review by the Centers for Medicare & Medicaid Services (CMS), or alternatively, CMS enables hospital participation if they are accredited by a private body, such as The Joint Commission, and a select few other organizations that have been recently granted deeming authority.

The Joint Commission operates on a three-year accreditation cycle, and transitioned from pre-anounced, to unannounced, full-survey visits in 2008. Beginning in 2001, the Joint Commission adapted some of the recommendations in the IOM report and introduced new standards that focused directly on patient safety and quality. Surveys are conducted every 18-39 months after each unannounced visit. Surveyors currently talk to patients and caregivers whereas prior to 1999, the focus of surveys was a records and policies review. Surveys are performed to verify compliance with standards that encompass performance expectations, structures, and processes in place for quality health care. Survey reports include Requirements for Improvement (RFI), and organizations have 45-60 days to respond to these reports before accreditation decisions are made. Beginning in 2002, accredited hospitals began collecting data on core performance measures and their outcomes. Indicator scores are public, and comparisons can be made between hospitals. Provider participation in this data collection and reporting is linked to CMS reimbursements.

Current TJC goals for health care organizations include requiring procedures for identifying and responding to caregivers who create a negative culture, and promoting patient participation in

hospital safety. Critiques from the research community have included concerns that patient safety goals have been enacted without sufficient guidance,\(^{70}\) and that TJC’s approaches to patient safety goals lack strong supporting evidence.\(^{71}\) Additionally, in 2004, the Government Accountability Office (GAO) concluded that 78 percent of the time, the Joint Commission survey process did not identify serious deficiencies in patient safety that state auditors detected,\(^{72}\) resulting in the recommendation that more federal oversight be required over TJC accreditation activities. TJC also does not mandate hospitals to report on outcome progress related to patient safety goals.\(^{73}\) Accreditation has served as a quality indicator and has functioned as a placeholder for public regulation of hospital quality.

State regulation efforts in the patient safety movement have included requirements to report serious adverse events and strong encouragement that hospitals conduct error analyses.\(^{74}\) Other recent public sector efforts have included federal grant support for health information technology (IT) implementation, and increasing engagement of HHS’s Agency for Health Care Research & Quality (AHRQ). AHRQ has sponsored the development and dissemination of a quality indicators (QI) toolkit that measures hospital quality and safety using inpatient data. This tool can be used for hospital self-assessment. AHRQ also funds a Medical Liability Reform and Patient Safety Grant Initiative; which aims to strengthen the link between patient safety and medical liability reforms.\(^{75}\)

TJC is the main source of health care organization credentialing, but appears to have limited effectiveness in improving patient safety outcomes, and has been the subject of more than one Government Accountability Office study about conflict of interest.\(^{76}\) Keenan\(^{77}\) recently documented private sector alternatives to TJC that have recently been granted deeming authority by CMS and appear to be engaging in promising practices that address some of the concerns that have plagued TJC. The Health Care Facilities Accreditation Program (HFAP) offers accreditation standards that are closely aligned with CMS, and also integrates information from recent, successful public health campaigns. Other newly granted credentialing organizations engage in more outcome-based, rather than inspection-focused, surveys.

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77 Kenniston, E. 2011
Lessons learned from child welfare and health care monitoring

- Reform is an iterative process that requires feedback from states and other stakeholders, including practitioners, family members, and advocates.
- Assessing child, family, or patient outcomes is a labor-intensive and complicated process that may require several revisions before achieving the right balance of federal and state engagement.
- The goals of an increased federal or third party presence should include building the data and infrastructure capacity for self-monitoring that could inform quality improvement.
- Third party approaches to credentialing and standards development on safety are promising, but require alignment with federal policy and oversight of the mandatory reporting of outcomes.

The Differential Monitoring Model and Statistical/Risk-Based Approaches

A blanket monitoring system that treats all organizations equally can be inefficient. A better approach is to base monitoring and oversight on past performance or on an assessment of risk for non-compliance with standards. Such “differential monitoring” approaches have garnered attention as methods to better target limited funds and resources.

Federal and state research has explored methods for determining when to adjust the frequency or depth of monitoring across ECE settings based on a provider’s level of compliance with regulations. These approaches are called differential monitoring, of which statistical/ risk-based monitoring are subtypes. These methods are consistent with NARA recommendations for best practices, which specifies that monitoring agencies:

*Maintain a research-based risk-assessment method whereby industry-wide and facility-specific risks, including both immediate and cumulative risks, are identified and prioritized; focuses inspections and technical assistance accordingly; and, applies the agency’s enforcement continuum systematically to avert or abate priority risks, to build consistent compliance, and to improve overall consumer protection across all relevant domains.*

Richard Fiene, a researcher from Penn State University, has spent several years in consultation with states and the federal government formulating key indicator and risk assessment approaches to differential monitoring. He has helped implement these approaches in states, sometimes in conjunction with NARA. His work suggests that statistical and risk-based approach to monitoring have the benefit of reducing overlap between multiple systems. Data from across systems can be integrated and analyzed to tease apart correlations and support greater efficiency in data collection strategies, monitoring activities, and technical assistance.

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78 NARA, 2009
decisions. Although Fiene’s work is extensive and well documented, it has not been extensively subjected to peer-review.

In this section, two approaches to differential monitoring will be discussed: key indicators and risk assessment. Examples of how each leads to differential monitoring will be addressed within each section with case examples.

**Elements of a key indicator approach.** An abbreviated approach, through the use of key indicators in monitoring allows the regulatory agency to track key indicators of compliance, better target monitoring and technical assistance resources, and address compliance deterioration. Key indicators are standards that demonstrate statistical correlation with broader compliance or non-compliance on performance standards and regulations. Examples of key indicators that are relevant to ECE settings include:

- Background checks and medical clearances for teachers and staff;
- Cleanliness of the physical space;
- Securing of hazardous substances;
- Ensuring teachers and staff complete pre-service and ongoing trainings;
- Maintaining appropriate child: staff ratios for different age ranges of children;
- Safety of outdoor premises; and
- Maintenance of medical records for children

Under a key indicator approach, agencies with oversight over early childhood programs are able to assess preliminary compliance using key indicators of health and safety or program integrity, and base monitoring, technical assistance, and other decisions on this review. An indicator-based approach to monitoring increases agencies’ ability to more efficiently target scarce monitoring and technical assistance resources. Compliance or non-compliance with key indicators in this approach triggers different consequences for programs. For example, programs that demonstrate compliance with key indicators might receive abbreviated, targeted, or focused monitoring reviews, while programs that indicate significant non-compliance with key indicators could receive more comprehensive reviews, technical assistance, and other consequences. To prevent programs from “gaming” the system, a larger number of key indicators that could trigger consequences could rotate over time, so that programs do not strive for compliance with key indicators to the detriment of other aspects of program quality. Finally, self-inspection alone should not be part of a risk-based monitoring system.

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Case Study: The Head Start Key Indicator (HSKI) Pilot Study. The Office of Head Start (OHS) has been working on a Key Indicator Project and Pilot Study with Richard Fiene of Penn State University and other researchers and experts to determine which data elements collected by OHS (from monitoring and other reporting) are correlated with quality. The team is developing a list of key indicators that could be collected and monitored to assess compliance and risk and eventually drive monitoring, technical assistance, and other decisions.

The HSKI-C Protocol is a research-based monitoring instrument designed to identify grantees at low risk for non-compliance and, as a result, should receive differential monitoring. An abbreviated version of the comprehensive monitoring protocols, the HSKI-C protocol is comprised of 27 compliance measures that were selected based on how strongly they differentiated between high- and low-performing grantees. The HSKI-C covers the following review areas:

- Management Systems & Program Governance
- Comprehensive Services & School Readiness
- Fiscal Integrity

The HSKI-C is a critical part of the aligned monitoring system that will be implemented in FY 2015. OHS designed the aligned monitoring system to provide a different review process based on the grantee’s history.

The Comprehensive Monitoring Process and the Differential Monitoring Process. The monitoring process that a grantee receives is determined by whether it meets a specific set of criteria. The criteria include:

- No findings on the previous review cycle,
- No fiscal findings in the past two review cycles,
- No findings in the annual audits,
- No Designation Renewal System (DRS) criteria met,
- No significant program changes (e.g., changes in program leadership), and
- No concerns identified through input from the Regional Office.

Grantees that do not meet the above listed criteria will engage in the Comprehensive Monitoring Process. Those grantees that do meet the criteria will engage in the Differential Monitoring Process.

Comprehensive Monitoring Process: The Comprehensive Monitoring Process includes the following individual review events conducted over the first 3 years of a 5-year grant cycle: Environmental Health and Safety, Fiscal Integrity, the Classroom Assessment Scoring System (CLASS), Management Systems & Program Governance, and Comprehensive Services and School Readiness.

Differential Monitoring Process: In an effort to recognize grantees that have demonstrated strong performance through a history of compliance, OHS developed the Differential Monitoring Process. Grantees eligible for this process will first receive the HSKI-C Review Event. Head Start grantees that are successful in the HSKI-C Review Event will receive the Environmental Health and Safety and CLASS Review Events. EHS grantees that are successful will receive Environmental Health and Safety and Comprehensive Services and School Readiness since CLASS is not used in EHS programs. Grantees that are unsuccessful in the HSKI-C Review Event, meaning one or more indicators are triggered during their HSKI-C Review event, will go through the Comprehensive Monitoring Process.
The HSKI-C Tool was developed in consultation with Richard Fiene. With Fiene’s support, the OHS team analyzed monitoring data from FY 2012-FY 2014 (N = 1,099) to identify compliance measures that were 1) best suited to differentiate between high-performing grantees (i.e., compliant grantees) and low-performing grantees (i.e., grantees with findings) and 2) tended to be cited in reviews that have the most findings. Psychometric analysis examined whether HSKI-C review results agreed with the results of a comprehensive review. Based on FY2014 data, the results of the 27-item HSKI-C had a 91 percent agreement rate with the comprehensive review results.

The monitoring system includes the ability to capture specific and timely performance metrics (including data from environmental rating scales such as CLASS), demographic data, fiscal data, and service utilization information on the children and families served. This would represent a major resource shift in the short term but could potentially lead to greater efficiency and better use of data that are collected. This constitutes a way of re-structuring and re-framing the resources that already exist for monitoring by making sure programs with low compliance are seen more often. Differential monitoring in Head Start represents a budget-neutral change in which resources that are currently being devoted to comprehensive reviews for all grantees would be targeted to screening for those grantees who are performing well and comprehensive reviews for those grantees who need the support. In this aligned monitoring system, grantees who receive differential monitoring in one 5-year grant cycle would be required to have a comprehensive monitoring review in the next cycle. Grantees that are found to be out of compliance through the HSKI-C would have to undergo comprehensive reviews more frequently.

The key indicator approach is a promising one for child care monitoring systems, and in fact, many states currently use these methods. Using 2011 data, NCCCQI found that more than 50 percent of states are working on methods that target monitoring and TA resources. This approach will help ensure that support is made available to ECE programs who are struggling with licensing compliance. These states include Kansas, Washington, Illinois, and California. Child care licensing staff from Kansas recently articulated the benefits of a key indicator system, including:

- The regulatory agency is able to spend more time monitoring and providing TA to noncompliant ECE providers;
- A reduction of the administrative burden for compliant providers through shorter inspections;

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- Children in out-of-home care are better protected in a more efficient system; and
- Taxpayers are assured that strong licensing continues, even in the face of reductions in resources.

Kansas has been implementing their key indicator system since 2013, and has developed a key indicator inspection process for: 1) determining which providers are eligible for indicator inspections; 2) conducting inspections measuring compliance with statistically identified indicator regulations; 3) measuring regulations identified at random; 4) expanding the scope of indicator inspections if violations are detected; 5) conducting comprehensive inspections every third year in addition to interim indicator inspections; and 6) re-calculating indicators every three years. Other states are in different phases of development and implementation of their key indicator systems, and to move forward with these efforts, robust state licensing data should be used as a basis for determining the statistical power of key indicators, similar to the way Tri-Annual Review data were used to validate HSKI.

**Elements of a risk assessment approach.** A risk assessment approach identifies rules or regulations that place children at greatest risk of injury or death. Unlike the key indicator approach, the risk assessment approach does not statistically predict overall compliance with licensing rules or regulations. Instead, risk assessment helps determine the rules or regulations that pose a greater risk of harm to children if violated. Risk assessment is most often used to classify or categorize violations, distinguish levels of regulatory compliance, or determine enforcement actions using categories of violations. There are a number of ways licensing regulations can be assessed for risk, including the following:

- Probability of harm (high, medium, low);
- Severity of harm (extreme, serious, moderate, low); or
- Frequency of violations (numerous, repeated) based on those considered most critical to protecting children’s health and safety

The real strength of key indicator and risk assessment approaches is when they are used in tandem rather than individually, which is the case in Illinois that is described below. Fiene has advocated the combined approach as being the most cost effective and efficient differential monitoring system.

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Case Study: The development of a weighted key indicator licensing system in Illinois. The Division of Licensing and Monitoring at the Illinois Department of Children and Family Services (DCFS) is responsible for upholding Illinois licensing standards in 8,000 day care homes (family child care), 3,000 day care centers, and 700 group day care homes across the state. In FY 2013, the division investigated more than 1,300 complaints about ECE providers. Currently, each licensed ECE provider should receive an annual, unannounced, comprehensive inspection visit.

For many years in Illinois, momentum had been building for a different approach to licensing and enforcement. Concerns were raised by the advocacy community and agency staffs about the high caseloads experienced by child care licensing staff at DCFS, and ECE providers were generally frustrated with the efficiency and timeliness of the licensing process. Further straining the system, DCFS, which administers child protective services, experienced budget cuts in a number of funding cycles. These issues were highlighted in 2009 when early childhood offices across agencies were co-located in the Governor’s Office of Early Learning. The funding for actually reforming the licensing system came together through the state’s Race to the Top—Early Learning Challenge (RTT—ELC) award.

Illinois is currently working with a team from NARA that includes Richard Fiene on a key indicator approach that in Illinois will be called a “weighted licensing key indicator system.” The system will assign weights or numerical scores to each section of Illinois’s Day Care Home regulations based on the relative risk to children if the regulation is not met. As part of the development process, DCFS provided NARA with several years of data on serious injuries and deaths.

NARA is also administering a survey in English, Spanish, and Polish to relevant stakeholders, including ECE providers and practitioners associated with centers and family child care homes. When these surveys are complete, NARA will analyze the numerical scores assigned by each respondent and calculate a mean weight for each regulatory item. The mean weights obtained from this analysis will be the basis for the weighted licensing system, which will ultimately focus on more serious violations. The weighted system will take into account provider licensing and inspection histories. Providers with few noted concerns will experience more streamlined inspections. The weighted system will eventually be dovetailed with the key indicator system that is being developed at the same time. This weighted licensing key indicator system will concurrently provide Illinois with statistical predictor rules and high risk rules.

A depiction of the Illinois’ QRIS

The state’s QRIS, ExceleRate, a major RTT-ELC implementation project, facilitated reform of the licensing system. The state is working to more fully integrate DCFS licensing with the larger system of supports for early care and education. Licensed providers, for example, are automatically enrolled in ExceleRate. The state hopes that administering inspections more efficiently will free child care licensing staff to mentor providers on attaining higher levels of quality, and licensing staff are excited about the new roles they may be able to take on through the weighted system.
These latest developments in designing and implementing differential monitoring strategies will continue as states consider ways to increase the efficiency of their monitoring systems. Research is also currently underway that compares results from monitoring systems associated with licensing, QRIS, and key indicator and risk assessment systems. In some cases where state licensing or monitoring compliance records are extensive, Fiene has also conducted internal validation studies of key indicator systems. In these cases, false positive and negative rates of key indicator reviews are calculated by comparing compliance data from comprehensive reviews to compliance results from key indicator reviews. To date, only Head Start (HSKI-C) and Georgia’s Core Rule Approaches have been validated. Additional research must be conducted to validate the approaches to differential monitoring and to determine other approaches that show merit.

Options for monitoring across ECE settings

1. Monitoring policies and procedures could be aligned across funding streams, and grounded in a universal set of health, safety, and performance standards that are research-based and endorsed by professional organizations.

Our ECE system is currently fragmented, offering a mixed bag of options to families with different levels of resources. Distinct funding sources each have different purposes that have created competing demands for accountability. For infants, toddlers, young children, and their families nested between and within these systems, it has been difficult to discern whether minimum standards—let alone higher levels of quality—are being met. To ensure that there is a minimum floor of health and safety, especially for children and families using subsidized care, greater continuity across programs and funding streams is needed.

As stated earlier, Caring for Our Children Basics, a companion resource to the third edition of Caring for our Children, was released for public comment in 2014 and will provide voluntary guidance to state regulatory agencies on the minimum health and safety standards necessary in all ECE settings. These standards are aligned with both HS/EHS performance standards and OCC guidance to states about providers who meet the minimum recommended standards for serving children and families who are eligible for subsidies. In addition, Basics references common health and safety standards across other federal programs, including the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices/American Academy of Pediatrics/American Academy of Family Physicians-approved guidelines on immunizations, the U.S. Department of

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Agriculture’s (USDA) Child and Adult Care Food Program (CACFP) regulations, and the Consumer Product Safety Commission guidelines for playground safety. Incorporating research-based, interdisciplinary standards and recommendations in state regulations is intended to reduce the burden on programs, and increase the likelihood that children will be served in settings that are safe and conducive to their learning.

In the examples from states, it is clear that ECE providers are subject to multiple inspections every year under parallel—but not yet aligned—systems. A more unified ECE system built on core early learning and performance standards that are applicable to different kinds of providers is needed. States should use common administrative and monitoring protocols regardless of funding streams. Some of the RTT—ELC states that have been required to revise current or design new QRIS have started implementing a more aligned system. Co-locating and cross-training state regulatory, quality improvement, Pre-K, and HS/EHS staff who could have been originally housed in different human services and education agencies is one promising approach.

At a minimum, ensuring that representative stakeholders from across agencies of early learning are all involved in ECE system reform is essential. States that have been attempting to build a QRIS that includes all ECE sectors of HS/EHS, Pre-K, special education and child care, have faced difficulties accessing federal monitoring data that corresponds with minimum quality thresholds, for example from ECE environmental ratings or ratings of teacher-child interactions. It will be important to build the data infrastructure and communications systems to share monitoring information across federal and state settings. Under uniform standards developed and implemented across regulatory agencies, national credentialing organizations, and the agencies that manage federal and state grants to ECE providers, basic health and safety compliance will be addressed in such a way that allows accountability systems to focus on higher levels of quality linked to child and family outcomes.

2. **After further validation by the research community, systems of differential monitoring could be piloted and implemented to help states target technical assistance and monitoring resources to the ECE providers who are at the greatest risk for providing unsafe learning environments.**

Many states are using differential monitoring to make monitoring more efficient. As opposed to “one size fits all” systems of monitoring, differential monitoring determines the frequency and depth of needed monitoring from an assessment of the provider’s history of compliance with standards and regulations. Providers who maintain strong records of compliance are inspected less frequently, while providers with a history of non-compliance may be subject to more announced and unannounced inspections. In some states, more

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frequent inspections are conducted for providers who are on a corrective action plan, or after a particularly egregious violation.

Differential monitoring, however, should not replace routine inspection of all licensed providers. A study of Vermont’s differential licensing system demonstrates that although it can be effective to inspect centers with a poorer compliance record more frequently, centers with a good compliance record also need routine inspection or risk deteriorating compliance. It is also important to put in place precautions that will prevent providers from anticipating abbreviated or more focused monitoring reviews.

At a minimum, all early care and education providers could receive a comprehensive inspection to determine the baseline level of compliance with standards and regulations. In addition, the National Association for Regulatory Administration (NARA) recommends that “routine monitoring inspections occur with sufficient frequency to protect consumers and to prevent or reduce compliance deterioration—at least twice-yearly— unless the agency has a reliable system to reduce the frequency of routine monitoring for stable, high-compliance facilities, provided that all facilities are inspected at least once a year.”

A risk-based, or key indicator, approach to monitoring complements differential monitoring by allowing the monitoring agency to track key indicators of compliance, better target monitoring and technical assistance resources, and combat compliance deterioration. The HSKI Pilot Project provides an important model for how monitoring resources can be re-distributed to focus limited resources on the programs that are out of compliance in the most crucial areas for the protection of children, and several states are already designing and implementing this kind of approach.

A note of caution: Although differential monitoring models have been implemented in states, this research has not been submitted to the rigor of peer-review. It will be important to validate these efforts in the scientific community before differential monitoring practices are significantly expanded or further endorsed by states or federally.

3. Third party accreditation and credentialing by national organizations could be expanded. This strategy is widely used in analogous sectors.

Although 98 percent of military child care providers have attained national accreditation, only 10 percent of civilian ECE centers and 1 percent of family and group child care homes are accredited. Providers who embark on accreditation are often committed to more

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89 NARA, 2009
stringent standards for class sizes, teacher: child ratios, staff qualifications and professional development, and salaries than state regulatory guidelines require. Providers who are nationally accredited publicize this achievement, and presumably, families recognize national accreditation as a mark of quality. Although research is limited in this area, it suggests that nationally accredited providers offer safer learning environments.

One way states and territories have created incentives to become nationally accredited is by offering ECE providers higher subsidy rates. Continuing to provide incentives to providers to commit to higher levels of quality takes some of the burden off state regulatory agencies, who are already struggling to meet the staff caseloads ratios of one child care consultant to 50 ECE providers that are recommended by the National Association for Regulatory Administration (NARA). National accreditation should also bear some relationship to QRIS in states. Toward this end, several states are consulting with NAEYC and other national accreditation organizations to determine how QRIS standards align with national accreditation standards.

4. For ECE programs that are also federal grantees subject to monitoring, federal and state agencies could share any negative findings or instances of non-compliance.

Many states developing QRIS that is meant to be inclusive of Head Start have had difficulty incorporating Head Start grantees in ways that will incentivize participation, rather than increase the burden on these grantees. It is clear that federally-administered Head Start monitoring occurs in ways that are often more rigorous than basic health and safety monitoring conducted by state regulatory agencies. In addition, the Office of Head Start has been experimenting with a research-based, differential monitoring approach since 2013. Although data from federal monitoring visits may eventually be made available to grantees for the purposes of quality improvement, it is currently neither shared with state licensing agencies, nor QRIS staff. Under these circumstances, participation in additional state quality improvement endeavors—such as QRIS—has the potential to add to an already extensive reporting burden for Head Start grantees. Similarly, the USDA’s Child and Adult Care Food Program (CACFP) conducts federal monitoring of many of the same programs that accept CCDF subsidies in states, but monitoring results are not shared with state administrators. Aligning monitoring protocols and results of monitoring visits across federal and state agencies will increase efficiency and decrease the time and effort of grantees. Notably, in the context of discussions about implementing the CCDBG Reauthorization, several states have already begun to convene interagency groups to map out staffing the enhanced monitoring requirements. These discussions have involved work on aligning inspection and training requirements across CCDF and the CACFP. On a federal level, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture have also started collaborating in considering guidance to states about how to improve streamline standards and requirements across programs. Some of these discussions have

91 NARA, 2009
focused on cross-training monitoring staff, and examining funding mechanisms to cross-train and cross-monitor.

5. Federal and state agencies could partner to increase understanding among the community of providers that the larger purpose of monitoring is to keep children, families, and staff safe.

Different federal and state agencies may have different purposes for monitoring. Examples of the intent of monitoring that were highlighted by different sources include monitoring for:

- Basic compliance with health and safety standards;
- A high standard of quality;
- Determining whether to close down an ECE program; and
- Determining whether an ECE program receives additional funding.

Considering the different purposes monitoring could serve, it may be difficult to come to an agreement on a more universal vision of monitoring across sectors and funding streams. However, federal and state agencies could begin the process of reaching consensus on the foundational components of monitoring that are meant to keep children, families, and staff safe. Once these basic elements are met, ECE programs could work with state and federal regulatory agencies on higher levels of quality that are associated with children’s readiness to learn.

Current research on aligning monitoring across sectors

The Administration of Children and Families (ACF) recently invested in a Child Care and Early Education Policy Research and Analysis (CCEPRA) project that is being conducted by the research organization Child Trends. The project is focused on cross-sector monitoring issues in early care and education that:

- Supports a more unified early childhood system;
- Provides a foundation for cross-sector work in other areas, such as professional development;
- Reaches agreement on some basic elements of quality;
- Helps focus on some basic elements of quality;
- Minimizes inconsistencies across ECE sectors;
- Increases the efficiency in the early childhood system; and
- Reduces burden on early childhood programs.

Addressing these considerations, the Child Trends project will articulate the dimensions of a cross-sector monitoring system that will provide tools for state and federal agencies to think through the infrastructure necessary to institute such a system across funding streams. We hope that some of the foundational work in this white paper on state practice and the current federal system will inform work on cross-sector monitoring.
Conclusion
As demonstrated in this white paper, a range of entities monitor and regulate individual ECE programs in ways that are often duplicative and burdensome. Advancing the field in monitoring will likely occur in response to the reauthorization of the CCDBG Act. These recent legislative changes have been the result of advocacy, examination of best practices in states, recommendations of experts through the hearing process in the Senate and House, and bi-partisan support. Any reform in monitoring should more effectively promote children’s health, safety, and optimal development. The current system operates under both inefficiencies and promising practices. Analogous sectors, such as child welfare and health care, offer some insights about how iterative the process of reforming monitoring systems can be, and how necessary it is to carefully gather feedback from stakeholders in and outside of government. We have learned that the right balance of federal and state engagement has been difficult to attain, and have highlighted the importance of activities to build the infrastructure necessary to support a data-driven monitoring system that has the potential of informing continuous quality improvement. We hope this white paper, and the upcoming research on alignment across ECE sectors, will provide states with some of the resources necessary to collaborate in building a cross-sector monitoring system that is centered on aligning federal and state programs, increasing efficiencies, reducing administrative burdens, targeting support to programs that require the greatest assistance, and ensuring all children in out-of-home care are safe and ready to learn.
Introduction

While States’ licensing systems primary goal is to improve the health and safety of children in child care, important decisions must be made in order to also maximize administrative cost efficiencies. With limited resources, licensing administrators work to ensure that monitoring visits focus on what is most important in keeping children safe. In the absence of research that assesses the efficacy of various approaches, States are moving ahead with different methods to identify and reduce the risk of harm to children. Some strategies include:

- Identifying licensing rules where violations pose a greater risk to children;
- Assigning a weight to each rule to further distinguish levels of regulatory compliance;
- Focusing monitoring visits on key indicators from the rules that predict compliance and reduce risks;
- Increasing monitoring frequency for programs with low levels of compliance;
- Increasing monitoring depth for programs with low levels of compliance;
- Helping providers, parents, and licensing staff better understand the potential consequences of serious noncompliance;
- Identifying providers in need of technical assistance; and
- Using more sophisticated data systems to target case management and improve consistency in enforcement actions.

The purpose of this report is to describe various methods States are using to monitor child care facilities efficiently and effectively. It provides descriptions and examples of these methods and details of States’ practices.
Methodology

To support the Office of Child Care’s goal of children served in safe, healthy child care settings, the National Center on Child Care Quality Improvement (NCCCQI) contracted with a group of nationally-recognized consultants with expertise in administering and researching licensing systems to prepare a series of written reports about critical licensing issues.

The information provided in these reports was obtained by surveying and interviewing representatives of state licensing agencies in nine States: CT, FL, GA, NC, OH, OK, TX, UT, and WA. The States selected are not a representative sample but were chosen based on the consultants’ knowledge that they are implementing effective and innovative practices which may be helpful to other state licensing agencies. Additionally, an effort was made to achieve some degree of geographic representation through the States selected.

Licensing personnel from the nine States selected first completed a written survey instrument and then spoke with the consultants in a telephone interview. All individuals interviewed were licensing agency directors or top-level administrators.

Information from Research Brief #1: Trends in Child Care Center Licensing Regulations and Policies for 2011 (NCCCQI, 2013) and The 50-State Child Care Licensing Study: 2011-2013 Edition (National Association for Regulatory Administration [NARA], 2013) are also included to provide national data and context to the information gathered from the nine States. Both of these reports include data gleaned from a national survey of licensing agencies conducted by NARA. Responses to the NARA survey were received from licensing agencies in all 50 States and the District of Columbia.  

Methods for Monitoring for Compliance

In an effort to ensure the health and safety of children in child care facilities, States seek to identify and assess the risk of harm to children and increase monitoring in programs with lower levels of compliance. At the same time, state licensing agencies need to make the most efficient and effective use of available, and often shrinking, resources.

NARA, in Recommended Best Practices for Human Care Regulatory Agencies (2009), presents the characteristics of a strong licensing agency, including:

Maintains a research-based risk-assessment method whereby industry-wide and facility-specific risks, including both immediate and cumulative risks, are identified and prioritized; focuses inspections and technical assistance accordingly; and, applies the agency’s enforcement continuum systematically to avert or abate priority risks, to build consistent compliance, and to improve overall consumer protection across all relevant domains. (p. 6)

2 In the NCCCQI and NARA reports, and in this report, the District of Columbia is included in state counts and not listed separately.
There are a variety of methods that many States are using, often in combination, in their monitoring and enforcement of licensing rules and regulations. This report explores these methods:

- **Differential Monitoring**: A regulatory method for determining the *frequency or depth of monitoring* based on an assessment of a facility's history of compliance with rules;

- **Full and Abbreviated Compliance Reviews**: Conducting an inspection by monitoring *all rules* (full review) or a *selected set of rules* (abbreviated review);

- **Risk Assessment**: An approach that focuses on identifying and monitoring those rules that place children at *greater risk of mortality or morbidity* if violations or citations occur; and

- **Key Indicators**: An approach that focuses on identifying and monitoring those rules that statistically predict compliance with all the rules.

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**All Licensing Rules – Full Compliance Reviews**

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**Differential Monitoring**

- **How Often to Visit?**
  - More Often
  - Less Often

- **What is Reviewed?**
  - Risk Assessment
  - Key Indicators Predictors

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Note: This graphic is adapted from a graphic developed by Dr. Richard Fiene and used in: Fiene, R. (2013) Differential monitoring logic model and algorithm (DMLMA: A new early childhood program quality indicator model (ECPQI(MA))© for early care and education regulatory agencies, Middletown, PA: Research Institute for Key Indicators.

The relationship among these methodologies is often confused, partly because of varying definitions. The graphic below explains the relationship of the methodologies with differential monitoring as the overarching approach and risk assessment and key indicators as types of abbreviated compliance.
**Differential Monitoring**

Differential monitoring is a regulatory method for determining the frequency or depth of monitoring based on an assessment of a facility’s history of compliance with licensing rules. A differential monitoring system can be used to recognize a provider’s strong record of licensing compliance with abbreviated or less frequent inspections if there have been no serious violations for a period of time. For providers with rule violations and compliance issues, licensing agencies can use differential monitoring to focus more attention on those facilities with additional monitoring visits, targeting visits on the problem areas, and providing technical assistance. When inspections are focused on a subset of rules, States often have an option for licensing staff to conduct a full review when necessary.

In its analysis of licensing trends, NCCQI (2013) noted that more than 50 percent of States report having a method for determining the frequency or depth of monitoring based on an assessment of compliance with regulations. *The number of States using differential monitoring increased significantly from 11 States in 2005 to 26 States in 2011.*

**Differential Monitoring Policies in Oklahoma**

Oklahoma increases the number of monitoring visits from the required three annual visits if there is a pattern of noncompliance. Technical assistance is provided during all visits as needed. According to the Oklahoma Department of Human Services’ (2012) policies:

After each monitoring visit, licensing staff enter the monitoring frequency plan... [in] the licensing database. Any changes in the monitoring plan must be reviewed by the supervisor. Examples of the required number of visits include:

- One visit per year for inactive child care centers, part-day, or school-age facilities;
- Two visits per year for part-year programs;
- Three visits per year for facilities with a history of compliance;
- Six visits per year for applications, six-month permits, and changes in facility class except a large FCC home changing to a FCC home; and
- Twelve visits per year for seriously noncompliant facilities.

On occasions when licensing staff visit a facility between monitoring visits for purposes such as picking up paperwork, providing consultation on a specific issue, or verifying a required repair or purchase, a full monitoring visit is not required and the visit is not counted toward the required number of visits. If numerous, repeated or serious noncompliance is observed during the visit, a complete monitoring visit is conducted. If caseloads prevent licensing staff from conducting the required number of monitoring visits, the supervisor consults with the staff on case management, and the number of required visits may be reduced if approved by the regional program manager. This adjustment is approved and documented in the case record by the supervisor. Required visits to nonproblematic licensed facilities may be reduced by one visit per year for no longer than a one-year period. More information about 340:110-1-9. *Case Management, Instructions to Staff,* is available at [http://www.okdhs.org/library/policy/oac340/110/01/0009000.htm](http://www.okdhs.org/library/policy/oac340/110/01/0009000.htm).
Full and Abbreviated Compliance Reviews

States generally conduct full compliance reviews during monitoring visits where all possible areas of regulatory compliance are measured and every rule is checked for compliance. According to NARA (2013), States typically conduct a full compliance review of programs every 1 – 2 years, most often as part of the license renewal process.

A growing number of States are using an abbreviated compliance review to conduct at least some inspections. NCCCQI (2013) reported that more than 55 percent of States in 2011 were using abbreviated compliance reviews for some inspections, mostly during routine compliance reviews.

States have different approaches to deciding if and when to use an abbreviated compliance form. NARA (2013) reported that in 2011, most of the States that use abbreviated compliance forms had policies on when to switch from an abbreviated compliance review to a full compliance review. The following examples illustrate how States determine when to use full and abbreviated compliance reviews:

- **Florida** inspects centers a minimum of three times per year and family child care (FCC) homes two times per year. As part of the 1996 WAGES Act, the Florida Legislature directed the Department of Children and Families and local licensing agencies to develop and implement an abbreviated inspection plan for child care facilities based on certain statutory criteria. Florida has an automated child care inspection system that tracks violation data and identifies the providers eligible for abbreviated inspections. Eligible providers have had no Class I or Class II (most serious) violations for two consecutive years. If violations are found during an abbreviated visit, the provider is no longer eligible to be monitored using the shorter form and must have a full compliance review. Florida’s laws about conducting abbreviated inspections are available in 2013 Florida Statutes Sections 402.26 – 402.319 Child Care at http://nrckids.org/default/assets/File/StateRegs/FL/FL_Statutes_402_26-402_319_Child_Care.pdf.

- The **Georgia** licensing agency conducts a minimum of two visits per year, including a licensing study and a monitoring visit. The licensing study is a full inspection using an inspection form that includes all rules, with the core rules highlighted (see page 8 for more detail). Monitoring visits involve the use of an abbreviated form that only includes the core rules.

- **North Carolina**’s state statute requires that all providers are inspected by the licensing agency at least once per year, in addition to annual inspections by local or state health and fire inspection agencies. For programs to receive an abbreviated monitoring visit, they must have a four- or five-star license and a compliance score of 85 percent over the past 18 months prior to the scheduled visit date. In the rated license system, higher star levels are obtained by meeting additional requirements related to program quality standards and education levels of staff. “Chapter 110 Child Care Facilities,” in North Carolina General Statutes (2013) is available at http://nrckids.org/default/assets/File/StateRegs/NC/07-13%20Article%2007.pdf.

- **Texas** inspectors and investigators determine which standards to evaluate prior to the inspection but have the ability to add standards during the inspection, if needed. All standards must be evaluated at least once every two years. Standards may be re-evaluated as a result of investigations, follow up on previous deficiencies, or as part of a corrective action. Texas policies on Preparing for Inspections are in Section 4140 in the Texas’ Licensing Policy and Procedures Handbook at http://www.dfps.state.tx.us/handbooks/Licensing/Files/LPPH_pg_4000.asp#LPPH_4140.

- **Utah** inspects centers and FCC homes twice a year. All providers receive an abbreviated unannounced compliance review and a full announced compliance review annually. All of Utah’s announced (full) and unannounced (abbreviated) inspection checklists are available on its Web site at http://health.utah.gov/licensing/centerinspectionchecklists.htm (centers) and at http://health.utah.gov/licensing/HomeInspectionChecklists.htm (FCC homes).
Approaches to Identifying Critical Rules

Often differential monitoring involves monitoring programs using a subset of the licensing rules to determine compliance. There are two methods that States have used to identify these critical rules:

- **Key Indicators:** An approach that focuses on identifying and monitoring those rules that statistically predict compliance with all the rules; and

- **Risk Assessment:** An approach that focuses on identifying and monitoring those rules that place children at greater risk of mortality or morbidity if violations or citations occur.

Focusing on specific rules, whether through a key indicator or risk assessment process or a combination of both, can assist the licensing agency to:

- Implement a differential monitoring policy;
- Guide case management such as targeted technical assistance or witnessed visits;
- Determine enforcement actions based on categories of violations; and
- Assist families in better understanding the potential impact of noncompliance on their child’s care.

**Key Indicators**

Here we describe the key indicator approach, where States identify those rules that statistically predict overall compliance. A methodology for key indicators was developed by Dr. Richard Fiene at Pennsylvania State University. Dr. Fiene (2014) states that “if a program is 100% in compliance with the Key Indicators, the program will also be in substantial to full compliance with all rules. The reverse is also true in that if a program is not 100% in compliance with the Key Indicators, the program will also have other areas of non-compliance with all the rules.” (p. 3)

The indicator methodology was based on research to study the impact of child care quality on children’s development and the relationship between program quality and compliance with state licensing rules (Fiene, 2013). Several conducted in Pennsylvania in the 1980s found that programs in substantial compliance with licensing rules had better quality than those with 100% compliance (with a focus on recordkeeping), which led to including more program items in licensing rules. The studies supported greater use of indicators to save monitoring time and permit more technical assistance and consultation on quality improvement (Fiene, 1986, Kontos & Fiene, 1987).

The key indicators approach is often used to determine the rules to include in an abbreviated inspection form or checklist. Some States have worked with Dr. Fiene to implement his statistical methodology; however, other States have determined indicators by reviewing their rules and choosing by consensus those considered most critical to protecting children’s health and safety. In addition, States that use key indicators often include a few additional rules in their inspections, based on level of risk or random selection.
Washington Employs Key Indicator System

Washington based its system of monitoring checklists on the thirteen indicators developed by Dr. Richard Fiene (2002) for the U.S. Department of Health and Human Services a number of years ago. These are used across all types of programs—centers, FCC homes, and school-age programs. Providers with nonexpiring full licenses are monitored using an abbreviated checklist when the site has demonstrated a high level of compliance since the prior visit. This includes, but is not limited to, no valid complaints, compliance agreements, or other information demonstrating noncompliance with licensing rules. Licensors are required by policy to move to a full checklist in cases where providers are not in compliance with any of the key indicators. Washington has started to use electronic licensing forms and data gathering that will allow for statistical weighting in future years, after the data have matured. Washington’s licensing agency includes some rules in addition to the key indicators in their abbreviated checklists.

Policies and Procedures

Monitoring Tools

Risk Assessment

A risk assessment approach can be used to determine the rules that pose a greater risk of harm to children if violated. Risk assessment is most often tied to classifying or categorizing rule violations and can be used to identify rules where violations pose a greater risk to children, distinguish levels of regulatory compliance, or determine enforcement actions based on categories of violations.

There are a number of ways licensing regulations can be assessed for risk, including the following:
- Probability of harm (high, medium, low);
- Severity of harm (extreme, serious, moderate, low); or
- Frequency of violation (numerous, repeated) based on those considered most critical to protecting children’s health and safety.

States that choose a risk assessment approach must determine whether to assign a risk category to all rules or a selected set of rules. A risk category might be assigned to all rules so that enforcement can be tied to level of risk. For example, Florida has categorized all rule violations based on the threat of harm to children:

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**Child Care Center Full Licensing Checklist**


**Child Care Center Abbreviated Monitoring Checklist**


**FCC Home Full Licensing Checklist**


**FCC Home Abbreviated Monitoring Checklist**

“Class I Violations” are the most serious in nature, pose an imminent threat to a child including abuse or neglect, and could or do result in death or serious harm to the health, safety, or well-being of a child;

“Class II Violations” are less serious in nature than Class I violations, and could be anticipated to pose a threat to the health, safety, or well-being of a child, although the threat is not imminent; and

“Class III Violations” are less serious in nature than either Class I or Class II violations, and pose a low potential for harm to children.

Alternatively, a licensing agency might only assign a risk category to a subset of rules if the primary purpose of risk assessment is to determine the need for further monitoring visits. Ohio has defined Serious Risk Noncompliances (SRNC) for centers and group child care homes based on requirements with the highest risk of harm if violated. Regulations are organized into three large categories: 1) Lack of Supervision, 2) Administrative Negligence, and 3) Environmental Hazards. If a program has a certain number of serious risk violations, they receive additional full compliance inspections. A summary document of the requirements chosen as SRNC is available at http://jfs.ohio.gov/cdc/RiskRules.pdf.

Oklahoma has also identified serious noncompliances that expose children to conditions that present an imminent risk of harm. Their policies clarify that “Imminent risk of harm must be assessed based on the age of the child, the amount of time the caregiver was out of compliance, and the caregiver’s efforts to mitigate the risk. Serious noncompliances are identified through licensing observations, confirmed complaint investigations, and/or self-reported incidences.” The policies are available at http://www.okdhs.org/library/policy/oac340/110/01/0009003.htm.

Some States use risk assessment to classify violations and determine enforcement approaches. For example, in Florida, violations of the minimum health and safety standards are automatically classified as Class I, Class II, or Class III based on the potential for harm to a child. Enforcement actions, such as monetary fines, are determined by the classification of violations and number of occurrences in a progressive enforcement model. Licensing inspection reports are posted on the Florida Department for Children and Families Web site and include violation classifications. The definitions of the three classes are found in “Chapter 65C-22 Child Care Standards” of the Florida Administrative Code (8/1/2013) at http://nrckids.org/default/assets/File/StateRegs/FL/FL_Chapter_65C-22.pdf.

In Utah, rule violations are classified as Level 1, 2, or 3 violations, depending on both the seriousness of harm to a child that could result from the violation, as well as the likelihood that harm will occur. Level 1 findings are categorized as “cited” findings the first time they occur. Level 2 and 3 findings are initially classified as “technical assistance” findings, which mean that providers are given technical assistance and the opportunity to correct the violation. The number of rule violations and the severity of the violations determine if providers may be placed on a conditional license with additional monitoring inspections. The frequency of monitoring inspections may also increase due to noncompliance during the conditional period. Definitions of the violation levels are available in the “Introduction” section of the Child Care Center Rule Interpretation Manual at http://health.utah.gov/licensing/rules/Interpretation/Center/Section%201-%20Introduction.pdf. Utah’s interpretation manuals include noncompliance levels for each licensing requirement. The manuals are available at http://health.utah.gov/licensing/rules.htm.
## Texas’ Weighted Standards Based on Risk

In **Texas**, all of the Child Care Licensing Minimum Standards have been assigned a weight (High, Medium High, Medium, Medium Low, or Low) based on the risk that a violation of that standard presents to children. Weights are noted within the minimum standards documents in the left margin next to each standard or subsection. Only those standards that can be violated (marked as a deficiency) are weighted. The weighted enforcement system utilizes the program’s operations compliance history including the repetition of violations, investigations, types, and number and weight of deficiencies to generate the enforcement recommendations. The Texas licensing standards are available at [http://nrckids.org/index.cfm/resources/state-licensing-and-regulation-information/texas-regulations/](http://nrckids.org/index.cfm/resources/state-licensing-and-regulation-information/texas-regulations/).

In Texas, inspectors and investigators determine which standards to evaluate prior to the inspection but have the ability to add standards during the inspection, if needed. All standards must be evaluated at least once every two years. Standards may be re-evaluated as a result of investigations, follow up on previous deficiencies, or as part of a corrective action. The weighted enforcement system utilizes the operations compliance history, including the repetition of violations, investigations, types, and number and weight of deficiencies to generate the enforcement recommendations.

Licensing staff document observations to capture the scope and severity of the deficiency, but the weighted standards are now part of the licensing database and decisionmaking process, resulting in more consistent and equitable enforcement practices. The Child Care Licensing Automation Support System (CLASS)* Risk Review is a tool that supplements the professional assessments of licensing staff. The CLASS Risk Review produces enforcement recommendations based upon the type, number, weight, and repetition of violations over the course of an operation’s two-year compliance history. A Risk Analysis summary can be requested by staff seeking feedback on corrective actions. Facilities with serious deficiencies or a significant number of deficiencies, repeat deficiencies, or that fail to make timely corrections, are inspected more frequently to monitor the level of risk to children.

For more information, see “Section 4500: Evaluating Risk to Children” in the *Texas Licensing Policy and Procedures Handbook* at [http://www.dfps.state.tx.us/handbooks/Licensing/Files/LPPH_pg_4300.asp#LPPH_4500](http://www.dfps.state.tx.us/handbooks/Licensing/Files/LPPH_pg_4300.asp#LPPH_4500).

*CLASS is the Child Care Licensing Automation Support System. It is a computer application used by Texas licensing staff for record management.*
Georgia’s Core Rules

Georgia uses a core rule reference chart to determine and assess the health and safety risk of noncompliance to children. When child care licensing consultants conduct inspections, they use the chart to assess the level of severity of the violation and guide their decisionmaking on issuing citations. Each time any core rule within the core rule categories is cited, the risk level of the citation is also assessed. Risk level is assigned at low, medium, high, and extreme levels. The number of core rule categories cited and the assigned risk level determines the annual compliance level. A facility’s annual compliance status is determined on June 30 of each year, based on the performance for the past fiscal year (July 1-June 30), is posted on the public Web site, and remains in place for the next fiscal year. Additional information about Georgia’s core rules is available at http://decal.ga.gov/ChildCareServices/CoreRulesInformation.aspx.

Family Day Care Home Rule Categories
- Criminal Records Check
- Discipline
- Field Trips
- Infant Sleeping Safety Requirements
- Overcrowding Registration Requirements
- Physical Plant
- Playgrounds
- Staff:Child Ratios
- Supervision
- Swimming Pools and Water Related Activities

Child Care Learning Center and Group Day Care Home Core Rule Categories
- Diapering Areas and Practices
- Discipline
- Field Trips
- Infant Sleeping Safety Requirements
- Hygiene
- Medications
- Physical Plant
- Playgrounds
- Staff:Child Ratios
- Supervision
- Swimming Pools and Water Related Activities
- Transportation

Issues To Consider

The goal of differential monitoring, abbreviated compliance tools, risk assessment and key indicators is to create efficiencies and greater effectiveness in monitoring and enforcement, permitting more time for monitoring, especially of those facilities with lower compliance that need more technical assistance and program consultation. It should be noted, however, that these strategies should only be implemented when built on a strong licensing structure with a foundation of adequate periodic unannounced inspections. The States surveyed for this report use different tools and methodologies for measuring compliance, and feel that this practice has increased their enforcement capability. The increased use of these methodologies across States raises some questions for the field to consider:

- While abbreviated compliance forms are widely used, most are not developed using a methodology that statistically predicts compliance. Are all of these methods equally effective in measuring the level of compliance with licensing rules?
- Are all abbreviated compliance systems successful in creating both efficient and effective use of resources? What are the similarities and differences and what is their impact on effective regulation?
- What is the best mix of the measurement methodologies discussed in this report for consistent and strong enforcement of the licensing rules?
How do these methods impact the relationship between licensing and other entities that monitor child care programs, such as Head Start, Quality Rating and Improvement Systems, prekindergarten, and national accreditation?

States must continue to educate providers on the importance of meeting all licensing rules, not only those that are identified as being critical to children’s health and safety. Licensing staff should receive training and guidance on remaining diligent during all on-site inspections, and carefully observing and assessing all facets of the physical facility and program including interaction between staff and children. Licensing policy and procedures should also guide staff on what factors will trigger a full compliance review at any inspection using an abbreviated tool. Lastly, research is needed to compare the various forms of abbreviated compliance systems for their effectiveness in measuring compliance levels and fostering improved compliance and quality.

References


Caring for Our Children Basics
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Introduction

Evidence continues to mount that demonstrates the profound influence children's earliest experiences have on later success. Nurturing and stimulating care given in the early years builds optimal brain architecture that allows children to maximize their potential for learning. Interventions in the first years of life are capable of altering the course of development and shift the odds for those at risk of poor outcomes toward more adaptive ones.

To meet the needs of our nation’s most vulnerable children and families, the early care and education programs administered by the Administration for Children and Families (ACF) are designed to both provide enriching early childhood experiences that promote the long-term success of children and assist low-income working parents with the cost of child care. In partnership with families, all early care and education programs should support children's needs and age-appropriate progress across domains of language and literacy development; cognition and general knowledge; approaches to learning; physical health and well-being and motor development, and social and emotional development that will improve readiness for kindergarten. Head Start, Early Head Start, pre-Kindergarten, and child care programs aim to support the ability of parents, teachers, child care providers and other community members to interact positively with children in stable and stimulating environments to help create a sturdy foundation for later school achievement, economic productivity, and responsible citizenship.

ACF strives to achieve the following goals in all early childhood programs:

- Build successful Early Learning and Development Systems across Early Head Start, Head Start, child care, and pre-Kindergarten.
- Promote high quality and accountable early learning and development programs for all children.
- Ensure an effective early childhood workforce.
- Improve the physical, developmental, mental health, and social well-being of children in early learning and development settings.
- Promote family engagement and support in a child’s development with the recognition that parents are their children’s primary teachers and advocates.
- Build on the strengths and address the needs of culturally and linguistically diverse children and families.
- Improve the health and safety of early learning and development settings

While high quality early care and education settings can have significant developmental benefits and other positive long term effects for children well into their adult years, poor quality settings can result in unsafe environments that disregard children's basic physical and emotional needs leading to neglect, toxic stress, injury, or even death. As a result, it is not surprising that health and safety has been identified in multiple parent surveys as one of the most important factors to consider when evaluating child care options (Shlay, 2010). Health and
safety practices provide the foundation on which states and communities build quality early care and education settings.

Licensing of center-based care and family child care homes is a process that establishes the minimum requirements necessary to protect the health and safety of children in care. State licensing requirements are regulatory requirements, including registration or certification requirements, established under State law necessary for a provider to legally operate and provide child care services.

From 2009 to 2011, more than half of states made changes to licensing regulations for center-based care and family child care homes. For example, states increased the pre-service training requirements for center directors, and increased the number of ongoing training hours for all center staff roles, as well as family child care providers. Specifically, 47 States require center staff and 37 States require family child care providers to complete first aid training. With respect to CPR, 46 States require training of center staff and 36 require it of family child care providers. More than half of States require center staff to complete training on child abuse and neglect (27 States) or the prevention of communicable diseases (25 States). The number of States requiring fingerprint checks of federal records and checks of sex offender registries has increased since 2007. All States that license centers and more than 85% that license family child care homes have requirements about the nutritional content of meals and snacks served to children. States have added requirements about fences for outdoor space, transportation, and emergency preparedness, and more States prohibit firearms in child care centers (Office of Child Care National Center on Child Care Quality Improvement and National Association for Regulatory Administration, 2013).

Great progress has been made in States to safeguard children in out of home care, yet more work must be done to ensure children can learn, play, and grow in settings that are safe and secure. States vary widely in the number and content of health and safety standards as well as the means by which they monitor compliance. Some early care and education programs may receive no monitoring while others receive multiple visits. Further, some programs who receive funding from multiple sources may receive repeated monitoring visits that evaluate programs against complicated, and sometimes conflicting, standards. While there are differences in health and safety requirements by funding stream (e.g. Head Start, Child Care Development Fund, Individuals with Disabilities Education Act, and Title I), early childhood program type (e.g. center-based, family child care homes) and length of time in care, there are basic standards that must be in place to protect children no matter what type of variation in program. Until now, there has been no federal guidance that supports States in creating basic, consistent health and safety standards across early care and education settings.

ACF is pleased to announce Caring for Our Children Basics: Health and Safety Foundations for Early Care and Education. Caring for our Children Basics represents the minimum health and safety standards experts believe should be in place where children are cared for outside of their homes. Caring for our Children Basics seeks to reduce the conflicts and redundancy found in program standards linked to multiple funding streams. Caring for our Children Basics should not
be construed to represent all standards that should be present to achieve the highest quality of care and early learning. For example, the caregiver training requirements outlined in these standards are designed only to prevent harm to children, not to ensure their optimal development and learning.

*Caring for our Children Basics* is the result of work from both federal and non-federal experts and is founded on *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition*, created by the American Academy of Pediatrics; American Public Health Association; and National Resource Center for Health and Safety in Child Care and Early Education with funding from the Maternal and Child Health Bureau. The Office of Child Care, Office of Head Start, Office of the Deputy Assistant Secretary for Early Childhood, and the Maternal and Child Health Bureau were instrumental in this effort. Although use of *Caring for our Children Basics* is not federally required, the set of standards was posted for public comment in the Federal Register to provide ACF with practical guidance to aid in refinement and application. The standards, regulations, and guidance with which *Caring for our Children Basics* was produced are located at the end of this document.

Quality care can be achieved with consistent, basic health and safety practices in place. Though voluntary, ACF hopes *Caring for Our Children Basics* will be a helpful resource for states and other entities as they work to improve health and safety standards in both licensing and quality rating improvement systems (QRIS). As more states build their QRIS, it is hoped that *Caring for Our Children Basics* will support continuous quality improvement in programs as they move to higher levels of quality and improve the overall health and well-being of all children in out-of-home settings. In addition, ACF anticipates *Caring for Our Children Basics* will support efficiency and effectiveness of monitoring systems for early care and education settings. A common framework will assist the Nation in working towards and achieving a more consistent foundation for quality upon which families can rely.
**Staffing**

**1.1.1.1-1.1.1.5 Ratios for Centers and Family Child Care Homes**

Appropriate ratios should be kept during all hours of program operation. Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their needs and the extent of their disabilities.

In center-based care, child-provider ratios should be determined by the age of the majority of children and the needs of children present.

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum Child: Provider Ratio</th>
</tr>
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<tbody>
<tr>
<td>≤ 12 months</td>
<td>4:1</td>
</tr>
<tr>
<td>13-23 months</td>
<td>4:1</td>
</tr>
<tr>
<td>24-35 months</td>
<td>4:1-6:1</td>
</tr>
<tr>
<td>3-year-olds</td>
<td>9:1</td>
</tr>
<tr>
<td>4- to 5-year-olds</td>
<td>10:1</td>
</tr>
</tbody>
</table>

In family child care homes, the provider’s own children under the age of 6, as well as any other children in the home temporarily requiring supervision, should be included in the child: provider ratio. In family child care settings where there are mixed age groups that include infants and toddlers, a maximum ratio of 6:1 should be maintained and no more than two of these children should be 24 months or younger. If all children in care are under 36 months, a maximum ratio of 4:1 should be maintained and no more than two of these children should be 18 months or younger. If all children in care are 3 years old, a maximum ratio of 7:1 should be preserved. If all children in care are 4 to 5 years of age, a maximum ratio of 8:1 should be maintained.

**1.2.0.2 Background Screening**

All caregivers/teachers and staff in early care and education settings (in addition to any individual age 18 and older, or a minor over age 12 if allowed under State law and if a registry/database includes minors, residing in a family child care home) should undergo a complete background screening upon employment and once at least every five years thereafter. Screening should be conducted as expeditiously as possible and should be completed within 45 days after hiring. Caregivers/teachers and staff should not have unsupervised access to children until screening has been completed. Consent to the background investigation should be required for employment consideration. The comprehensive background screening should include the following:

a) A search of the State criminal and sex offender registry or repository in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years;
b) A search of State-based child abuse and neglect registries and databases in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years; and
c) A Federal Bureau of Investigation fingerprint check using Next Generation Identification.

Directors/programs should review each employment application to assess the relevancy of any issue uncovered by the complete background screening, including any arrest, pending criminal charge, or conviction, and should use this information in employment decisions in accordance with state laws.

1.4.1.1/1.4.2.3 Pre-service Training/Orientation
Before or during the first three months of employment, training and orientation should detail health and safety issues for early care and education settings including, but not limited to, typical and atypical child development; pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); poison prevention; shaken baby syndrome and abusive head trauma; standard precautions; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs. Caregivers/teachers should complete training before administering medication to children. See Standard 3.6.3.3 for more information. All directors or program administrators and caregivers/teachers should document receipt of training.

Providers should not care for children unsupervised until they have completed training in pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); standard precautions for the prevention of communicable disease; poison prevention; and shaken baby syndrome/abusive head trauma.

1.4.3.1 First Aid and CPR Training for Staff
All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.

1.4.4.1/1.4.4.2 Continuing Education for Directors, Caregivers/Teachers in Centers, and Family Child Care Homes
Directors and caregivers/teachers should successfully complete intentional and sequential education/professional development in child development programming and child health, safety, and staff health based on individual competency and any special needs of the children in their care.

1.4.5.2 Child Abuse and Neglect Education
Caregivers/teachers should be educated on child abuse and neglect to establish child abuse and neglect prevention and recognition strategies for children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or
emotional abuse and neglect. Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state's child abuse reporting laws.

Program Activities for Healthy Development

2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening
Programs should have a process in place for age-appropriate developmental and behavioral screenings for all children at the beginning of a child's enrollment in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. Providers may choose to conduct screenings, themselves; partner with a local agency/health care provider/specialist who would conduct the screening; or work with parents in connecting them to resources to ensure that screening occurs. This process should consist of parental/guardian education, consent, and participation as well as connection to resources and support, including the primary health care provider, as needed. Results of screenings should be documented in child records.

2.1.2.1/2.1.3.1 Personal Caregiver/Teacher Relationships for Birth to Five-Year-Olds
Programs should implement relationship-based policies and program practices that promote consistency and continuity of care, especially for infants and toddlers. Early care and education programs should provide opportunities for each child to build emotionally secure relationships with a limited number of caregivers/teachers. Children with special health care needs may require additional specialists to promote health and safety and to support learning.

2.2.0.1 Methods of Supervision of Children
In center-based programs, caregivers/teachers should directly supervise children under age 6 by sight and sound at all times. In family child care settings, caregivers should directly supervise children by sight or sound. When children are sleeping, caregivers may supervise by sound with frequent visual checks.

Developmentally appropriate child-to-staff ratios should be met during all hours of operation, and safety precautions for specific areas and equipment should be followed. Children under the age of 6 should never be inside or outside by themselves.

2.2.0.4 Supervision near Water
Constant and active supervision should be maintained when any child is in or around water. During swimming and/or bathing where an infant or toddler is present, the ratio should always be one adult to one infant/toddler. During wading and/or water play activities, the supervising adult should be within an arm’s length providing “touch supervision.” Programs should ensure that all pools have drain covers that are used in compliance with the Virginia Graeme Baker Pool and Spa Safety Act.
2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services

Programs should have a comprehensive discipline policy that includes developmentally appropriate social-emotional and behavioral health promotion practices as well as discipline and intervention procedures that provide specific guidance on what caregivers/teachers and programs should do to prevent and respond to challenging behaviors. Programs should ensure all caregivers/teachers have access to pre- and in-service training on such practices and procedures. Practices and procedures should be clearly communicated to all staff, families, and community partners, and implemented consistently and without bias or discrimination. Preventive and discipline practices should be used as learning opportunities to guide children’s appropriate behavioral development.

Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline (including limiting services); these exclusionary measures should be used only in extraordinary circumstances where there are serious safety concerns\(^1\) that cannot otherwise be reduced or eliminated by the provision of reasonable modifications.

2.2.0.9 Prohibited Caregiver/Teacher Behaviors

The following behaviors should be prohibited in all early care and education settings:

a) The use of corporal punishment\(^1\) including, but not limited to:
   i. Hitting, spanking, shaking, slapping, twisting, pulling, squeezing, or biting;
   ii. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
   iii. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
   iv. Exposing a child to extremes of temperature.

b) Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;

c) Binding, tying to restrict movement, or taping the mouth;

d) Using or withholding food or beverages as a punishment;

e) Toilet learning/training methods that punish, demean, or humiliate a child;

f) Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;

g) Any abuse or maltreatment of a child;

h) Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child’s family;

i) Any form of public or private humiliation, including threats of physical punishment (1);

j) Physical activity/outdoor time taken away as punishment;

k) Placing a child in a crib for a time-out or for disciplinary reasons.

\(^1\) Determinations of safety concerns must be based on actual risks, best available objective evidence, and cannot be based on stereotypes or generalizations.
Health Promotion and Protection

3.1.3.1 Active Opportunities for Physical Activity
Programs should promote developmentally appropriate active play for all children, including infants and toddlers, every day. Children should have opportunities to engage in moderate to vigorous activities indoors and outdoors, weather permitting.

3.1.4.1 Safe Sleep Practices and SIDS Risk Reduction
All staff, parents/guardians, volunteers, and others who care for infants in the early care and education setting should follow safe sleep practices as recommended by the American Academy of Pediatrics (AAP). Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards. See Standard 5.4.5.2 for more information.

3.1.5.1 Routine Oral Hygiene Activities
Caregivers/teachers should promote good oral hygiene through learning activities including the habit of regular tooth brushing.

3.2.1.4 Diaper Changing Procedure
The following diaper changing procedure should be posted in the changing area and followed to protect the health and safety of children and staff:

- **Step 1:** Before bringing the child to the diaper changing area, perform hand hygiene and bring supplies to the diaper changing area.
- **Step 2:** Carry/bring the child to the changing table/surface, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change. Always keep a hand on the child.
- **Step 3:** Clean the child's diaper area.
- **Step 4:** Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.
- **Step 5:** Put on a clean diaper and dress the child.
- **Step 6:** Wash the child's hands and return the child to a supervised area.
- **Step 7:** Clean and disinfect the diaper-changing surface. Dispose of the disposable paper liner if used on the diaper changing surface in a plastic-lined, hands-free, covered can. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home.
- **Step 8:** Perform hand hygiene and record the diaper change, diaper contents, and/or any problems.

Caregivers/teachers should never leave a child unattended on a table or countertop. A safety strap or harness should not be used on the diaper changing table/surface.
3.2.2.1 Situations that Require Hand Hygiene

All staff, volunteers, and children should abide by the following procedures for hand washing, as defined by the U.S. Centers for Disease Control and Prevention (CDC):

a) Upon arrival for the day, after breaks, or when moving from one group to another.

b) Before and after:
   - Preparing food or beverages;
   - Eating, handling food, or feeding a child;
   - Brushing or helping a child brush teeth;
   - Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
   - Playing in water (including swimming) that is used by more than one person; and
   - Diapering.

c) After:
   - Using the toilet or helping a child use a toilet;
   - Handling bodily fluid (mucus, blood, vomit);
   - Handling animals or cleaning up animal waste;
   - Playing in sand, on wooden play sets, and outdoors; and
   - Cleaning or handling the garbage.

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, diapering, and toileting areas.

3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting

Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during use.

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

Early care and education programs should adopt the use of Standard Precautions, developed by the Centers for Disease Control and Prevention (CDC), to handle potential exposure to blood and other potentially infectious fluids. Caregivers and teachers are required to be educated regarding Standard Precautions before beginning to work in the program and annually thereafter. For center-based care, training should comply with requirements of the Occupational Safety and Health Administration (OSHA).

3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs

Directors, caregivers, volunteers, and staff should not be impaired due to the use of alcohol, illegal drugs or prescription medication during program hours. Tobacco, alcohol, and illegal drug use should be prohibited on the premises (both indoor and outdoor environments) and in any vehicles used by the program at all times. In family child care settings, tobacco and alcohol should be inaccessible to children.

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2 Family child care homes are exempt from posting procedures for hand washing but should follow all other aspects of this standard.
3.4.3.1 Emergency Procedures
Programs should have a procedure for responding to situations when an immediate emergency medical response is required. Emergency procedures should be posted and readily accessible. Child-to-provider ratios should be maintained, and additional adults may need to be called in to maintain the required ratio. Programs should develop contingency plans for emergencies or disaster situations when it may not be possible to follow standard emergency procedures. All providers and/or staff should be trained to manage an emergency until emergency medical care becomes available.

3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
Because caregivers/teachers are mandated reporters of child abuse and neglect, each program should have a written policy for reporting child abuse and neglect. The written policy should specify that in any instance where there is reasonable cause to believe that child abuse or neglect has occurred, the individual who suspects child abuse or neglect should report directly to the child abuse reporting hotline, child protective services, or the police, as required by state and local laws.

3.4.4.3 Preventing and Identifying Shaken Baby Syndrome and Abusive Head Trauma
All programs should have a policy and procedure to identify and prevent shaken baby syndrome and abusive head trauma. All caregivers/teachers who are in direct contact with children, including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome and abusive head trauma; recognition of potential signs and symptoms of shaken baby syndrome and abusive head trauma; strategies for coping with a crying, fussing, or distraught child; and the development and vulnerabilities of the brain in infancy and early childhood.

3.4.5.1 Sun Safety Including Sunscreen
Caregivers/teachers should ensure sun safety for themselves and children under their supervision by keeping infants younger than six months out of direct sunlight, limiting sun exposure when ultraviolet rays are strongest and applying sunscreen with written permission of parents/guardians. Manufacturer instructions should be followed.

3.4.6.1 Strangulation Hazards
Strings and cords long enough to encircle a child's neck, such as those on toys and window coverings, should not be accessible to children in early care and education programs.

3.5.0.1 Care Plan for Children with Special Health Care Needs
Children with special health care needs are defined as “...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (McPherson, 1998).

Any child who meets these criteria in an early care and education setting should have an up-to-date Routine and Emergent Care Plan, completed by their primary health care provider with input from parents/guardians, included in their on-site health record and readily accessible to
those caring for the child. Community resources should be used to ensure adequate information, training, and monitoring is available for early care and education staff. Caregivers should undergo training in pediatric first aid and CPR that includes responding to an emergency for any child with a special health care need.

### 3.6.1.1 Inclusion/Exclusion/Dismissal of Children

The program should notify parents/guardians when children develop new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion, and parents/guardians should remove children from the early care and education setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification to the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary health care provider visit before re-entering care.

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home. The caregiver/teacher should determine if the illness:

a) Prevents the child from participating comfortably in activities;

b) Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;

c) Poses a risk of spread of harmful diseases to others;

d) Causes a fever and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, and diarrhea). An unexplained temperature above 100 °F (37.8 °C) (armpit) in a child younger than 6 months should be medically evaluated. Any infant younger than 2 months of age with fever should get immediate medical attention.

If any of the above criteria are met, the child should be removed from direct contact with other children and monitored and supervised by a staff member known to the child until dismissed to the care of a parent/guardian, primary health care provider, or other person designated by the parent. The local or state health department will be able to provide specific guidelines for exclusion.

### 3.6.1.4 Infectious Disease Outbreak Control

During the course of an identified outbreak of any reportable illness at the program, a child or staff member should be excluded if the local health department official or primary health care provider suspects that the child or staff member is contributing to transmission of the illness, is not adequately immunized when there is an outbreak of a vaccine-preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary health care provider who made the initial determination decides that the risk of transmission is no longer present. Parents/guardians should be notified of any determination.

### 3.6.3.1/3.6.3.2 Medication Administration and Storage

The administration of medicines at the facility should be limited to:
a) Prescription or non-prescription medication (over-the-counter) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Prescription medication should be labeled with the child’s name; date the prescription was filled; name and contact information of the prescribing health professional; expiration date; medical need; instructions for administration, storage, and disposal; and name and strength of the medication.

b) Labeled medications (over-the-counter) brought to the early care and education facility by the parent/guardian in the original container. The label should include the child's name; dosage; relevant warnings as well as specific; and legible instructions for administration, storage; and disposal.

Programs should never administer a medication that is prescribed for one child to another child. Documentation that the medicine/agent is administered to the child as prescribed is required. Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal.

All medications, refrigerated or unrefrigerated, should have child-resistant caps; be stored away from food at the proper temperature, and be inaccessible to children.

3.6.3.3 Training of Caregivers/Teachers to Administer Medication
Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The course should be repeated according to state and/or local regulation and taught by a trained professional. Skill and competency should be monitored whenever an administration error occurs.

Nutrition and Food Service

4.2.0.3 Use of U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP) Guidelines
Programs should serve nutritious and sufficient foods that meet the requirements for meals of the child care component of the USDA CACFP as referenced in 7 CFR 226.20.

4.2.0.6 Availability of Drinking Water
Clean, sanitary drinking water should be readily accessible in indoor and outdoor areas, throughout the day. On hot days, infants receiving human milk in a bottle may be given additional human milk, and those receiving formula mixed with water may be given additional formula mixed with water. Infants should not be given water, especially in the first six months of life.

4.2.0.10 Care for Children with Food Allergies
Each child with a food allergy should have a written care plan that includes:
   a) Instructions regarding the food(s) to which the child is allergic and steps to be taken to avoid that food;
b) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of prompt administration of any medications. The plan should include specific symptoms that would indicate the need to administer one or more medications.

Based on the child's care plan and prior to caring for the child, caregivers/teachers should receive training for, demonstrate competence in, and implement measures for:

a) Preventing exposure to the specific food(s) to which the child is allergic;

b) Recognizing the symptoms of an allergic reaction;

c) Treating allergic reactions.

The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.

The program should notify the parents/guardians immediately of any suspected allergic reactions, as well as the ingestion of or contact with the problem food even if a reaction did not occur. The program should contact the emergency medical services system immediately whenever epinephrine has been administered.

Each child's food allergies should be posted prominently in the classroom and/or wherever food is served with permission of the parent/guardian.

4.3.1.3 Preparing, Feeding, and Storing Human Milk
Programs should develop and follow procedures for the preparation and storage of expressed human milk that ensures the health and safety of all infants, as outlined by the Academy of Breastfeeding Medicine Protocol #8; Revision 2010, and prohibits the use of infant formula for a breastfed infant without parental consent. The bottle or container should be properly labeled with the infant's full name and date; and should only be given to the specified child. Unused breast milk should be returned to parent in the bottle or container.

4.3.1.5 Preparing, Feeding, and Storing Infant Formula
Programs should develop and follow procedures for the preparation and storage of infant formula that ensures the health and safety of all infants. Formula provided by parents/guardians or programs should come in sealed containers. The caregiver/teacher should always follow the parent or manufacturer's instructions for mixing and storing of any formula preparation. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines. Bottles of prepared or ready-to-feed formula should be labeled with the child's full name, time, and date of preparation. Prepared formula should be discarded daily if not used.
4.3.1.9 Warming Bottles and Infant Foods
Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, or a parent requests they be warmed, bottles should be warmed under running, warm tap water; using a commercial bottle warmer, stove top warming methods, or slow-cooking device; or by placing them in container of warm water. Bottles should never be warmed in microwaves. Warming devices should not be accessible to children.

4.5.0.10 Foods that Are Choking Hazards
Caregivers/teachers should not offer foods that are associated with young children's choking incidents to children under 4 years of age. Food for infants should be cut into pieces ¼ inch or smaller, food for toddlers should be cut into pieces ½ inch or smaller to prevent choking. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately.

4.8.0.1 Food Preparation Area Access
Access to areas where hot food is prepared should only be permitted when children are supervised by adults who are qualified to follow sanitation and safety procedures.

4.9.0.1 Compliance with U.S. Food and Drug Administration (FDA) Food Code and State and Local Rules
The program should conform to applicable portions of the FDA Food Code and all applicable state and local food service rules and regulations for centers and family child care homes regarding safe food protection and sanitation practices.

Facilities, Supplies, Equipment, and Environmental Health

5.1.1.2 Inspection of Buildings
Existing and/or newly constructed, renovated, remodeled, or altered buildings should be inspected by a building inspector to ensure compliance with applicable state and local building and fire codes before the building can be used for the purpose of early care and education.

5.1.1.3 Compliance with Fire Prevention Code
Programs should comply with a state-approved or nationally recognized fire prevention code, such as the National Fire Protection Association (NFPA) 101: Life Safety Code.

5.1.1.5 Environmental Audit of Site Location
An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster to properly evaluate and, where necessary, remediate or avoid sites where children's health could be compromised. A written report that includes any remedial action taken should be kept on file. The audit should include assessments of:
   a) Potential air, soil, and water contamination on program sites and outdoor play spaces;
b) Potential toxic or hazardous materials in building construction, such as lead and asbestos; and

c) Potential safety hazards in the community surrounding the site.

5.1.6.6 Guardrails and Protective Barriers
Guardrails or protective barriers, such as baby gates, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a 30 inch vertical distance to fall.

5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets
All accessible electrical outlets should be “tamper-resistant electrical outlets” that contain internal shutter mechanisms to prevent children from sticking objects into receptacles. In settings that do not have “tamper-resistant electrical outlets,” outlets should have “safety covers” that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. “Safety plugs” may also be used if they cannot be easily removed from outlets by children and do not pose a choking risk.

5.2.4.4 Location of Electrical Devices near Water
No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.

5.2.8.1 Integrated Pest Management
Programs should adopt an integrated pest management program to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations.

5.2.9.1 Use and Storage of Toxic Substances
All toxic substances should be inaccessible to children and should not be used when children are present. Toxic substances should be used as recommended by the manufacturer and stored in the original labeled containers. The telephone number for the poison control center should be posted and readily accessible in emergency situations.

5.2.9.5 Carbon Monoxide Detectors
Programs should meet state or local laws regarding carbon monoxide detectors, including circumstances when detectors are necessary. Detectors should be tested monthly, and testing should be documented. Batteries should be changed at least yearly. Detectors should be replaced according to the manufacturer’s instructions.

5.3.1.1/5.5.0.6/5.5.0.7 Safety of Equipment, Materials, and Furnishings
Equipment, materials, furnishings, and play areas should be sturdy, safe, in good repair, and meet the recommendations of the CPSC. Programs should attend to, including, but not limited to, the following safety hazards:

  a) Openings that could entrap a child’s head or limbs;
b) Elevated surfaces that are inadequately guarded;

c) Lack of specified surfacing and fall zones under and around climbable equipment;

d) Mismatched size and design of equipment for the intended users;

e) Insufficient spacing between equipment;

f) Tripping hazards;

g) Components that can pinch, shear, or crush body tissues;

h) Equipment that is known to be of a hazardous type;

i) Sharp points or corners;

j) Splinters;

k) Protruding nails, bolts, or other parts that could entangle clothing or snag skin;

l) Loose, rusty parts;

m) Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;

n) Strangulation hazards (e.g., straps, strings, etc.);

o) Flaking paint;

p) Paint that contains lead or other hazardous materials; and

q) Tip-over hazards, such as chests, bookshelves, and televisions.

Plastic bags that are large enough to pose a suffocation risk as well as matches, candles, and lighters should not be accessible to children.

5.3.1.12 Availability and Use of a Telephone or Wireless Communication Device

The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use on the premises of the child care program, in each vehicle used when transporting children, and on field trips. While transporting children, drivers should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or traffic.

5.4.5.2 Cribs and Play Yards


Programs should only use cribs for sleep purposes and ensure that each crib is a safe sleep environment as defined by the American Academy of Pediatrics. Each crib should be labeled and used for the infant's exclusive use. Cribs and mattresses should be thoroughly cleaned and sanitized before assignment for use by another child. Infants should not be placed in the cribs with items that could pose a strangulation or suffocation risk. Cribs should be placed away from window blinds or draperies.
5.5.0.8 Firearms
Center-based programs should not have firearms or any other weapon on the premises at any time. If present in a family child care home, parents should be notified and these items should be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.

5.6.0.1: First Aid and Emergency Supplies
The facility should maintain up-to-date first aid and emergency supplies in each location in which children are cared. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from the program. First aid kits or supplies should be restocked after each use.

Play Areas/Playgrounds and Transportation

6.1.0.6/6.1.0.8/6.3.1.1 Location of Play Areas near Bodies of Water/ Enclosures for Outdoor Play Areas/Enclosure of Bodies of Water
The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the supervision of children by caregivers/teachers. If a fence is used, it should be in good condition and conform to applicable local building codes in height and construction. These areas should have at least two exits, with at least one being remote from the buildings.

Gates should be equipped with self-closing and positive self-latching closure mechanisms that are high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than 3 ½ inches. The fence and gates should be constructed to discourage climbing. Outside play areas should be free from unsecured bodies of water. If present, all water hazards should be inaccessible to unsupervised children and enclosed with a fence that is 4 to 6 feet high or higher and comes within 3 ½ inches of the ground.

6.2.3.1 Prohibited Surfaces for Placing Climbing Equipment
Equipment used for climbing should not be placed over, or immediately next to, hard surfaces not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over a shock-absorbing material that is either the unitary or the loose-fill type extending beyond the perimeter of the stationary equipment. Organic materials that support colonization of molds and bacteria should not be used. This standard applies whether the equipment is installed outdoors or indoors. Programs should follow CPSC guidelines and ASTM International Standards F1292-13 and F2223-10.
6.2.5.1 Inspection of Indoor and Outdoor Play Areas and Equipment
The indoor and outdoor play areas and equipment should be inspected daily for basic health and safety, including, but not limited to:

a) Missing or broken parts;
b) Protrusion of nuts and bolts;
c) Rust and chipping or peeling paint;
d) Sharp edges, splinters, and rough surfaces;
e) Stability of handholds;
f) Visible cracks;
g) Stability of non-anchored large play equipment (e.g., playhouses);
h) Wear and deterioration
i) Vandalism or trash

Any problems should be corrected before the playground is used by children.

6.3.2.1 Lifesaving Equipment
Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. This equipment should be long enough to reach the center of the pool from the edge of the pool, kept in good repair, and stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment. Children should be familiarized with the use of the equipment based on their developmental level.

6.3.5.2 Water in Containers
Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

6.5.1.2 Qualifications for Drivers
In addition to meeting the general staff background check standards, any driver or transportation staff member who transports children for any purpose should have:

a) A valid driver’s license that authorizes the driver to operate the type of vehicle being driven;
b) A safe driving record for more than 5 years, with no crashes where a citation was issued, as evidenced by the state Department of Motor Vehicles records;
c) No use of alcohol, drugs, or any substance that could impair abilities before or while driving;
d) No tobacco use while driving;
e) No medical condition that would compromise driving, supervision, or evacuation capability;
f) Valid pediatric CPR and first aid certificate if transporting children alone.

The driver’s license number and date of expiration, vehicle insurance information, and verification of current state vehicle inspection should be on file in the facility.
6.5.2.2 Child Passenger Safety
When children are driven in a motor vehicle other than a bus, all children should be transported only if they are restrained in a developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child's weight and age in accordance with state and federal laws and regulations. The child should be securely fastened, according to the manufacturer's instructions. The child passenger restraint system should meet the federal motor vehicle safety standards contained in 49 CFR 571.213 and carry notice of compliance. Child passenger restraint systems should be installed and used in accordance with the manufacturer's instructions and should be secured in back seats only.

Car safety seats should be replaced if they have been recalled, are past the manufacturer's “date of use” expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer's criteria for replacement of seats after a crash.

If the program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:
   a) The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures’ instructions in a forward-facing direction;
   b) The wheelchair occupant should be secured by a three-point tie restraint during transport;
   c) At all times, school buses should be ready to transport children who must ride in wheelchairs;
   d) Manufacturers’ specifications should be followed to assure that safety requirements are met.

6.5.2.4 Interior Temperature of Vehicles
The interior of vehicles used to transport children for field trips and out-of-program activities should be maintained at a temperature comfortable to children. All vehicles should be locked when not in use, head counts of children should be taken before and after transporting to prevent a child from being left in a vehicle, and children should never be left in a vehicle unattended.

6.5.3.1 Passenger Vans
Early care and education programs that provide transportation for any purpose to children, parents/guardians, staff, and others should not use 15-passenger vans when avoidable.

Infectious Disease

7.2.0.1 Immunization Documentation
Programs should require that all parents/guardians of enrolled children provide written documentation of receipt of immunizations appropriate for each child's age. Infants, children, and adolescents should be immunized as specified in the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years,” developed by the Advisory Committee on
Immunization Practices of the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians. Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions.

7.2.0.2 Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition, a statement from the child’s primary health care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents'/guardians' religious or philosophical beliefs, a legal exemption with notarization, waiver, or other state-specific required documentation signed by the parent/guardian should be on file. Parents/guardians of an enrolling or enrolled infant who has not been immunized due to the child’s age should be informed if/when there are children in care who have not had routine immunizations due to exemption.

The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. Children who are in foster care or experiencing homelessness as defined by the McKinney-Vento Act should receive services while parents/guardians are taking necessary actions to comply with immunization requirements of the program. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible.

If a vaccine-preventable disease to which children are susceptible occurs and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

7.2.0.3 Immunization of Caregivers/Teachers

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the “Recommended Adult Immunization Schedule” in the following categories:

a) Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection); and

b) Recommended if a specific risk factor is present.

If a staff member is not appropriately immunized for medical, religious, or philosophical reasons, the program should require written documentation of the reason. If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department
should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

**Policies**

**9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents**
The program should have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. Caregiver/teacher and staff training procedures should also be included. The management, documentation, and reporting of the following types of incidents should be addressed:
   a) Lost or missing child;
   b) Suspected maltreatment of a child (also see state's mandates for reporting);
   c) Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the program;
   d) Injuries to children requiring medical or dental care;
   e) Illness or injuries requiring hospitalization or emergency treatment;
   f) Mental health emergencies;
   g) Health and safety emergencies involving parents/guardians and visitors to the program;
   h) Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the early care and education program, even if the death occurred outside of early care and education hours;
   i) The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

**9.2.4.3/9.2.4.5 Disaster Planning, Training and Communication/Emergency and Evacuation Drills**
Early care and education programs should consider how to prepare for and respond to emergency situations or natural disasters that may require evacuation, lock-down, or shelter-in-place and have written plans, accordingly. Written plans should be posted in each classroom and areas used by children. The following topics should be addressed, including but not limited to regularly scheduled practice drills, procedures for notifying and updating parents, and the use of the daily class roster(s) to check attendance of children and staff during an emergency or drill when gathered in a safe space after exit and upon return to the program. All drills/exercises should be recorded.

**9.2.4.7 Sign-In/Sign-Out System**³
Programs should have a sign-in/sign-out system to track those who enter and exit the facility. The system should include name, contact number, relationship to facility (e.g., parent/guardian, vendor, guest, etc.), and recorded time in and out.

³ Family Child Care is exempt.
9.2.4.8 Authorized Persons to Pick Up Child
Children may only be released to adults authorized by parents or legal guardians whose identity has been verified by photo identification. Names, addresses, and telephone numbers of persons authorized to pick up child should be obtained during the enrollment process and regularly reviewed, along with clarification/documentation of any custody issues/court orders. The legal guardian(s) of the child should be established and documented at this time.

9.4.1.12 Record of Valid License, Certificate, or Registration of Facility or Family Child Care Home
Every facility and/or child care home should hold a valid license, certificate, or documentation of registration prior to operation as required by the local and/or state statute.

9.4.2.1 Contents of Child Records
Programs should maintain a confidential file for each child in one central location on-site and should be immediately available to the child's caregivers/teachers (who should have parental/guardian consent for access to records), the child's parents/guardians, and the licensing authority upon request. The file for each child should include the following:
   a) Pre-admission enrollment information;
   b) Admission agreement signed by the parent/guardian at enrollment;
   c) Initial and updated health care assessments, completed and signed by the child's primary care provider, based on the child's most recent well care visit;
   d) Health history completed by the parent/guardian at admission;
   e) Medication record;
   f) Authorization form for emergency medical care;
   g) Results of developmental and behavioral screenings;
   h) Record of persons authorized to pick up child;
   i) Written informed consent forms signed by the parent/guardian allowing the facility to share the child's health records with other service providers.

10.4.2.1 Frequency of Inspections for Child Care Centers and Family Child Care Homes
Licensing inspectors or monitoring staff should make on-site inspections to measure program compliance with health, safety, and fire standards prior to issuing an initial license and no less than one, unannounced inspection each year thereafter to ensure compliance with regulations. Additional inspections should take place if needed for the program to achieve satisfactory compliance or if the program is closed at any time. The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States should post results of licensing inspections, including complaints, on the internet for parent and public review. Parents/guardians should have easy access to licensing rules and made aware of how to report complaints to the licensing agency.

Sufficient numbers of licensing inspectors should be qualified to inspect early care and education programs and trained in related health and safety requirements among other requirements of the State licensure.
**Resources Consulted in Development**


# Caring for Our Children Basics Health and Safety Standards Alignment Tool for Child Care Centers and Family Child Care Homes

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Introduction

*Caring for Our Children Basics (CFOCB)* represents the **minimum** health and safety standards experts believe should be in place where children are cared for outside their own homes, whether in a home-based program or center-based facility. It does not, however, represent all standards that should be present to achieve the highest quality of care and early learning. For example, the caregiver training requirements outlined in these standards are designed only to prevent harm to children, not to ensure children’s optimal development and learning.

Although use of *Caring for Our Children Basics* is **voluntary**, the Administration for Children and Families (ACF) hopes *Caring for Our Children Basics* will be a helpful resource for States and other entities as they work to improve health and safety standards in both licensing and quality rating improvement systems (QRIS). This tool provides a simple format for States and Territories to compare their current early childhood program requirements and standards against the recommended health and safety standards in CFOCB. It may also be used as a reference by the following:

- Professional development program staff when reviewing training content
- Licensing staff and policy developers when drafting new standards or best practice guidelines and training new staff
- Quality rating and improvement system staff when developing and evaluating quality standards
- Training and technical assistance professionals in their work with child care providers
- Advocates and advisory councils as a blueprint for long-term planning

Instructions

1. Compare state licensing or QRIS standards to *Caring for Our Children Basics (CFOCB)*. State licensing or QRIS standards can be copied into the standard section. The notes section can be used to document gaps in state standards or ways state standards exceed CFOCB standards.
2. Indicate whether the state standards reflect full, partial, or no alignment with each CFOCB standard.

**Full alignment** means the two standards **align with one another on every element, but may not match word for word**. For example, CFOCB 1.4.3.1, First Aid and CPR Training for Staff, reads as follows: “All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.”

---

1 Caring for Our Children Basics (CFOCB) is the result of work from both Federal and non-Federal experts. The Office of Child Care, Office of Head Start, Office of the Deputy Assistant Secretary for Early Childhood, and the Maternal and Child Health Bureau were instrumental in this effort. CFOCB is available at [http://www.acf.hhs.gov/programs/ecd/caring-for-our-children-basics](http://www.acf.hhs.gov/programs/ecd/caring-for-our-children-basics).

CFOCB is based on Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition (CFOC3), developed by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education, with funding from the Maternal and Child Health Bureau. CFOC3 is a collection of 686 national standards that represent the best evidence, expertise, and experience in the country on quality health and safety practices and policies that should be followed in today’s early care and education settings. CFOC3 is often used by state regulatory agencies when they are revising and updating state child care regulations. CFOC3 is available at [http://cfoc.nrckids.org/](http://cfoc.nrckids.org/).
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<td>The state standard reads, “All caregivers with direct care responsibilities must have current certification in pediatric CPR and documentation of current training in pediatric first aid. Training records must be on file at the operation and available for review upon request.”</td>
<td>The following elements are found in both standards: applies to all persons who provide direct care, requires pediatric first aid and pediatric CPR, training must be current, and documentation must be at the facility.</td>
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**Partial alignment** means the state standard aligns with CFOCB on most but not all elements. The following example uses the same CFOCB standard, 1.4.3.1, First Aid and CPR Training for Staff. “All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.”

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<td>The state standard reads, “All direct caregivers must complete pediatric first aid training. At least one person per center, group or classroom must have training in pediatric CPR. Training records must be on file at the facility.”</td>
<td>The state standard does not require that all caregivers be certified in pediatric CPR.</td>
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**No alignment** indicates that the state standard significantly varies from CFOCB; that is, fewer than half of the elements align with one another, no elements align with one another, or there is no state standard that aligns with CFOCB. The following example uses the same CFOCB standard, 1.4.3.1, First Aid and CPR Training for Staff. “All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.”

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<td>The state standard does not require pediatric first aid or pediatric CPR. Only one person per classroom is required to have CPR training, not all direct caregivers. Training records are not addressed in the standard.</td>
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3. In addition to capturing alignment similarities and differences, the notes section can be used to capture information for implementation plans, stakeholder comments, ideas for future rule and standard development, or where the current state standard exceeds CFOCB recommendations. It can also be noted if the CFOCB standard is addressed in other ways such as policies or guidance.

4. Because this tool is lengthy, users can start by completing the sections of greatest interest by clicking on the topic title in the Table of Contents.
CFOCB Health and Safety Standards Alignment Tool

Staffing

1.1.1.1–1.1.1.5 Ratios for Centers and Family Child Care Homes

Appropriate ratios should be kept during all hours of program operation. Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their needs and the extent of their disabilities.

In center-based care, child-provider ratios should be determined by the age of the majority of children and the needs of children present.

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<td>4- to 5-year-olds</td>
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In family child care homes, the provider’s own children under the age of 6, as well as any other children in the home temporarily requiring supervision, should be included in the child: provider ratio. In family child care settings where there are mixed age groups that include infants and toddlers, a maximum ratio of 6:1 should be maintained and no more than two of these children should be 24 months or younger. If all children in care are under 36 months, a maximum ratio of 4:1 should be maintained and no more than two of these children should be 18 months or younger. If all children in care are 3 years old, a maximum ratio of 7:1 should be preserved. If all children in care are 4 to 5 years of age, a maximum ratio of 8:1 should be maintained.

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1.2.0.2 Background Screening

All caregivers/teachers and staff in early care and education settings (in addition to any individual age 18 and older, or a minor over age 12 if allowed under State law and if a registry/database includes minors, residing in a family child care home) should undergo a complete background screening upon employment and once at least every five years thereafter. Screening should be conducted as expeditiously as possible and should be completed within 45 days after hiring. Caregivers/teachers and staff should not have unsupervised access to children until screening has been completed. Consent to the background investigation should be required for employment consideration.

The comprehensive background screening should include the following:

- a. A search of the State criminal and sex offender registry or repository in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years;
- b. A search of State-based child abuse and neglect registries and databases in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years; and

Directors/programs should review each employment application to assess the relevancy of any issue uncovered by the complete background screening, including any arrest, pending criminal charge, or conviction, and should use this information in employment decisions in accordance with state laws.

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1.4.1.1/1.4.2.3 Pre-service Training/Orientation

Before or during the first three months of employment, training and orientation should detail health and safety issues for early care and education settings including, but not limited to, typical and atypical child development; pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); poison prevention; shaken baby syndrome and abusive head trauma; standard precautions; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs. Caregivers/teachers should complete training before administering medication to children. See Standard 3.6.3.3 for more information. All directors or program administrators and caregivers/teachers should document receipt of training.

Providers should not care for children unsupervised until they have completed training in pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); standard precautions for the prevention of communicable disease; poison prevention; and shaken baby syndrome/abusive head trauma.
1.4.3.1 First Aid and CPR Training for Staff

All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.

1.4.4.1/1.4.4.2 Continuing Education for Directors, Caregivers/Teachers in Centers, and Family Child Care Homes

Directors and caregivers/teachers should successfully complete intentional and sequential education/professional development in child development programming and child health, safety, and staff health based on individual competency and any special needs of the children in their care.
1.4.5.2 Child Abuse and Neglect Education

Caregivers/teachers should be educated on child abuse and neglect to establish child abuse and neglect prevention and recognition strategies for children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state’s child abuse reporting laws.

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Program Activities for Healthy Development

2.1.1.4 Monitoring Children’s Development/Obtaining Consent for Screening

Programs should have a process in place for age-appropriate developmental and behavioral screenings for all children at the beginning of a child’s enrollment in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. Providers may choose to conduct screenings, themselves; partner with a local agency/health care provider/specialist who would conduct the screening; or work with parents in connecting them to resources to ensure that screening occurs. This process should consist of parental/guardian education, consent, and participation as well as connection to resources and support, including the primary health care provider, as needed. Results of screenings should be documented in child records.

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2.1.2.1/2.1.3.1 Personal Caregiver/Teacher Relationships for Birth to Five-Year-Olds

Programs should implement relationship-based policies and program practices that promote consistency and continuity of care, especially for infants and toddlers. Early care and education programs should provide opportunities for each child to build emotionally secure relationships with a limited number of caregivers/teachers. Children with special health care needs may require additional specialists to promote health and safety and to support learning.

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2.2.0.1 Methods of Supervision of Children

In center-based programs, caregivers/teachers should directly supervise children under age 6 by sight and sound at all times. In family child care settings, caregivers should directly supervise children by sight or sound. When children are sleeping, caregivers may supervise by sound with frequent visual checks.

Developmentally appropriate child-to-staff ratios should be met during all hours of operation, and safety precautions for specific areas and equipment should be followed. Children under the age of 6 should never be inside or outside by themselves.
2.2.0.4 Supervision Near Water

Constant and active supervision should be maintained when any child is in or around water. During swimming and/or bathing where an infant or toddler is present, the ratio should always be one adult to one infant/toddler. During wading and/or water play activities, the supervising adult should be within an arm’s length providing “touch supervision.” Programs should ensure that all pools have drain covers that are used in compliance with the Virginia Graeme Baker Pool and Spa Safety Act.\(^2\)

2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services

Programs should have a comprehensive discipline policy that includes developmentally appropriate social-emotional and behavioral health promotion practices as well as discipline and intervention procedures that provide specific guidance on what caregivers/teachers and programs should do to prevent and respond to challenging behaviors. Programs should ensure all caregivers/teachers have access to pre- and in-service training on such practices and procedures. Practices and procedures should be clearly communicated to all staff, families, and community partners, and implemented consistently and without bias or discrimination. Preventive and discipline practices should be used as learning opportunities to guide children’s appropriate behavioral development.

Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline (including limiting services); these exclusionary measures should be used only in extraordinary circumstances where there are serious safety concerns that cannot otherwise be reduced or eliminated by the provision of reasonable modifications.

---

2.2.0.9 Prohibited Caregiver/Teacher Behaviors

The following behaviors should be prohibited in all early care and education settings:

a. The use of corporal punishment, including, but not limited to:
   i. Hitting, spanking, shaking, slapping, twisting, pulling, squeezing, or biting;
   ii. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
   iii. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
   iv. Exposing a child to extremes of temperature.

d. Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;

e. Binding, tying to restrict movement, or taping the mouth;

f. Using or withholding food or beverages as a punishment;

g. Toilet learning/training methods that punish, demean, or humiliate a child;

h. Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;
   i. Any abuse or maltreatment of a child;
   j. Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child’s family;

k. Any form of public or private humiliation, including threats of physical punishment;

l. Physical activity/outdoor time taken away as punishment;

m. Placing a child in a crib for a time-out or for disciplinary reasons.
### Health Promotion and Protection

#### 3.1.3.1 Active Opportunities for Physical Activity

Programs should promote developmentally appropriate active play for all children, including infants and toddlers, every day. Children should have opportunities to engage in moderate to vigorous activities indoors and outdoors, weather permitting.

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#### 3.1.4.1 Safe Sleep Practices and SIDS Risk Reduction

All staff, parents/guardians, volunteers, and others who care for infants in the early care and education setting should follow safe sleep practices as recommended by the American Academy of Pediatrics (AAP). Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards. See Standard 5.4.5.2 for more information.

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3.1.5.1 Routine Oral Hygiene Activities

Caregivers/teachers should promote good oral hygiene through learning activities including the habit of regular tooth brushing.

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3.2.1.4 Diaper Changing Procedure

The following diaper changing procedure should be posted in the changing area and followed to protect the health and safety of children and staff:

- Step 1: Before bringing the child to the diaper changing area, perform hand hygiene and bring supplies to the diaper changing area.
- Step 2: Carry/bring the child to the changing table/surface, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change. Always keep a hand on the child.
- Step 3: Clean the child’s diaper area.
- Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.
- Step 5: Put on a clean diaper and dress the child.
- Step 6: Wash the child’s hands and return the child to a supervised area.
- Step 7: Clean and disinfect the diaper-changing surface. Dispose of the disposable paper liner if used on the diaper changing surface in a plastic-lined, hands-free, covered can. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home.
- Step 8: Perform hand hygiene and record the diaper change, diaper contents, and/or any problems.

Caregivers/teachers should never leave a child unattended on a table or countertop. A safety strap or harness should not be used on the diaper changing table/surface.

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3.2.2.1 Situations that Require Hand Hygiene

All staff, volunteers, and children should abide by the following procedures for hand washing, as defined by the U.S. Centers for Disease Control and Prevention (CDC):⁵

a. Upon arrival for the day, after breaks, or when moving from one group to another.

b. Before and after:
   - Preparing food or beverages;
   - Eating, handling food, or feeding a child;
   - Brushing or helping a child brush teeth;
   - Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
   - Playing in water (including swimming) that is used by more than one person; and
   - Diapering.

c. After:
   - Using the toilet or helping a child use a toilet;
   - Handling bodily fluid (mucus, blood, vomit);
   - Handling animals or cleaning up animal waste;
   - Playing in sand, on wooden play sets, and outdoors; and
   - Cleaning or handling the garbage.

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, diapering, and toileting areas.

[Note: Family child care homes are exempt from posting procedures for hand washing but should follow all other aspects of this standard.]

---

3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting

Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during use.

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3.2.3.4 Prevention of Exposure to Blood and Body Fluids

Early care and education programs should adopt the use of Standard Precautions, developed by the Centers for Disease Control and Prevention (CDC),\(^6\) to handle potential exposure to blood and other potentially infectious fluids. Caregivers and teachers are required to be educated regarding Standard Precautions before beginning to work in the program and annually thereafter. For center-based care, training should comply with requirements of the Occupational Safety and Health Administration (OSHA).

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3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs

Directors, caregivers, volunteers, and staff should not be impaired due to the use of alcohol, illegal drugs or prescription medication during program hours. Tobacco, alcohol, and illegal drug use should be prohibited on the premises (both indoor and outdoor environments) and in any vehicles used by the program at all times. In family child care settings, tobacco and alcohol should be inaccessible to children.

---

\(^6\) Standard precautions include the use of hand washing and appropriate personal protective equipment such as gloves, gowns, and masks whenever touching or exposure to patients’ body fluids is anticipated.


### 3.4.3.1 Emergency Procedures

Programs should have a procedure for responding to situations when an immediate emergency medical response is required. Emergency procedures should be posted and readily accessible. Child-to-provider ratios should be maintained, and additional adults may need to be called in to maintain the required ratio. Programs should develop contingency plans for emergencies or disaster situations when it may not be possible to follow standard emergency procedures. All providers and/or staff should be trained to manage an emergency until emergency medical care becomes available.

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### 3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation

Because caregivers/teachers are mandated reporters of child abuse and neglect, each program should have a written policy for reporting child abuse and neglect. The written policy should specify that in any instance where there is reasonable cause to believe that child abuse or neglect has occurred, the individual who suspects child abuse or neglect should report directly to the child abuse reporting hotline, child protective services, or the police, as required by state and local laws.

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3.4.4.3 Preventing and Identifying Shaken Baby Syndrome and Abusive Head Trauma

All programs should have a policy and procedure to identify and prevent shaken baby syndrome and abusive head trauma. All caregivers/teachers who are in direct contact with children, including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome and abusive head trauma; recognition of potential signs and symptoms of shaken baby syndrome and abusive head trauma; strategies for coping with a crying, fussing, or distraught child; and the development and vulnerabilities of the brain in infancy and early childhood.

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3.4.5.1 Sun Safety Including Sunscreen

Caregivers/teachers should ensure sun safety for themselves and children under their supervision by keeping infants younger than six months out of direct sunlight, limiting sun exposure when ultraviolet rays are strongest and applying sunscreen with written permission of parents/guardians. Manufacturer instructions should be followed.

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3.4.6.1 Strangulation Hazards

Strings and cords long enough to encircle a child’s neck, such as those on toys and window coverings, should not be accessible to children in early care and education programs.

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3.5.0.1 Care Plan for Children with Special Health Care Needs

Children with special health care needs are defined as “. . . those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (McPherson, 1998).

Any child who meets these criteria in an early care and education setting should have an up-to-date Routine and Emergent Care Plan, completed by their primary health care provider with input from parents/guardians, included in their on-site health record and readily accessible to those caring for the child. Community resources should be used to ensure adequate information, training, and monitoring is available for early care and education staff. Caregivers should undergo training in pediatric first aid and CPR that includes responding to an emergency for any child with a special health care need.

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3.6.1.1 Inclusion/Exclusion/Dismissal of Children

The program should notify parents/guardians when children develop new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion, and parents/guardians should remove children from the early care and education setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification to the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary health care provider visit before re-entering care.

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home. The caregiver/teacher should determine if the illness:

a. Prevents the child from participating comfortably in activities;

b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;

c. Poses a risk of spread of harmful diseases to others;

d. Causes a fever and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, and diarrhea). An unexplained temperature above 100 °F (37.8 °C) (armpit) in a child younger than 6 months should be medically evaluated. Any infant younger than 2 months of age with fever should get immediate medical attention.

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If any of the above criteria are met, the child should be removed from direct contact with other children and monitored and supervised by a staff member known to the child until dismissed to the care of a parent/guardian, primary health care provider, or other person designated by the parent. The local or state health department will be able to provide specific guidelines for exclusion.

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### 3.6.1.4 Infectious Disease Outbreak Control

During the course of an identified outbreak of any reportable illness at the program, a child or staff member should be excluded if the local health department official or primary health care provider suspects that the child or staff member is contributing to transmission of the illness, is not adequately immunized when there is an outbreak of a vaccine-preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary health care provider who made the initial determination decides that the risk of transmission is no longer present. Parents/guardians should be notified of any determination.

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### 3.6.3.1/3.6.3.2 Medication Administration and Storage

The administration of medicines at the facility should be limited to:

a. Prescription or non-prescription medication (over-the-counter) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Prescription medication should be labeled with the child’s name; date the prescription was filled; name and contact information of the prescribing health professional; expiration date; medical need; instructions for administration, storage, and disposal; and name and strength of the medication.

b. Labeled medications (over-the-counter) brought to the early care and education facility by the parent/guardian in the original container. The label should include the child’s name; dosage; relevant warnings as well as specific; and legible instructions for administration, storage; and disposal.

Programs should never administer a medication that is prescribed for one child to another child. Documentation that the medicine/agent is administered to the child as prescribed is required. Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal.
All medications, refrigerated or unrefrigerated, should have child-resistant caps; be stored away from food at the proper temperature, and be inaccessible to children.

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**3.6.3.3 Training of Caregivers/Teachers to Administer Medication**

Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The course should be repeated according to state and/or local regulation and taught by a trained professional. Skill and competency should be monitored whenever an administration error occurs.

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Nutrition and Food Service

4.2.0.3 Use of U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP) Guidelines

Programs should serve nutritious and sufficient foods that meet the requirements for meals of the child care component of the USDA CACFP as referenced in 7 CFR 226.20.8

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4.2.0.6 Availability of Drinking Water

Clean, sanitary drinking water should be readily accessible in indoor and outdoor areas, throughout the day. On hot days, infants receiving human milk in a bottle may be given additional human milk, and those receiving formula mixed with water may be given additional formula mixed with water. Infants should not be given water, especially in the first six months of life.

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4.2.0.10 Care for Children with Food Allergies

Each child with a food allergy should have a written care plan that includes:

a. Instructions regarding the food(s) to which the child is allergic and steps to be taken to avoid that food;

b. A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of prompt administration of any medications. The plan should include specific symptoms that would indicate the need to administer one or more medications.

Based on the child’s care plan and prior to caring for the child, caregivers/teachers should receive training for, demonstrate competence in, and implement measures for:

a. Preventing exposure to the specific food(s) to which the child is allergic;

b. Recognizing the symptoms of an allergic reaction;

c. Treating allergic reactions.

The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.

The program should notify the parents/guardians immediately of any suspected allergic reactions, as well as the ingestion of or contact with the problem food even if a reaction did not occur. The program should contact the emergency medical services system immediately whenever epinephrine has been administered.

Each child’s food allergies should be posted prominently in the classroom and/or wherever food is served with permission of the parent/guardian.

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4.3.1.3 Preparing, Feeding, and Storing Human Milk

Programs should develop and follow procedures for the preparation and storage of expressed human milk that ensures the health and safety of all infants, as outlined by the Academy of Breastfeeding Medicine Protocol #8; Revision 2010, and prohibits the use of infant formula for a breastfed infant without parental consent. The bottle or container should be properly labeled with the infant’s full name and date; and should only be given to the specified child. Unused breast milk should be returned to parent in the bottle or container.

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#### 4.3.1.5 Preparing, Feeding, and Storing Infant Formula

Programs should develop and follow procedures for the preparation and storage of infant formula that ensures the health and safety of all infants. Formula provided by parents/guardians or programs should come in sealed containers. The caregiver/teacher should always follow the parent or manufacturer's instructions for mixing and storing of any formula preparation. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines. Bottles of prepared or ready-to-feed formula should be labeled with the child’s full name, time, and date of preparation. Prepared formula should be discarded daily if not used.

#### Warming Bottles and Infant Foods

Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, or a parent requests they be warmed, bottles should be warmed under running, warm tap water; using a commercial bottle warmer, stove top warming methods, or slow-cooking device; or by placing them in container of warm water. Bottles should never be warmed in microwaves. Warming devices should not be accessible to children.

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4.5.0.10 Foods that Are Choking Hazards

Caregivers/teachers should not offer foods that are associated with young children’s choking incidents to children under 4 years of age. Food for infants should be cut into pieces $\frac{1}{4}$ inch or smaller, food for toddlers should be cut into pieces $\frac{1}{2}$ inch or smaller to prevent choking. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately.

4.8.0.1 Food Preparation Area Access

Access to areas where hot food is prepared should only be permitted when children are supervised by adults who are qualified to follow sanitation and safety procedures.
4.9.0.1 Compliance with U.S. Food and Drug Administration (FDA) Food Code and State and Local Rules

The program should conform to applicable portions of the FDA Food Code\textsuperscript{11} and all applicable state and local food service rules and regulations for centers and family child care homes regarding safe food protection and sanitation practices.

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Facilities, Supplies, Equipment, and Environmental Health

5.1.1.2 Inspection of Buildings

Existing and/or newly constructed, renovated, remodeled, or altered buildings should be inspected by a building inspector to ensure compliance with applicable state and local building and fire codes before the building can be used for the purpose of early care and education.

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5.1.1.3 Compliance with Fire Prevention Code

Programs should comply with a state-approved or nationally recognized fire prevention code, such as the National Fire Protection Association (NFPA) 101: Life Safety Code.12

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5.1.1.5 Environmental Audit of Site Location

An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster to properly evaluate and, where necessary, remediate or avoid sites where children’s health could be compromised. A written report that includes any remedial action taken should be kept on file.

The audit should include assessments of:

a. Potential air, soil, and water contamination on program sites and outdoor play spaces;

b. Potential toxic or hazardous materials in building construction, such as lead and asbestos; and

c. Potential safety hazards in the community surrounding the site.

5.1.6.6 Guardrails and Protective Barriers

Guardrails or protective barriers, such as baby gates, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a 30 inch vertical distance to fall.

5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets

All accessible electrical outlets should be "tamper-resistant electrical outlets" that contain internal shutter mechanisms to prevent children from sticking objects into receptacles. In settings that do not have "tamper-resistant electrical outlets," outlets should have "safety covers" that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. "Safety plugs" may also be used if they cannot be easily removed from outlets by children and do not pose a choking risk.
5.2.4.4 Location of Electrical Devices near Water

No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.

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5.2.8.1 Integrated Pest Management

Programs should adopt an integrated pest management program to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations.

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5.2.9.1 Use and Storage of Toxic Substances

All toxic substances should be inaccessible to children and should not be used when children are present. Toxic substances should be used as recommended by the manufacturer and stored in the original labeled containers. The telephone number for the poison control center should be posted and readily accessible in emergency situations.

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5.2.9.5 Carbon Monoxide Detectors

Programs should meet state or local laws regarding carbon monoxide detectors, including circumstances when detectors are necessary. Detectors should be tested monthly, and testing should be documented. Batteries should be changed at least yearly. Detectors should be replaced according to the manufacturer’s instructions.

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5.3.1.1/5.5.0.6/5.5.0.7 Safety of Equipment, Materials, and Furnishings

Equipment, materials, furnishings, and play areas should be sturdy, safe, in good repair, and meet the recommendations of the CPSC. Programs should attend to, including, but not limited to, the following safety hazards:

- a. Openings that could entrap a child’s head or limbs;
- b. Elevated surfaces that are inadequately guarded;
- c. Lack of specified surfacing and fall zones under and around climbable equipment;
- d. Mismatched size and design of equipment for the intended users;
- e. Insufficient spacing between equipment;
- f. Tripping hazards;
- g. Components that can pinch, shear, or crush body tissues;
- h. Equipment that is known to be of a hazardous type;
- i. Sharp points or corners;
- j. Splinters;
- k. Protruding nails, bolts, or other parts that could entangle clothing or snag skin;
- l. Loose, rusty parts;
- m. Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;
- n. Strangulation hazards (e.g., straps, strings, etc.);
- o. Flaking paint;


p. Paint that contains lead or other hazardous materials; and
q. Tip-over hazards, such as chests, bookshelves, and televisions.

Plastic bags that are large enough to pose a suffocation risk as well as matches, candles, and lighters should not be accessible to children.

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### 5.3.1.12 Availability and Use of a Telephone or Wireless Communication Device

The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use on the premises of the child care program, in each vehicle used when transporting children, and on field trips. While transporting children, drivers should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or traffic.

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### 5.4.5.2 Cribs and Play Yards

Before purchase and use, cribs and play yards should be in compliance with current CPSC and ASTM International safety standards that include ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, ASTM F406-13, Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500—Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.\(^{14}\)

Programs should only use cribs for sleep purposes and ensure that each crib is a safe sleep environment as defined by the American Academy of Pediatrics.\(^ {15}\) Each crib should be labeled and used for the infant’s exclusive use. Crib and mattresses should be thoroughly cleaned and sanitized before assignment for use by another child. Infants should not be placed in the cribs with items that could pose a strangulation or suffocation risk. Cribs should be placed away from window blinds or draperies.

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### 5.5.0.8 Firearms

Center-based programs should not have firearms or any other weapon on the premises at any time. If present in a family child care home, parents should be notified and these items should be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.

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### 5.6.0.1 First Aid and Emergency Supplies

The facility should maintain up-to-date first aid and emergency supplies in each location in which children are cared. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from the program. First aid kits or supplies should be restocked after each use.

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Play Areas/Playgrounds and Transportation

6.1.0.6/6.1.0.8/6.3.1.1 Location of Play Areas near Bodies of Water/Enclosures for Outdoor Play Areas/Enclosure of Bodies of Water

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the supervision of children by caregivers/teachers. If a fence is used, it should be in good condition and conform to applicable local building codes in height and construction. These areas should have at least two exits, with at least one being remote from the buildings.

Gates should be equipped with self-closing and positive self-latching closure mechanisms that are high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than 3 ½ inches. The fence and gates should be constructed to discourage climbing. Outside play areas should be free from unsecured bodies of water. If present, all water hazards should be inaccessible to unsupervised children and enclosed with a fence that is 4 to 6 feet high or higher and comes within 3 ½ inches of the ground.

6.2.3.1 Prohibited Surfaces for Placing Climbing Equipment

Equipment used for climbing should not be placed over, or immediately next to, hard surfaces not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over a shock-absorbing material that is either the unitary or the loose-fill type extending beyond the perimeter of the stationary equipment. Organic materials that support colonization of molds and bacteria should not be used. This standard applies whether the equipment is installed outdoors or indoors. Programs should follow CPSC guidelines and ASTM International Standards F1292-13 and F2223-10.16

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6.2.5.1 Inspection of Indoor and Outdoor Play Areas and Equipment

The indoor and outdoor play areas and equipment should be inspected daily for basic health and safety, including, but not limited to:

a. Missing or broken parts;
b. Protrusion of nuts and bolts;
c. Rust and chipping or peeling paint;
d. Sharp edges, splinters, and rough surfaces;
e. Stability of handholds;
f. Visible cracks;
g. Stability of non-anchored large play equipment (e.g., playhouses);
h. Wear and deterioration
i. Vandalism or trash

Any problems should be corrected before the playground is used by children.

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6.3.2.1 Lifesaving Equipment

Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd's hook that will not conduct electricity. This equipment should be long enough to reach the center of the pool from the edge of the pool, kept in good repair, and stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment. Children should be familiarized with the use of the equipment based on their developmental level.

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6.3.5.2 Water in Containers

Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

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6.5.1.2 Qualifications for Drivers

In addition to meeting the general staff background check standards, any driver or transportation staff member who transports children for any purpose should have:

a. A valid driver’s license that authorizes the driver to operate the type of vehicle being driven;
b. A safe driving record for more than 5 years, with no crashes where a citation was issued, as evidenced by the state Department of Motor Vehicles records;
c. No use of alcohol, drugs, or any substance that could impair abilities before or while driving;
d. No tobacco use while driving;
e. No medical condition that would compromise driving, supervision, or evacuation capability;
f. Valid pediatric CPR and first aid certificate if transporting children alone.

The driver’s license number and date of expiration, vehicle insurance information, and verification of current state vehicle inspection should be on file in the facility.

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6.5.2.2 Child Passenger Safety

When children are driven in a motor vehicle other than a bus, all children should be transported only if they are restrained in a developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child’s weight and age in accordance with state and federal laws and regulations. The child should be securely fastened, according to the manufacturer’s instructions. The child passenger restraint system should meet the
federal motor vehicle safety standards contained in 49 CFR 571.213\(^\text{17}\) and carry notice of compliance. Child passenger restraint systems should be installed and used in accordance with the manufacturer’s instructions and should be secured in back seats only.

Car safety seats should be replaced if they have been recalled, are past the manufacturer’s “date of use” expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer’s criteria for replacement of seats after a crash.

If the program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:

a. The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures’ instructions in a forward-facing direction;

b. The wheelchair occupant should be secured by a three-point tie restraint during transport;

c. At all times, school buses should be ready to transport children who must ride in wheelchairs;

d. Manufacturers’ specifications should be followed to assure that safety requirements are met.

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### 6.5.2.4 Interior Temperature of Vehicles

The interior of vehicles used to transport children for field trips and out-of-program activities should be maintained at a temperature comfortable to children. All vehicles should be locked when not in use, head counts of children should be taken before and after transporting to prevent a child from being left in a vehicle, and children should never be left in a vehicle unattended.

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6.5.3.1 Passenger Vans

Early care and education programs that provide transportation for any purpose to children, parents/guardians, staff, and others should not use 15-passenger vans when avoidable.

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Infectious Disease

7.2.0.1 Immunization Documentation

Programs should require that all parents/guardians of enrolled children provide written documentation of receipt of immunizations appropriate for each child’s age. Infants, children, and adolescents should be immunized as specified in the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years,” developed by the Advisory Committee on Immunization Practices of the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians. Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions.

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7.2.0.2 Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition, a statement from the child’s primary health care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents’/guardians’ religious or philosophical beliefs, a legal exemption with notarization, waiver, or other state-specific required documentation signed by the parent/guardian should be on file.

Parents/guardians of an enrolling or enrolled infant who has not been immunized due to the child’s age should be informed if/when there are children in care who have not had routine immunizations due to exemption. The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. Children who are in foster care or experiencing homelessness as defined by the McKinney-Vento Act should receive services while parents/guardians are taking necessary actions to comply with immunization requirements of the program. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible.

If a vaccine-preventable disease to which children are susceptible occurs and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

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### 7.2.0.3 Immunization of Caregivers/Teachers

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the "Recommended Adult Immunization Schedule" in the following categories:

- a. Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection); and
- b. Recommended if a specific risk factor is present.

If a staff member is not appropriately immunized for medical, religious, or philosophical reasons, the program should require written documentation of the reason. If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.
Policies

9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents

The program should have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. Caregiver/teacher and staff training procedures should also be included. The management, documentation, and reporting of the following types of incidents should be addressed:

a. Lost or missing child;

b. Suspected maltreatment of a child (also see state’s mandates for reporting);

c. Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the program;

d. Injuries to children requiring medical or dental care;

e. Illness or injuries requiring hospitalization or emergency treatment;

f. Mental health emergencies;

g. Health and safety emergencies involving parents/guardians and visitors to the program;

h. Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the early care and education program, even if the death occurred outside of early care and education hours;

i. The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

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9.2.4.3/9.2.4.5 Disaster Planning, Training and Communication/Emergency and Evacuation Drills

Early care and education programs should consider how to prepare for and respond to emergency situations or natural disasters that may require evacuation, lock-down, or shelter-in-place and have written plans, accordingly. Written plans should be posted in each classroom and areas used by children. The following topics should be addressed, including but not limited to regularly scheduled practice drills, procedures for notifying and updating parents, and the use of the daily class roster(s) to check attendance of children and staff during an emergency or drill when gathered in a safe space after exit and upon return to the program. All drills/exercises should be recorded.
### 9.2.4.7 Sign-In/Sign-Out System

Programs should have a sign-in/sign-out system to track those who enter and exit the facility. The system should include name, contact number, relationship to facility (e.g., parent/guardian, vendor, guest, etc.), and recorded time in and out. [Note: Family child care is exempt.]

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### 9.2.4.8 Authorized Persons to Pick Up Child

Children may only be released to adults authorized by parents or legal guardians whose identity has been verified by photo identification. Names, addresses, and telephone numbers of persons authorized to pick up child should be obtained during the enrollment process and regularly reviewed, along with clarification/documentation of any custody issues/court orders. The legal guardian(s) of the child should be established and documented at this time.

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### 9.4.1.12 Record of Valid License, Certificate, or Registration of Facility or Family Child Care Home

Every facility and/or child care home should hold a valid license, certificate, or documentation of registration prior to operation as required by the local and/or state statute.

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### 9.4.2.1 Contents of Child Records

Programs should maintain a confidential file for each child in one central location on-site and should be immediately available to the child’s caregivers/teachers (who should have parental/guardian consent for access to records), the child’s parents/guardians, and the licensing authority upon request. The file for each child should include the following:

- a. Pre-admission enrollment information;
- b. Admission agreement signed by the parent/guardian at enrollment;
- c. Initial and updated health care assessments, completed and signed by the child’s primary care provider, based on the child’s most recent well care visit;
- d. Health history completed by the parent/guardian at admission;
- e. Medication record;
- f. Authorization form for emergency medical care;
- g. Results of developmental and behavioral screenings;
- h. Record of persons authorized to pick up child;
- i. Written informed consent forms signed by the parent/guardian allowing the facility to share the child’s health records with other service providers.

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10.4.2.1 Frequency of Inspections for Child Care Centers and Family Child Care Homes

Licensing inspectors or monitoring staff should make on-site inspections to measure program compliance with health, safety, and fire standards prior to issuing an initial license and no less than one, unannounced inspection each year thereafter to ensure compliance with regulations. Additional inspections should take place if needed for the program to achieve satisfactory compliance or if the program is closed at any time. The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States should post results of licensing inspections, including complaints, on the internet for parent and public review. Parents/guardians should have easy access to licensing rules and made aware of how to report complaints to the licensing agency.

Sufficient numbers of licensing inspectors should be qualified to inspect early care and education programs and trained in related health and safety requirements among other requirements of the State licensure.

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FY 2016 Office of Head Start
HSKI-C
Monitoring Protocol
FY2016 HS Key Indicator-Compliance (HSKI-C) Protocol: Overview

Overview

The Office of Head Start (the OHS) presents the **FY 2016 Head Start Key Indicator-Compliance (HSKI-C)**. The HSKI-C is an evidence-based tool that identifies whether grantees qualify for differential monitoring. Grantees that qualify for and pass the HSKI-C will receive an Environmental Health & Safety (EnvHS) Review and a CLASS® Review over their 5-year grant period. Grantees that do not qualify for the HSKI-C or are not successful with the HSKI-C Review will receive comprehensive monitoring, which includes a Fiscal Integrity and ERSEA Review, Comprehensive Services and School Readiness Review, and Leadership, Governance, Management Systems Review.

The OHS will look at the following criteria to identify grantees that are eligible for the HSKI-C review: a compliant review with no additional findings since the last monitoring cycle; no fiscal findings in the last two monitoring cycles; not meeting any DRS criteria, including CLASS; and a history of clean annual audits. In addition, the Regional Office will provide input to determine the grantee’s eligibility for differential monitoring. The HSKI-C Protocol is an indicator tool designed only to determine whether a grantee needs to undergo the Comprehensive Monitoring process. As a result, the HSKI-C Protocol will not be used to identify findings. Findings would be identified through the Comprehensive Monitoring Process.

Following the HSKI-C Review event, the OHS will send a letter to the grantee indicating whether the HSKI-C Review was successful. In order to be considered successful, the grantee must be successful for all 27 Key Indicators in the HSKI-C Protocol. Grantees that are not successful in the HSKI-C Review event will move to the Comprehensive Monitoring process, while those that are successful will move to the Differential Monitoring process. Note that the HSKI-C letter will inform the grantee of the overall results of the HSKI-C review; however, it will not indicate the area or areas in which issues were identified. The HSKI-C tool is designed to identify the path for subsequent monitoring events for each grantee and is not intended to identify findings. Grantees can learn more about both the Comprehensive and Differential Monitoring processes by visiting the Aligned Monitoring System training modules and reviewing the materials posted in the Virtual Expo.

Organization of the Protocol

**Content Areas**

The HSKI-C Protocol is used to gather information to assess grantee performance across the following content areas:

- Fiscal Integrity
- Leadership and Governance
- Management Systems
- Comprehensive Services and School Readiness, which includes Child Health & Safety, Family & Community Engagement, and Child Development & Education
**Fiscal Integrity.** The Fiscal Integrity section of the HSKI-C Protocol focuses on assessing whether the program maintains effective financial management systems, timely and complete financial records, signed and approved time records, and necessary and reasonable non-Federal-share (NFS) contributions, as well as complete and accurate equipment records.

**Leadership and Governance.** For Leadership and Governance, the HSKI-C Protocol guides the Reviewer in assessing the composition of the Policy Council, training and technical assistance provided to the governing body and the Policy Council, the extent to which the governing body fulfills its responsibilities regarding program administration and operations, and the effectiveness of the program’s reporting to the governing body and the Policy Council.

**Management Systems.** The HSKI-C Protocol’s Management Systems section enables the OHS to assess the effectiveness of the program’s annual Self-Assessment, its practices and system for ongoing monitoring of program services and operations, and the program’s system for maintaining up-to-date and accurate records. The Management Systems section also guides the assessment of several aspects of the program’s Human Resources function, including its establishment of standards of conduct and process for ensuring all staff abide by the standards and the program’s completion of criminal record checks for its staff. A final focus of this section is on the publication and availability of the Annual Report to the Public.

**Comprehensive Services & School Readiness.** This section of the HSKI-C Protocol guides the review of the grantee’s delivery of comprehensive, individualized services to children, pregnant women, and families. Comprehensive Services & School Readiness includes:

- **Child Health & Safety:** An assessment of whether and how the grantee establishes each child’s health status and provides follow-up and referral as required.
- **Family & Community Engagement:** An assessment of how the grantee educates parents in order to promote positive parent-child relationships and makes Mental Health services available to support parents and staff. Also, this section assesses the grantee’s partnerships with Local Education Agencies (LEAs) and other Part C agencies that support services to children and their families.
- **Child Development & Education:** An assessment of the grantee’s system used to track and report on school readiness goals, the grantee’s use of an evidence-based curriculum, and the individualization of services to meet children’s specific needs.

**Key Indicators**
The HSKI-C Protocol is composed of a series of Key Indicators. (Key Indicators are the specific statements that ground the HSKI-C review.)

**Targeted Questions**
Targeted Questions (TQs) for each Key Indicator are designed to provide guidance to on-site Reviewers and ensure a standardize method for evidence collection. TQs indicate questions to ask within interviews, information to retrieve from documents, and observations to conduct. Reviewers are required to answer all TQs for each Key Indicator.
Guides

The HSKI-C Protocol contains organizing tools called Guides. In the OHS Monitoring System (OHSMS) software, the Guides align the TQs according to the method of collecting information while on site. The Guides pull together all the TQs related to a particular method and source of evidence collection (e.g., Policy Council Interview, Staff File Review). The responses to each TQ in a Guide are linked to the appropriate Key Indicator.

HSKI-C Reviewers use the following Guides:

- Interviews
- Staff file review
- Document review

In the OHSMS software, the Guides and HSKI-C Protocol are customized to reflect the type of program being reviewed (e.g., center-based, Family Child Care, home-based, and migrant) and the types of children or populations served by the program (e.g., infants and toddlers, preschool-age children, and pregnant women and new mothers).
Head Start Key Indicator-Compliant (HSKI-C) #1

Program Governance

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The program has established a Policy Council elected by parents of currently enrolled children whose membership is composed of a majority of parents of children currently enrolled in the program as well as members of the community served by the Head Start agency.</td>
<td>642(c)(2)(B)(i)</td>
</tr>
<tr>
<td></td>
<td>642(c)(2)(B)(ii)(I)</td>
</tr>
<tr>
<td></td>
<td>642(c)(2)(B)(ii)(II)</td>
</tr>
</tbody>
</table>

*Note: Applies to grantees only*

Targeted Questions

Policy Council—Interview

- Ask the Policy Council to describe the composition of its membership and share relevant documentation that confirms that the Policy Council has the appropriate composition, and members are elected.

Does the Policy Council membership meet the following requirements?

- At least 51 percent of the members are parents of children currently enrolled in the Head Start program (including delegate agencies).
- At least one member is from the at-large community served by the program or any delegate agency.
- Members are elected by parents of children currently enrolled in the program.

Ask the program to provide the documents needed and review them with you to confirm the Policy Council’s membership.
Program Governance

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</thead>
<tbody>
<tr>
<td>Members of the governing body and the Policy Council receive appropriate training and technical assistance to ensure that they understand the information they receive and can provide effective oversight of, make appropriate decisions for, and participate in programs of the Head Start agency.</td>
<td>642(d)(3)</td>
</tr>
</tbody>
</table>

Note: Applies to grantees only

Targeted Questions

Policy Council—Interview

► Ask the program to provide you with documentation of Policy Council training, (e.g., Policy Council meeting agendas and minutes), which you will review with staff while discussing this item.

Ask the Policy Council members to describe the training they received and provide examples of how the training has helped them make decisions about the Head Start program.

Governing Body—Interview

► Ask the program to provide you with documentation of governing body training, (e.g., governing body meeting agendas and minutes), which you will review with staff while discussing this item.

Ask the governing body members to describe the training received and provide examples of how the training has helped them make decisions about the Head Start program.
Program Governance

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</thead>
<tbody>
<tr>
<td>The governing body is responsible for required activities and makes decisions pertaining to program administration and operations, including selecting delegates and service areas; establishing procedures and criteria for recruitment, selection, and enrollment; reviewing all applications for funding; and establishing procedures for selecting Policy Council members.</td>
<td>642(c)(1)(E)(iv)(I)</td>
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<tr>
<td></td>
<td>642(c)(1)(E)(iv)(II)</td>
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<tr>
<td></td>
<td>642(c)(1)(E)(iv)(III)</td>
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<tr>
<td></td>
<td>642(c)(1)(E)(iv)(VI)</td>
</tr>
</tbody>
</table>

Targeted Questions

Governing Body—Interview

► Ask the governing body members to explain their role in program planning and to provide specific examples. Did the governing body play a role in:

- Establishing procedures and criteria for recruiting, selecting, and enrolling children?
- Selecting delegate agencies, as appropriate?
- Developing procedures for selecting Policy Council members?
- Reviewing applications for funding and amendments to applications for funding?
**Head Start Key Indicator-Compliant (HSKI-C) #4**

### Program Governance

<table>
<thead>
<tr>
<th><strong>Key Indicator</strong></th>
<th><strong>Federal Regulation</strong></th>
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</thead>
<tbody>
<tr>
<td>The Policy Council approves and submits decisions about identified program activities to the governing body.</td>
<td>642(c)(2)(A)</td>
</tr>
<tr>
<td></td>
<td>642(c)(2)(D)(i)</td>
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<td></td>
<td>642(c)(2)(D)(ii)</td>
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<td>642(c)(2)(D)(iii)</td>
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<td>642(c)(2)(D)(iv)</td>
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<td>642(c)(2)(D)(v)</td>
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<td>642(c)(2)(D)(vi)</td>
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<td></td>
<td>642(c)(2)(D)(vii)</td>
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<td></td>
<td>642(c)(2)(D)(viii)</td>
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</table>

*Note: Applies to grantees only*

### Targeted Questions

**Policy Council—Interview**

- Ask the Policy Council members to describe their involvement in and provide examples of decisions made in the areas listed below.

  Is the Policy Council actively involved in the following?
  - Activities to support the active involvement of parents in supporting program operations, including policies to ensure that the Head Start program is responsive to community and parent needs
  - Program recruitment, selection, and enrollment priorities
  - Applications for funding and amendments to applications for funding
  - Budget planning for program expenditures, including policies for reimbursement related to and participation in Policy Council activities
  - Developing by-laws for the operation of the Policy Council
  - Program personnel policies and decisions regarding the employment of program staff consistent with 642(c)(1)(E)(iv)(IX) and including standards of conduct for program staff, contractors, and volunteers and criteria for the employment and dismissal of program staff
  - Developing procedures for how members of the Policy Council of the Head Start program are elected
  - Providing recommendations on the selection of delegate agencies and the service areas for such agencies
  - Program design and operations
  - Planning goals and objectives
**Head Start Key Indicator-Compliant (HSKI-C) #5**

**Program Governance**

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</table>
| Governing body and Policy Council members regularly receive and use information or reports about program planning, policies, and operations, including:  
  • Monthly financial statements (including credit card expenditures), program information summaries, program enrollment reports (including attendance reports for children whose care is partially subsidized by another public agency), and reports of meals and snacks provided through U.S. Department of Agriculture (USDA) programs  
  • The annual financial audit, Self-Assessment (including findings related to such assessment), and Program Information Report (PIR)  
  • The community-wide strategic planning and needs assessment (Community Assessment) of the Head Start agency, including applicable updates  
  • Communication and guidance from the Secretary | 642(d)(2)(A)  
|                                                                             | 642(d)(2)(B)  
|                                                                             | 642(d)(2)(C)  
|                                                                             | 642(d)(2)(D)  
|                                                                             | 642(d)(2)(E)  
|                                                                             | 642(d)(2)(F)  
|                                                                             | 642(d)(2)(G)  
|                                                                             | 642(d)(2)(H)  
|                                                                             | 642(d)(2)(I)  |

*Note: Applies to grantees only. Single or multiple reports may be used to capture the information listed above.*

**Targeted Questions**

**Policy Council—Interview**

► Ask the Policy Council members how often they receive the reports listed below. Discuss whether the reports provided to the Policy Council contain the information needed to provide effective oversight.

Document whether the Policy Council receives the following reports as often as required:

- **Annual reports**
  - The financial audit
  - The Self-Assessment, including any related findings
  - The Program Information Report (PIR)

- **Monthly Reports**
  - Financial statements, including credit card expenditures (if the program uses credit cards)
  - Program information summaries
Policy Council—Interview (continued)

Monthly Reports (continued)
- Program enrollment reports, including attendance reports for children whose care is partially subsidized by another public agency
- Reports of meals and snacks provided through programs of the U.S. Department of Agriculture (USDA)

Additional reports
- Every 3 years, the community-wide strategic planning and needs assessment (Community Assessment) of the Head Start agency
- Applicable current updates from the Secretary (i.e., Program Instructions, Information Memoranda, etc.)

Ask the members whether the reports they received contributed useful and timely information to support the Policy Council’s decision-making. If the reports are of poor quality and cannot be used by the Policy Council, capture that in your notes.

Governing Body—Interview

► Ask the governing body members how often they receive the reports listed below.
Document whether the governing body receives the following reports as often as required.

Annual reports
- The financial audit
- The Self-Assessment, including any related findings
- The Program Information Report (PIR)

Monthly Reports
- Financial statements, including credit card expenditures (if the program uses credit cards)
- Program information summaries
- Program enrollment reports, including attendance reports for children whose care is partially subsidized by another public agency
- Reports of meals and snacks provided through programs of the USDA

Additional reports
- Every 3 years, the community-wide strategic planning and needs assessment (Community Assessment) of the Head Start agency
- Applicable and current updates from the Secretary (i.e., Program Instructions, Information Memoranda, etc.)
Management Systems

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>At least annually, the program conducts a Self-Assessment of program</td>
<td>641A(g)(1)</td>
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<td>effectiveness that:</td>
<td>641A(g)(2)(B)</td>
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<tr>
<td>• Assesses progress in meeting local program goals and objectives</td>
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<td>• Evaluates program compliance with Federal requirements</td>
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<tr>
<td>• Results in improvement plans</td>
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</table>

Targeted Questions

Head Start/Early Head Start Director—Interview/Debrief

► With the Director, review the program’s Self-Assessment. Discuss the process the program uses to conduct the Self-Assessment, including:

• How frequently it is conducted
• How the program evaluates progress toward program goals
• How improvement plans are developed
Management Systems

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>The program established and implements procedures for the ongoing monitoring of its operations and services to ensure compliance. The program’s ongoing monitoring: • Uses effective tools and procedures to ensure the program is in compliance and meets its goals and objectives • Clearly defines staff roles and responsibilities in program oversight • Conducts frequent, ongoing monitoring activities • Collects and uses data for planning activities and to ensure compliance • Ensures ongoing monitoring in delegate agencies takes place</td>
<td>641A(g)(3)</td>
</tr>
</tbody>
</table>

Targeted Questions

Head Start/Early Head Start Director—Interview/Debrief

► How does the program:
  • Use effective tools and procedures to ensure it is in compliance and meets its goals and objectives?
  • Clearly define staff roles and responsibilities in program oversight?
  • Conduct frequent ongoing monitoring activities?
  • Collect and use data for planning activities and to ensure compliance?
  • Ensure ongoing monitoring of delegate agencies takes place?

Health Services Coordinator—Interview

► How do you:
  • Monitor your program area to ensure high-quality services are being delivered to all children and families?
  • Define staff roles and responsibilities in monitoring your program area?
  • Collect and use data for planning activities and to change practices as needed?
Management Systems

<table>
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<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</thead>
<tbody>
<tr>
<td>The program develops and implements written standards of conduct that are available to all staff and contain provisions for appropriate penalties when violations occur.</td>
<td>1304.52(i)(1) 1304.52(i)(1)(i) 1304.52(i)(1)(ii) 1304.52(i)(1)(iv) 1304.52(i)(3)</td>
</tr>
</tbody>
</table>

Note: 1304.52(i)(1)(iii) was removed from this section and is now located in CHS 5.5.

Targeted Questions

Head Start/Early Head Start Director—Interview/Debrief

► Ask the Director to describe how the program informs staff about the standards of conduct. What policies and procedures does the program have in place to ensure that the standards are followed?

If there were any violations of the program’s standards of conduct, talk to the Director about such violations and determine what penalties were applied.
Management Systems

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>Prior to employing an individual, the program obtains a:</td>
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<tr>
<td>• Federal, State, or Tribal criminal record check (CRC) covering all</td>
<td>648A(g)(3)(A)</td>
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<td>jurisdictions in which it provides Head Start services to children</td>
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<tr>
<td>• Federal, State, or Tribal CRC as required by the law of the jurisdiction in</td>
<td>648A(g)(3)(B)</td>
</tr>
<tr>
<td>which the program provides Head Start services</td>
<td></td>
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<tr>
<td>• CRC as otherwise required by Federal law</td>
<td>648A(g)(3)(C)</td>
</tr>
</tbody>
</table>

Targeted Questions

Staff File Review

- Did the program obtain one of the following for the employee?
  - A State, Tribal, or Federal criminal record check (CRC) covering all jurisdictions in which the grantee provides Head Start services to children
  - A State, Tribal, or Federal CRC as required by the law of the jurisdiction in which the grantee provides Head Start services
  - A CRC as otherwise required by Federal law
- Was the employee hired within the last 12 months?
- Was the CRC conducted prior to employment?

Head Start/Early Head Start Director—Interview/Debrief

- If any staff members did not have a CRCs or were hired within the last 12 months and did not complete CRCs prior to hire, talk to the Head Start Director regarding the policies in place and determine why checks were not completed and what, if any, steps will be taken to correct the issue.
Head Start Key Indicator-Compliant (HSKI-C) #10

Management Systems

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</thead>
<tbody>
<tr>
<td>The program establishes and maintains a record-keeping system that supports</td>
<td>1304.51(g)</td>
</tr>
<tr>
<td>the delivery of services to children and families. The program:</td>
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<tr>
<td>• Consistently collects and records data in an accurate and timely manner</td>
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<tr>
<td>for children, families, and staff</td>
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<tr>
<td>• Generates reports to inform planning, communication, and ongoing monitoring</td>
<td></td>
</tr>
<tr>
<td>• Makes information accessible to appropriate parties</td>
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</tr>
<tr>
<td>• Maintains confidentiality</td>
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</table>

Targeted Questions

Child File Review

Head Start/Early Head Start Director—Interview/Debrief

► With the Head Start Director, discuss the program’s record-keeping system.

- What data system does the program use?
- How does the program ensure that the data are accurate and up to date? (e.g., ERSEA data, children kept up to date)
- In what ways does the program use its data?
- How does the program ensure data are kept confidential?
Head Start Key Indicator-Compliant (HSKI-C) #11

Management Systems

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
</tr>
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<tbody>
<tr>
<td>The program publishes and makes available to the public an Annual Report that contains: • An explanation of the budgetary expenditures and proposed budget for the fiscal year • An explanation of the agency's efforts to prepare children for kindergarten</td>
<td>644(a)(2)</td>
</tr>
<tr>
<td></td>
<td>644(a)(2)(B)</td>
</tr>
<tr>
<td></td>
<td>644(a)(2)(G)</td>
</tr>
</tbody>
</table>

Targeted Questions

Head Start/Early Head Start Director—Interview/Debrief

► With the Director, review the program’s Annual Report. Discuss how the Annual Report is made public. Describe the information included in the report, including:

• An explanation of budgetary expenditures and proposed budget for the fiscal year
• Information on school readiness and how the grantee works to prepare children for kindergarten
Fiscal Integrity

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The grantee’s financial management systems provide for effective control</td>
<td>75.302(b)(4-5)</td>
</tr>
<tr>
<td>over and accountability for grant and sub-grant funds, property, and</td>
<td>75.501(b)</td>
</tr>
<tr>
<td>other assets and ensure they are used solely for authorized purposes.</td>
<td>75.352(d)(1-3)</td>
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<tr>
<td></td>
<td>75.352(f)</td>
</tr>
<tr>
<td></td>
<td>75.352(g)</td>
</tr>
</tbody>
</table>

Targeted Questions

Delegate Agency—Document Review

► Does the grantee have one or more delegate agencies?
► How does the grantee use information in the audits and other information from delegate agencies—such as claims for reimbursement, support documentation, bank statements, and advance payment requests—for monitoring?
► Are recommendations discussed with the delegate agencies and corrective actions developed?
► How does the grantee ensure corrective actions occurred?
► If delegate agencies receive advance payments, how is the amount determined, and does the grantee recover the advanced amounts by the end of the grant year?
► What documentation is included with the requests for payment, and how are the requests processed?

Financial Reports/Accounting Records—Document Review

► Review grantee correspondence and notices from the Internal Revenue Service, State Income Tax, State Tax Withholding, Workers’ Compensation, and Unemployment Compensation documents. Does any correspondence indicate unresolved compliance issues, such as unpaid amounts that were past due; material significant penalties for late, missing, or incomplete returns; or reports? If yes, describe all unresolved issues in detail and indicate the amount of any levies, taxes, payments, penalties, and interest claimed by the authority.
If a review of grantee correspondence and notices from the Internal Revenue Service, State Income Tax, State Tax Withholding, Workers’ Compensation, and Unemployment Compensation documents revealed there were unresolved issues with late payroll taxes or late insurance premiums, can the agency document that no portion of the taxes or insurance premiums was related to the Head Start program?

Are there amounts due but not remitted (e.g., unpaid taxes or insurance premiums)? If yes, did the grantee draw down funds from the payment management system (PMS) for the unremitting taxes or premiums?

What method does the program use to ensure that funds are available for payment of any vested accrued leave owed to employees of the grantee?

What is the program’s procedure for reviewing credit card charges/retail-store credit charges to ensure that only authorized signatories use agency credit cards and that charges are reasonable and necessary for program operations?

Since the completion of the most recent audit, have there been significant changes in Fiscal staffing or the financial systems? If so, how has any potential negative impact associated with these changes been mitigated?

Is the grantee current with processing transactions, payments to vendors, and production of financial reports for staff, the Board, and the Policy Council? Please describe the evidence you observed in arriving at your conclusion.

What are your and your staff’s experience and educational levels?

Is the staffing level adequate to provide for appropriate segregation of duties? Please describe the evidence you observed in arriving at your conclusion.

Is the agency current in its payments to the Internal Revenue Service and State tax authorities (significant amounts not remitted when due and/or significant penalties, interest, or levies related to late filings or late remittance)? Please describe the evidence you observed in arriving at your conclusion.
General Ledger—Document Review

► Review a report or listing of aged payables. Are bills and invoices paid on time (not more than 30 days past due unless disputed)?

► Review two consecutive bank statements. Are bank statements reconciled to the General Ledger? Are reconciling items (including outstanding checks) resolved within 30 days? Do checks clear the bank by the second statement after the issue date?

► If the reconciliations show any checks outstanding more than 60 days, can the grantee show that payments were disbursed (checks signed and issued to the payees) on or near the date on which the checks were written?

► Do the grantee’s fiscal records differentiate development and administrative costs from program costs to ensure that development and administrative costs do not exceed 15 percent of the total grant (unless a waiver granting a higher percentage has been received)?

Non-Personnel Costs—Transaction Review

► How did the grantee ensure services were performed or goods received before the payment was processed? Please describe the evidence you observed in arriving at your conclusion.

► Was the cost supported by a contract or an invoice, if appropriate? Please describe the evidence you observed in arriving at your conclusion.

► Was the cost posted to the appropriate award period?

► Are approvals of the documents supporting this transaction consistent with the approval process described in the organization’s Fiscal Policies and Procedures? Is the approver someone other than the person making the order? Was a purchase order completed (if required by the organization’s policies and procedures)? Please describe the evidence you observed in arriving at your conclusion.

► If payment was made by check, has the check cleared the bank? If not, does the grantee maintain documentation to demonstrate the payment was disbursed (check written, signed, and issued to the vendor)? Please describe the evidence you observed in arriving at your conclusion.

► Is credit card use consistent with the organization’s written policies? Please describe the evidence you observed in arriving at your conclusion.
FIFO & Audit—Document Review

► Are there unresolved audit findings that should be considered by the Reviewer?
► Does the most recent audit include audit findings either directly or indirectly related to the Head Start program?
► Do audit reports disclose any companies related to the grantee organization providing services and/or facilities to the Head Start program?
► Does the latest audit report describe potential impairment of financial health or significant issues outside of audit findings that should be considered by the Reviewer?
► Are there specific issues involving key personnel that should be considered by the Reviewer?
► Did the Regional Office list any other issues that should be considered by the Reviewer?

Procurement—Transaction Review

► Were the grantee’s written procurement procedures followed (use of purchase orders, approvals, documentation of cost quotations, etc.)?
► How did the grantee ensure the services were performed or the goods received before the payment was processed?
► Are approvals of the documents supporting this transaction consistent with the approval process described in the organization’s fiscal policies and procedures? Is the approver someone other than the person making the order? Was a purchase order completed (if required by the organization’s policies and procedures)?
► If the payment was made by check, has the check cleared the bank? If not does the grantee maintain documentation to demonstrate the payment was disbursed (check written, signed and issued to the vendor)?
► Is credit card use consistent with the organization’s written policy?
Head Start Key Indicator-Compliant (HSKI-C) #13

**Fiscal Integrity**

<table>
<thead>
<tr>
<th><strong>Key Indicator</strong></th>
<th><strong>Federal Regulation</strong></th>
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</table>
| Financial reports and accounting records are timely and complete and contain accurate information pertaining to grant or sub-grant awards, authorizations, obligations, unobligated balances, assets, liabilities, outlays (total expenditures), income, and interest. Reports include:  
  - SF-425 (paper-based Federal Financial Report filed with Regional Office);  
  - SF-425 (web-based Federal Cash Transactions Report filed with Division of Payment Management); and  
  - USDA/Child and Adult Care Food Program (CACFP) reports. | 1304.23(b)(1)(i)  
1304.51(h)  
75.302(b)(2)  
75.302(b)(3) |

**Targeted Questions**

**Financial Reports/Accounting Records—Document Review**

- Using the most recent Final SF-425 and financial records, document the following and identify whether there is a difference among amounts recorded in the financial records, amounts reported on the audit, and amounts reported on the SF-425.
- Has the grantee reconciled any differences between the amounts recorded in the financial records and amounts reported on the SF-425?
- Describe any unreconciled differences and discuss with the Fiscal Officer.
- Did disbursements for the latest award reported on the most recent PMS report (the SF-425 submitted electronically each quarter) vary from the disbursements reflected in the grantee’s financial records? Describe any differences and discuss with the Fiscal Officer.
- Did the grantee’s accounting records separately identify the source and application for each Head Start award: Federal awards, authorizations, unobligated balances, assets, liabilities, outlays (total expenditures), income, and interest?
- Is the total recipient share (NFS) in the grantee’s financial records at least as much as the amount shown on the most recent Final SF-425? Please describe the evidence you observed in arriving at your conclusion.
- Were any USDA/CACFP claims reduced or rejected due to late or inaccurate reporting or improper documentation of costs, resulting in a disallowance or reduced payment to the program?
► Compare the actual USDA revenue reported in the paper-based Final SF-425 filed with the budgeted amount of USDA revenue reflected on the Grant Application Budget Instrument (GABI) and ask the grantee to document the total food costs for the Head Start program and show the sources from which the food costs were paid. Based on your review of this documentation, was Head Start charged for food costs that should have been paid by the USDA?

► Does the grantee’s most current USDA/CACFP compliance review identify any areas of noncompliance related to fiscal issues? If yes, did USDA/CACFP disallow any costs?

► Based on your review of the grantee’s repayment of costs disallowed by the USDA, were Head Start funds used to pay the disallowance?

► Based on your review of the grantee’s records, was it determined that the USDA removed the grantee from participation in the CACFP program?
Fiscal Integrity

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<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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Targeted Questions

Payroll—Transaction Review

► Is the transaction part of a payroll approved by a responsible official of the organization?

► Is the transaction supported by time and attendance records (e.g., timecards, timesheets, summary records, or other supporting documentation verifying attendance) and signed or electronically approved by the employee or a supervisor having first-hand knowledge of the actual work performed by the employee?

► Which of the following best describes the allocation of this position?

  • The position is allocated 100% to Head Start or 100% to Early Head Start (EHS).
  • The position is allocated only between Head Start and EHS.
  • The position is allocated between Head Start/EHS and a related program, such as Child Care or State Pre-K.
  • The allocation includes an unrelated program and/or Central Administration.

► Which of these best describes the allocation between Head Start/EHS and unrelated programs and/or Central Administration?

  • The allocation between Head Start/EHS and unrelated programs and/or Central Administration is based on actual activity.
• The allocation between Head Start/EHS and unrelated programs and/or Central Administration is based on budgeted dollars, ability to pay, or fixed percentages not supported by a rationale.
• The allocation between Head Start/EHS and unrelated programs and/or Central Administration is supported by an activity base (e.g., number of transactions, number of supervised staff).
• The grantee uses another allocation methodology not described above.

► Which of these best describes the allocation between Head Start/EHS and related program(s), such as State Pre-K or Child Care?
  o The allocation is based on actual activity.
  o The allocation base (e.g., total salary dollars in each program, total expenses in each program) typically requires a Negotiated Indirect Cost Rate Agreement.
  o The allocation methodology uses one or more activity bases, such as the number of children served, hours of operation, or a time study or similar analysis based on direct hours of identifiable services provided.

► Which of these best describes the allocation between Head Start and EHS?
  • The allocation between Head Start and EHS uses the same percentages as those used in the GABI accompanying the approved funding application.
  • The allocation is based on actual activity.
  • The allocation is based on budgeted dollars, ability to pay, historical time studies, or fixed percentages not supported by a rationale.
  • The allocation is supported by an activity base (e.g., hours of service, number of children, etc.).
  • The grantee uses another allocation methodology not described above.

► How has the grantee documented actual activity?
  • The grantee is an educational institution and uses a method recognizing the principle of after-the-fact confirmation.
  • The grantee is a government entity and uses periodic certification demonstrating (at least semi-annually) that the employee worked solely under the Head Start/EHS award during the period covered by the certification.
  • The grantee is a non-profit or government entity and uses personnel activity reports (PARs).

► Were the PARs prepared at least monthly, and did they coincide with one or more pay periods?

► Did the PAR account for the total activity for which the employee was compensated?
Payroll—Transaction Review (continued)

► Was the PAR signed by the individual employee or, for non-profit agencies only, by a responsible supervisory official having first-hand knowledge of the activities performed by the employee?

► Is the allocation supported by current data?

► Based on a review of available information (e.g., job description, organization chart, classroom rosters, list of programs served by the agency), is the salary properly allocated? Please describe the evidence supporting your conclusion.

► Is the allocation base an appropriate measure of the benefit received by each program? Please describe the evidence you observed in arriving at your conclusion.

► If the grantee uses another allocation methodology, please describe the allocation methodology used. Does the methodology allocate costs in proportion to the benefits received by each program? Please describe the evidence observed in arriving at your conclusion.
Fiscal Integrity

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The grantee can demonstrate that all contributions of non-Federal share (NFS), including cash and third-party in-kind (such as donated services, goods or supplies), are necessary and reasonable for accomplishing program objectives, allowable under applicable cost principles, and allocable if also benefiting another award. Financial records are also sufficient and support the verification of adherence to applicable cost principles.</td>
<td>75.306(b)(1-5) 75.306(e) 75.306(g) 75.306(i)(1-3) 75.434(d)</td>
</tr>
</tbody>
</table>

Targeted Questions

FIFO & Audit—Document Review

- Any there any issues related to NFS that should be considered by the Reviewer?

Non-Federal Share—Transaction Review

- Was the cash expended for allowable costs necessary and reasonable for the operation of the Head Start program?
- This question applies only if cash match was from State or local government funds. Has the grantee established that the claimed match is not from funds paid by the Federal Government under another award, except where authorized by Federal statute, or the funds were not used to match other Federal funds? Please describe the evidence you observed in arriving at your conclusion.
- Does the grantee administer other programs that require a match?
- How did the grantee establish that the donation has not been counted toward a match for another program? Please describe the evidence you observed in arriving at your conclusion.
- For cash matches, was the cash counted as match when expended and not when received? Please describe the evidence you observed in arriving at your conclusion.
- Does the claimed NFS appear to be allowable and necessary for the operation of the Head Start program?
- Were donated items intended to be taken home for personal use by the child or parent (e.g., clothing, household items)? Please describe the evidence you observed in arriving at your conclusion.
Non-Federal Share—Transaction Review (continued)

► Was the claimed match from funds paid by the Federal Government under another award?
► Did authorizing legislation allow the funds to be used as a match? Please describe the evidence you observed in arriving at your conclusion.
► How was value established, and is it reasonable? Is the rate consistent with the rates paid for similar services in the recipient’s organization (including fringe benefits) or the employee’s regular rate of pay (for services provided by the employee of another organization) or, for services not found within the recipient’s organization, consistent with the rates paid for similar services in the local labor market (including fringe benefits)? Please describe the evidence you observed in arriving at your conclusion.
► For donated services, is the nature and duration of the activity, service date, location in which the service was performed, and volunteer signature included in the documentation? Please describe the evidence you observed in arriving at your conclusion.
► If applicable to the type of donated service, are claims supported by records identifying the number of children served and the services provided?
► Did the volunteer receive payment or a stipend from another Federal program, such as Foster Grandparents?
► Was the value reduced by the amount of the stipend? Please describe the evidence you observed in arriving at your conclusion.
► For donated space (other than space in family homes or occasional space rental), is the claimed value supported by a current appraisal performed by a licensed independent appraiser (e.g., certified real-property appraiser or General Services Administration representative) and certified by a responsible official of the recipient? Please describe the evidence you observed in arriving at your conclusion.
► Is the rate consistent with the rates paid for similar services in the recipient’s organization (including fringe benefits), or, for services not found within the recipient’s organization, consistent with the rates paid for similar services in the local labor market (including fringe benefits)? Please describe the evidence you observed in arriving at your conclusion.
► Is the amount of time spent performing the activities reasonable? Please describe the evidence you observed in arriving at your conclusion.
► Does in-kind primarily benefit the parent or child (as outlined in OHS-PC-A-077) as opposed to benefiting the overall Head Start program?
This question applies to at-home activities. Are parents’ at-home activities related to doing things with the enrolled child that support the child’s Head Start experience as articulated by the teacher (or home visitor) and support the curriculum used by the program? Please describe the evidence you observed in arriving at your conclusion.

This question applies to claims for the use of parent in-home space. Did the grantee use an outside source (e.g., market survey) to support the claimed value? Please describe the evidence you observed in arriving at your conclusion.

Does this claim include parent transportation of children?
Head Start Key Indicator-Compliant (HISKI-C) #16

Fiscal Integrity

<table>
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<tr>
<th>Key Indicator</th>
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<tbody>
<tr>
<td>The grantee has safeguarded equipment purchased using Head Start funds by maintaining complete and accurate equipment records, verifying the accuracy of records by conducting a physical inventory, and following disposition requirements. The grantee obtained advance Regional Office permission for any encumbrance of equipment acquired using Head Start funds.</td>
<td>75.320(d)(1-2) 75.320(a)(2) 75.320(e)</td>
</tr>
</tbody>
</table>

Targeted Questions

Equipment—Transaction Review

- Does the total cost of all equipment purchased with Head Start funds exceed $50,000?
- Is the equipment supported by an entry in the grantee's equipment records, including all required information (description of the property; serial number or other identification number; source of the property; title holder; acquisition date; cost of the property; percentage of Federal participation in the cost of the property; location, use, and condition of the property; and ultimate disposition data, including date of disposal and sales price of the property)?
- Can the grantee document that the equipment was part of a physical inventory conducted at least once in the past 2 years?

Financial Reports/Accounting Records—Document Review

- Since the last review, has the grantee sold or disposed of any equipment with a fair-market value of $5,000 or more?
- How did the grantee determine the fair-market value? Please describe the evidence you observed in arriving at your conclusion.
- Did the grantee request and follow disposition instructions from the Regional Office?

Loan Review—Transaction Review

- If the loan agreement did not exclude assets having a Federal interest from use as collateral, did the grantee receive written approval from the Grants Management Officer (or designee) to encumber the Federal interest in Head Start equipment?
Comprehensive Services & School Readiness

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>The program has established procedures for tracking the provision of Health services.</td>
<td>1304.20(a)(1)(ii)(C)</td>
</tr>
</tbody>
</table>

Targeted Questions

Health Services Coordinator—Interview

- With the coordinator, review the program’s health-tracking system. Ask how often the system is updated and which staff are responsible for keeping it up to date. Does the system include all necessary information, including information on:
  - Medical services?
  - Dental health services?
  - Mental Health services?
  - Nutrition services?
For all of the above types of services, does the tracking system include:
  - Dates of services?
  - Types of screenings, assessments, and referrals?
  - Results and outcomes?
- When reviewing the tracking system, confirm that the information in the system aligns with the information documented in the child files. Look at a sample of information for 10 children to ensure the data align. Clearly document any discrepancies in the data observed and ask program staff to clarify why the data in the different sources may be different.
Comprehensive Services & School Readiness

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The program ensures that a Health staff member visits each newborn within 2 weeks after birth to ensure both the mother’s and the child's well-being.</td>
<td>1304.40(i)(6)</td>
</tr>
</tbody>
</table>

Note: Applies only to programs serving pregnant women and new mothers

Targeted Questions

Health Services Coordinator—Interview

- Ask the Health Services Coordinator how the program ensures that newborns and their mothers are visited by Health staff within 2 weeks after birth.
- With the Health Coordinator, review files of new mothers, and:
  - Look for documentation in the files indicating when visits occurred
  - If the visits occurred, determine whether a Health staff member made the visit to the newborn and mother
  - Document any visits that occurred more than 2 weeks after delivery or did not occur at all
  - If visits occurred later than 2 weeks after birth or did not occur at all, document the reason they were late or did not occur, including whether the mother refused or delayed the visit
Comprehensive Services & School Readiness

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</thead>
<tbody>
<tr>
<td>The program provides educational opportunities for parents to enhance their parenting skills that include: • Understanding the educational and developmental needs of their children • Sharing concerns and observations about their children with program staff</td>
<td>1304.40(e)(2) 1304.40(e)(3)</td>
</tr>
</tbody>
</table>

Targeted Questions

Parent—Interview

► Ask parents to discuss the following:
  • What types of information they have received about their children's developmental strengths or areas for growth
  • How they partner with staff in developing goals for their children
  • How the program shares information about their children’s progress
  • Whether they were provided opportunities to share concerns about their children’s development
  • Information the program shared about how they, as parents, could help promote their children’s success as they get ready to enter school

Teacher, FCC Provider, Home Visitor—Interview

► Ask the staff to describe how the program provides opportunities for developing parenting skills and knowledge in the following areas:
  • Expectant parenting and pre-natal health (as applicable)
  • Strategies to support their children’s development, including development of individual children’s goals and strategies for preparing their children for school
  • Ensuring the health and safety of their children
  • Providing input and sharing concerns regarding their children
**Head Start Key Indicator-Compliant (HSKI-C) #20**

### Comprehensive Services & School Readiness

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<tr>
<th><strong>Key Indicator</strong></th>
<th><strong>Federal Regulation</strong></th>
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<tbody>
<tr>
<td>Program staff:</td>
<td>1304.24(a)(1)(i)</td>
</tr>
<tr>
<td>• Educate parents about how to strengthen and nurture supportive environments and relationships in the home and at the program</td>
<td>1304.24(a)(1)(ii)</td>
</tr>
<tr>
<td>• Identify appropriate responses to children’s behaviors</td>
<td>1304.24(a)(1)(iii)</td>
</tr>
<tr>
<td>• Encourage parents to share concerns and observations about their children’s mental health</td>
<td>1304.24(a)(1)(iv)</td>
</tr>
<tr>
<td>• Share observations with parents regarding their children’s behavior and development</td>
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### Targeted Questions

#### Early Child Development (ECD) Coordinator—Interview

► Ask the ECD Coordinator about the types of training and materials shared with parents. Collect information about how the mental health professional and/or staff:

- Educate parents about how to strengthen and nurture supportive environments and relationships in the home and at the program
- Identify appropriate responses to children’s behaviors
- Encourage parents to share concerns and observations about their children’s mental health
- Share observations with parents regarding their children’s behavior and development

#### Teacher, Family Child Care (FCC) Provider, Home Visitor—Interview

► Ask how ECD Staff:

- Share information, observations, and concerns about children’s behavior and mental health with parents
- Seek parents’ input to clarify their understanding
- Provide parents with opportunities to share their own observations and concerns
Comprehensive Services & School Readiness

<table>
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<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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</table>
| The program makes provisions for Mental Health program services for parents and staff that include:  
  • Staff and parent education on mental health issues  
  • On-site mental health consultation with mental health professionals  
  • Activities promoting children’s mental wellness | 1304.24(a)(3)(ii) |

Targeted Questions

Family and Community Engagement (FCE) Coordinator and FCE Staff—Interview

► Ask the FCE Coordinator and staff to describe how they share information and educational resources regarding children’s mental health and wellness and whether they have access to the Mental Health Consultant.

Educational resources on mental health and wellness should be provided to groups and individuals as needed. Focus on the type and quality of services and information provided to individual or groups of parents.

ECD Coordinator—Interview

► Ask what types of educational resources related to mental health issues are provided by the program to staff and parents. Ask how the mental health professional is involved and whether consultation is provided on site.
Head Start Key Indicator-Compliant (HSKI-C) #22

Comprehensive Services & School Readiness

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<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>The program coordinates with and has current Interagency Agreements in place with Local Education Agencies (LEAs) and other agencies (Part C) within the service area.</td>
<td>1304.41(a)(4)</td>
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<tr>
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<td>1308.4(l)(3)</td>
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<td>1308.4(l)(4)</td>
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<td>1308.4(l)(5)</td>
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<td>1308.4(l)(7)</td>
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Targeted Questions

Disabilities Services Coordinator- Interview

► Review the program’s Interagency Agreements with all the LEAs and other agencies (including Part C agencies for programs serving infants and toddlers) within the grantee’s service areas and determine whether each of the following subjects is addressed:
  • Referrals for evaluations, Individualized Education Program/Individualized Family Service Plan meetings, and placement decisions
  • Transitions
  • File and resource sharing (school readiness goals and assessment information)
  • The current program year, with appropriate signatures and dates
► Ask the coordinator for the number of Interagency Agreements needed to ensure services are provided for all children with disabilities throughout the service area.
► When multiple districts exist, ask the coordinator to describe the process for ensuring effective Interagency Agreements are developed and maintained.
► If the program does not have formal agreements with some LEAs or Part C agencies, ask the coordinator the following:
  • Why agreements have not been made, with a description of efforts to date
  • Whether the Regional Office has been formally notified, and the recommended next steps
Comprehensive Services & School Readiness

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>The program has a system and processes in place to do the following in order to track, use, and report progress on school readiness goals:</td>
<td>1307.3(b)(2)(i) 1307.3(b)(2)(ii)</td>
</tr>
</tbody>
</table>

Aggregate and analyze the following:
- Individual, ongoing child-level assessment data for all children birth to age 5
- Child-level data at least three times a year using data from one or more valid and reliable assessment tools
- For programs serving dual-language learners (DLLs):
  - Status and progress in acquiring the knowledge and skills described in the Head Start Child Development and Early Learning Framework (demonstrated in any language, including the child’s home language) toward learning English

In order to use school readiness data:
- Combine input from parents and families with assessment data to determine each child’s status and progress in the five essential domains
- Individualize experiences, instructional strategies, and services to best support each child
- In combination with other program data, determine progress towards meeting program goals
- Assess the fidelity of implementation of the curriculum
- Direct continuous improvement related to the effectiveness of curriculum, instruction, professional development, and program design or other program decisions based on analysis of school readiness outcomes data

Report Results
- To inform parents and the community of the program’s progress in achieving school readiness goals

*Note: Programs in operation fewer than 90 days are required to have a system to aggregate and analyze data at least twice during their program operation period.*
Targeted Questions

School Readiness Assessment—Interview With ECD Coordinator and Head Start Director

► How does the program aggregate and analyze individual, ongoing child-level assessment data for children birth to age 5 in all program options (e.g., home-based, center-based, FCC, EHS, and Head Start)?

► Does the program have a plan to complete the required aggregate-data analysis?

► Ask the ECD Coordinator and Director to describe how the information gathered from the aggregated-data analysis helps the program assess progress toward achieving school readiness goals. (Ask them to provide specific examples, and document them in your notes.)

► Ask the ECD Coordinator and Director to describe how the program makes improvements in the following areas based on its analysis of school readiness outcomes. (Ask them to include examples, and document them in your notes.):
  • Curriculum and instruction
  • Professional development
  • Program design
  • Other program decisions

► Describe how the program supports DLLs in making progress toward school readiness goals and learning English.

► Describe how the program informs parents and the community of its progress in achieving school readiness goals.

► Ask the ECD Coordinator and Director to describe how the information gathered from the aggregated-data analysis helps the program assess progress toward achieving school readiness goals. (Ask them to provide specific examples, and document them in your notes.)

Teacher, Home Visitor, and FCC Provider-Interview

► Ask ECD staff to describe how they do the following. (Ask for specific examples, and document them in your notes.):
  • Use ongoing child-level assessment data to identify children’s levels of development
  • Provide experiences to support children’s development
  • Monitor children’s progress throughout the program year
Comprehensive Services & School Readiness

<table>
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<th>Key Indicator</th>
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<tbody>
<tr>
<td>The program selects and implements a curriculum that is evidence based and is linked to ongoing assessment, with developmental and learning goals and measurable objectives.</td>
<td>642(f)(3)(C)</td>
</tr>
</tbody>
</table>

Targeted Questions

ECD Coordinator—Interview

► List the curricula the program uses for each program option and age group.
► Ask the ECD Coordinator to indicate whether each selected curriculum:
  - Supports the evidence base for its selection by considering the program option and ages of the children served, as well as by addressing staff development and training
  - Is linked to ongoing assessment
  - Includes developmental and learning goals appropriate for the ages of the children and program option
  - Includes measurable objectives
► Ask the ECD Coordinator to describe how he or she determines whether staff are implementing the curriculum as designed.
Comprehensive Services & School Readiness

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<tr>
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</thead>
<tbody>
<tr>
<td>The program uses information from ongoing observations and evaluations, as well as insight from parents, to determine how best to respond to each child’s individual characteristics, strengths, and needs.</td>
<td>1304.20(f)(1)</td>
</tr>
</tbody>
</table>

*Note: Screenings results used for referring children for future evaluation is captured in Child Health and Safety and does not apply to individualizing in CDE.*

Targeted Questions

Teacher, Home Visitor, FCC Provider—Interview

► Ask ECD staff to discuss how they use information to develop goals and plan experiences that respond to each child’s individual characteristics, strengths, and needs.

Ensure the following are included when individualizing for children:

- Ongoing observations
- Ongoing assessments of progress
- Insights from each child's family
Comprehensive Services & School Readiness

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<thead>
<tr>
<th>Key Indicator</th>
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<tbody>
<tr>
<td>The program has secured the services of a mental health professional, including on-site consultation for program staff and families that provides for timely identification and interventions to address children’s mental health concerns.</td>
<td>1304.24(a)(3)(i) 1304.24(a)(2)</td>
</tr>
</tbody>
</table>

**Targeted Questions**

**Mental Health Services Coordinator—Interview**

- Ask the Mental Health Coordinator to describe how the program uses the services of the mental health professional to identify and provide interventions to address mental health concerns and how frequently these consultations occur.
- Determine the role of the Mental Health Consultant and the type of services he or she provides to the program. Describe how the coordinator and consultant are involved in the design and implementation of program practices.
- If applicable, review the mental health professional’s Consulting Agreement with the Mental Health Coordinator to determine the types of services for which the professional is responsible and the frequency with which he or she visits the program. If there are discrepancies between the content of the Consulting Agreement and the results of the interview, describe the discrepancies and follow up as appropriate.
Comprehensive Services & School Readiness

<table>
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<tr>
<th>Key Indicator</th>
<th>Federal Regulation</th>
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<tbody>
<tr>
<td>The program hires teachers with the required qualifications, training, and</td>
<td>645A(h)(1)</td>
</tr>
<tr>
<td>experience.</td>
<td>645A(h)(2)</td>
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<tr>
<td></td>
<td>648A(a)(3)(B)(i)</td>
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<td></td>
<td>648A(a)(3)(B)(ii)</td>
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<td></td>
<td>648A(a)(3)(B)(iii)</td>
</tr>
</tbody>
</table>

Targeted Questions

Teacher–Preschool—Staff File Review

▸ Please enter the qualifications of the preschool teacher:
  • A baccalaureate or advanced degree in Early Childhood Education (ECE)
  • A baccalaureate or advanced degree and coursework equivalent to a major relating to ECE, with experience teaching preschool-age children
  • An associate’s degree in ECE
  • An associate’s degree in a related field and coursework equivalent to a major relating to ECE, with experience teaching preschool-age children
  • A baccalaureate degree and admission into the Teach For America program, passing a rigorous Early Childhood content examination such as Praxis II, teaching preschool children in a Teach For America summer training institute, and receiving ongoing professional development and support from Teach For America’s professional staff
  • Does not meet the qualifications

▸ Is the professional development plan designed to ensure attainment of qualifications, or is the staff person currently enrolled in a degree program?

Teacher–Infant/Toddler—Staff File Review

▸ Please enter the qualifications of the infant/toddler teacher:
  • A minimum of a current Child Development Associate (CDA) credential and training (or equivalent coursework) in ECD with a focus on infant and toddler development
  • Does not meet qualifications

▸ Is the professional development plan designed to ensure attainment of qualifications, or is the staff person currently enrolled in a degree program?