

## **Developing a valid and reliable BASICS Health and Safety Checklist**

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High quality child care is built on the foundation of meeting standards for health and safety.<sup>1,2</sup> The Federal Race-to-the Top Early Learning Challenge helps states develop Quality Rating and Improvement Systems (QRIS) for early care and education (ECE) programs and identifies health and safety as the foundation of quality. The development of national health and safety standards for ECE programs has been supported since 1997 by the three Healthy Child Care America initiatives of the Maternal Child Health Bureau, the National Resource Center for Health and Safety in Child Care and Early Education, National Training Institute for Child Care Health Consultants (CCHCs), and the Child Care and Health Partnership at the American Academy of Pediatrics. In 2011, these lead agencies along with 86 technical experts updated and developed 686 evidence-based standards which were reviewed by 184 stakeholder agencies and published in *Caring for Our Children (CFOC3): National Health and Safety Performance Standards Guidelines for Early Care and Education Programs – 3rd Edition*. In 2015, the Administration for Children and Families (ACF), U.S. Department of Health and Human Services distributed *Caring for Our Children Basics (CFOC Basics): Health and safety foundation for early care and education*. There are 84 CFOC standards identified as the “minimum health and safety standards experts believe should be in place where children are cared for outside of their home” (p.6)<sup>3</sup>. Although these standards provide guidelines for assessing basic health and safety policies and practices, they are not available as a user-friendly, standardized instrument for ECE and health professionals.

In the United States, over 60% of children under six years of age spend time in out-of-home ECE programs, yet many of these programs provide moderate to low health and safety quality.<sup>4</sup> Research has shown that children who are in poor health at two and four years of age have low cognitive skills in kindergarten<sup>2</sup>. Therefore, children in ECE programs need to be in the optimal environment to support their health and safety and help them to be healthy and ready for kindergarten.

The number of infants and toddlers in child care has increased with 47% of infants and toddlers under two years of age with working mothers attending non-family child care programs. Parents are concerned about the health and safety of the child care programs where their children spend time.<sup>5</sup>

Young children's physical and mental health is related to their readiness for school.<sup>1,2</sup> Approximately 20% of children entering kindergarten have a health or developmental problem that potentially may interfere with their readiness to learn,<sup>6</sup> yet less than 30% of these children are identified as at-risk before they reach six years of age. Many research studies have shown that children's academic, socio-emotional and behavioral development is related to the overall

quality of the child care programs they attend.<sup>7-10</sup> Children who attend high quality early care and education (ECE) programs are better prepared for kindergarten compared to children in lower quality programs.<sup>11,12</sup>

Health interventions, such as providing child care health consultation services, can improve the quality of health and safety in child care programs and help children be healthy and ready for kindergarten. Child care health consultants are nurses who have specialized training in assessing the health and safety in ECE programs, providing trainings for ECE staff, individualizing interventions with the ECE directors and staff, providing educational materials for the ECE staff and parents, and providing ongoing consultation on health and safety issues.<sup>13</sup> Child care health consultation intervention programs have been shown to help child care staff maintain up-to-date health and safety policies, support healthy hygiene, and reduce infectious illnesses.<sup>14-17</sup>

The proposed revisions to the Child Care Development Fund (CCDF) Program by the Health and Human Services Department posted on the Federal Register 5/20/2013 at <http://federalregister.gov/a/2013-11673> stated that "...health and safety is the foundation for building a high quality early learning environment. " The proposal also states that regulations should focus on preventing situations in child care where children are being injured or even dying by increasing the accountability for "protecting the health and safety of children in child care." Accountability starts with measurement of performance and ability to meet national standards.

Children's early cognitive achievement in kindergarten is related to their health early in life.<sup>18</sup> Young children, 2 to 5 years old, from immigrant and/or minority families who have health problems also have lower cognitive skills in kindergarten compared to White children.<sup>18</sup> Poor children are also more likely to have chronic health conditions such as asthma, and other illnesses, such as dental caries, allergies, and ear infections.<sup>19</sup> Many of these health problems require management by teachers/ caregivers who promote healthful behaviors and make referrals to health professionals. Therefore, young children, especially poor children and their families benefit the most from attending high quality ECE programs, with documented increases in quantitative skills and fewer behavior problems noted in these participating children<sup>20</sup>. Some researchers have noted that health interventions early in a child's life may have a greater impact on their future than interventions that address children's socio-economic situation and family's educational status, which are more complex and challenging to change.<sup>18,19,21</sup> Health interventions, specifically child care health consultation services, can improve the quality of health and safety in child care programs and help children be healthy and ready for kindergarten.<sup>22,23</sup>

Child care health and safety regulations for legal operation are determined independently by each state. In addition, programs may be governed by accreditation standards of a professional organization (i.e., National Association for the Education of Young Children (NAEYC)) and/or government agency (i.e., Department of Defense, Head Start National Center of Health; National Institute for Early Education Research).

Child care and health professionals, along with researchers and policy makers need a standardized health and safety measure to assess and compare national health and safety standards for all child care programs across the U.S. This project will support the development of a psychometrically valid and reliable, observational, and objective BASICS Health and Safety Checklist based on the CFOC3 Basics. This study will be conducted in Pennsylvania (PA) and California (CA) since they have active child care health consultants.

## **Specific Aims**

The overarching goal of the proposed project is to develop a valid and reliable **BASICS Health and Safety Checklist** with minimum health and safety policies and practices for ECE centers.

The **objectives** of the project are:

1. To develop a new **BASICS Health and Safety Checklist** with policies and practices at the 8<sup>th</sup> grade reading level.
2. To pilot test the **BASICS Health and Safety Checklist** for ease of administration, and useability.
3. To establish the psychometric properties of a **BASICS Health and Safety Checklist** for ECE programs (inter-rater reliability, test-retest reliability, internal consistency).
4. To modify the items on the **BASICS Health and Safety Checklist** based on the process evaluation and psychometric analyses.
5. To develop an accompanying User Manual.
6. To develop the final **BASICS Health and Safety Checklist** and an accompanying User Manual accessible on mobile devices, websites, and in different formats (i.e., MS Excel, MS Word, pdf).
7. To develop an online **BASICS Health and Safety Checklist** with links to CFOC3 standards.

This project will assess the validity and reliability of the **BASICS Health and Safety Checklist** using the following analyses: inter-rater reliability, test-retest reliability, construct validity, and internal consistency reliability. The **BASICS Health and Safety Checklist** will be available in an MS Excel format and accessible via the Web or as a MS Word or pdf document and easy to complete onsite in a child care program. The mobile application will support the direct transfer of data to UCSF for monitoring data fidelity, data completion and for conducting data analysis. At the end of the project, the **BASICS Health and Safety Checklist** will be user-friendly for end users as it will be available in different formats and on multiple websites. The Web-based **BASICS Health and Safety Checklist** will include links to the full standards in *CFOC3*.

### **Project: Summary of Federal Programs and Gaps in Assessment Instruments**

The development of a new **BASICS Health and Safety Checklist** builds upon the development of the new CFOC **BASICS** standards distributed in 2015. The Checklist also builds upon the Maternal Child Health Bureau (MCHB) investments in the Healthy Child Care America Campaign Initiatives and State Early Childhood Comprehensive Systems Grants. It also supports the new proposed revisions to the CCDF Program by the Health and Human Services Department on the Federal Register and the Head Start Performance Standards. The lack of an up-to-date, standardized national instrument to assess the ACF- identified minimum health and safety standards in ECE programs is a barrier to the development and evaluation of health and safety interventions that protect children from harm. The Checklist addresses the following needs:

1. Provides minimum health and safety standards for state’s ECE regulations.
2. Enables ECE program staff and health professionals to assess the basic health and safety standards.
3. Provides a standardized comparison of health and safety standards across programs and states
4. Identifies the strengths and weaknesses in an ECE programs health and safety standards.
5. Determines the priorities for developing site-specific interventions to increase their ability to meet minimum health and safety standards.

**Table 1. BASICS Health and Safety Checklist Development by Psychometric Assessment**

**Goal.** To develop a valid and reliable **BASICS Health and Safety Checklist**.

<b>Psychometric</b>	<b>Informant: Time</b>	<b>Level of Measure</b>	<b>Analyses</b>
Face and Content Validity	CCHCs in PA and CA	Item	Process Evaluation
Inter-rater reliability	CCHCs, gold standard expert (Alkon)	Item	Percent agreement
Test-retest reliability (n=30 centers)	CCHCs	Subscale and total scores: mean(SD))	Pearson Correlation
Construct Validity	CCHCs	0= Never meets standard; 1= Sometimes; 2= Usually 3= Always; NA = not applicable; NO= not observed	Exploratory factor analysis (EFA)
Internal Consistency	CCHCs	Subscale and total scores: mean(SD)	Cronbach’s Alpha

**Impact**

This project has the potential to impact and improve the health and safety policies and practices in ECE programs through the use of an easily accessible standardized, well characterized novel BASICS Health and Safety Checklist. This BASICS Health and Safety Checklist could have great utility in other research, evaluation, program improvement and monitoring/ accreditation activities<sup>24</sup>. The BASICS Health and Safety Checklist will provide comparable data across states to help identify strengths and gaps and compare states’ child care licensing regulations. The project’s potential impact is multifactorial:

- (1) The **target populations** for this new BASICS Health and Safety Checklist in this study are health professionals, ECE professionals, parents, regulators and policy makers, as well as state and federal funding and regulatory agencies, if they complete the online training module.
- (2) The BASICS Health and Safety Checklist also provides a measure of the **foundations of a high quality** child care program by assessing a center’s ability to meet minimal national health and safety standards. If an ECE program has low scores on the BASICS Health and Safety

Checklist they may be putting children at risk and exposing them to potential health and safety hazards. For example, a state's **Race to the Top QRIS** could use the BASICS Health and Safety Checklist to identify the extent to which child care programs are providing adequate health and safety policies and practices and then design **interventions** to help them improve their ability to improve their performance as required in the standards. (3) The BASICS Health and Safety Checklist can complement other **quality assessment** tools which have limited health and safety content such as the ERS. (4) Since parents rate health and safety as their priority for choosing ECE programs for their child,<sup>5</sup> the performance scores from the BASICS Health and Safety Checklist could inform **parent choices**. (5) The BASICS Health and Safety Checklist can be a **self-assessment tool** used by ECE providers and directors. One study showed that completing a health and safety self-assessment has a positive effect on a child care center.<sup>25</sup> (6) State legislators and policy makers may support legislation and regulations to require that ECE programs establish ongoing **relationships with health professionals, such as child care health consultants**, on a monthly or six-month basis, depending on their scores on the BASICS Health and Safety Checklist. At this time, some states (i.e., Colorado) require centers that care for infants and toddlers to have a child care health consultant visit every six months. Connecticut requires monthly visits to centers that serve this youngest age group. Other states (e.g., Massachusetts) require centers to have the name and contact information for a health professional with whom they can consult, but there is no required interaction with the person. The majority of states have no requirement for any interaction with a health professional even though they require some type of school health program for schools that serve children in grades kindergarten through twelfth grade.

### C. Research Strategy

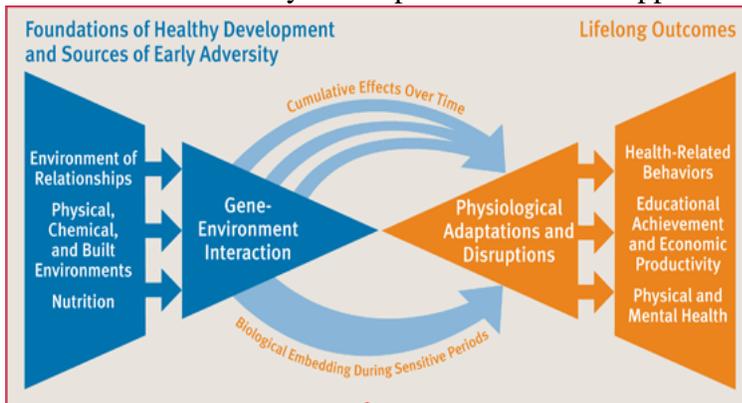
**Importance of the problem.** Concern about the health and safety of children in ECE programs is well documented and enumerated. In a national survey of parents whose children attend ECE programs, health and safety were their top concerns.<sup>5</sup> State regulations define the floor of legal operation which therefore focus on health and safety. According to the Centers for Disease Control and Prevention, injuries are the number one cause of childhood deaths. In child care, minor injuries are common but a two-year study found that children who sustained multiple minor injuries were more likely to have severe injuries.<sup>26</sup> In a study of 77 child care programs, the rate of medically-attended injuries was 0.05 per year.<sup>22</sup> In a study of 220 licensed child care programs by the Consumer Product Safety Commission there was at least one safety hazard in two-thirds of the programs. These hazards included soft bedding, no safety gates on stairs, and unsafe playground surfaces.<sup>27</sup> In the NICHD Study of Early Child Care, infants and toddlers were at higher risk of developing infectious diseases, such as respiratory illnesses and gastroenteritis, than children cared for only at home<sup>28</sup>.

Child Care Aware (formerly NACCRRRA) has produced health and safety benchmarking reports *We CAN Do Better* every two years, since 2007 (NACCRRRA 2007, 2009, 2011). These benchmarks are based upon a publication by the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services *Thirteen Indicators of Quality Child Care: Research Update*<sup>29</sup>. These programs support national health and safety standards for ECE programs, yet there is no national, validated health and safety assessment instrument.

**Changes in the field.** The development of a valid and reliable BASICS Health and Safety Checklist that is accessible to health and child care professionals may change and impact the child care field in several ways: (1) Increase the number of health and safety assessments conducted in child care programs. Programs with more frequent child care inspections/assessments have higher compliance with health and safety requirements.<sup>30</sup> (2) Include health and safety more prominently in QRIS since quality child care starts with a foundation of health and safety.<sup>1</sup> (3) Increase children’s readiness for kindergarten by providing health and safety interventions in ECE programs, including (but not limited to) identifying children with special health care needs, supporting their accommodations and making appropriate referrals. (4) Provide state QRIS and Federal programs, such as Head Start or CCDF, with a standardized assessment instrument to measure and compare health and safety in ECE programs. (5) Provide policy makers, child care regulators, state legislators and private funders with information to identify programs where children may be at risk and to allocate resources to improve health and safety standards in programs that care for and educate our youngest children.

**Theoretical Framework: Early childhood sets the foundations of lifelong health<sup>31,32</sup>**

Many young children under six years of age in the U.S. face adversities, and interventions early in life can support their physical, social, and cognitive development so they can enter kindergarten ready to learn. The biodevelopmental framework<sup>33</sup> (Figure below) provides the framework for the BASICS Health and Safety Checklist. As the model posits, children’s foundations for healthy development start with supportive relationships, good nutrition, and healthy environments. ECE



programs should provide young children with opportunities for developing trusting relationships with caregivers and peers, healthy and nutritious meals and snacks, environments free of chemicals, and safe environments to engage in physical activity and play. This study will provide ECE and health professionals with a health and safety assessment instrument to

evaluate the ECE’s physical and built environments, to assess the center’s ability to meet minimal health and safety performance standards and to guide interventions focused on improving health and safety. Reducing the cumulative adversities experienced early in life can have a positive impact on children’s physiological development and improve their lifelong health and productivity.

**Background.** This project proposes to develop a standardized BASICS Health and Safety Checklist using the expertise of our team who are experienced in instrument development and administration of health and safety assessment instruments. Over the past 15 years, we utilized the health and safety checklists developed by the University of North Carolina (UNC) Quality Enhancement Project,<sup>22</sup> California Childcare Health Program (CCHP),<sup>34</sup> ECELS-Healthy Child

Care PA,<sup>35</sup> Indiana's Child Care Health Consultant Program,<sup>36</sup> and recently the Health and Safety Checklist for ECE programs based on CFOC3.<sup>37</sup>

**CCHP's Development of Health and Safety Checklists based on CFOC.** The UCSF School of Nursing's California Childcare Health Program (CCHP) developed the CCHP Health and Safety Checklist in 2001, Checklist-Revised in 2005, and Checklist for ECE Programs based on CFOC3 in 2014.<sup>37</sup> The CCHP Health and Safety Checklist was designed to provide an **objective assessment** of an ECE program's ability to meet minimal standards in the 2<sup>nd</sup> Ed. of *SS and CFOC*.<sup>38</sup> The 66-item Checklist included a 3-point rating scale: '0' does not completely meet standard, '1' partially meets standard, '2' completely meets standard'.<sup>34</sup> Content and face validity and internal consistency were assessed. Reliability on six of the 10 subscales were analyzed using Cronbach's alpha and diapering, facilities, and outdoor/indoor equipment subscales showed showing moderate to strong on three subscales (alpha coefficient range 0.5 to 0.7). The **CCHP Health and Safety Checklist – Revised** was expanded (available at <http://www.ucsfchildcarehealth.org/pdfs/forms/H&SChecklist.pdf>) to include 82-items and simplified to be used by **child care and health professionals** in addition to researchers. The rating scale was 'completely meets standard' or 'does not completely meet the standard'. The items were reorganized into 11 subscales. Indiana's CCHC program modified the Checklist-Revised and there was moderate to strong internal consistency for the emergency prevention, handwashing, diapering, and infant/toddler food preparation/eating subscales (range 0.5 to 0.7) and strong internal consistency for all of the items (0.9).<sup>36</sup> The CCHP Health and Safety Checklist-Revised was used by CCHCs in at least 10 states including AZ, CA, Connecticut, Colorado, Indiana, Iowa, Pennsylvania, New Jersey, New York, and Washington. In addition, all of the Health Services Managers in Head Start programs in CA were trained to use the Checklist.

The **Health and Safety Checklist for ECE Programs using CFOC3** was developed in 2014.<sup>37</sup> The development of the Checklist included establishing face and content validity with a national advisory committee and a national Delphi study with child care health experts. The Checklist was pilot tested in Arizona, California and North Carolina by five CCHCs. The CCHCs completed the Checklist in 37 centers that served 2,627 low income, ethnically diverse children. The children were 36% White, 32% African-American, 16% Latino, 9% Asian, and 7% Native American. The pilot Checklists were completed in both infant/ toddler classrooms (75%) and preschool-age classrooms (25%). We oversampled the infant/toddler classrooms since these children are at high risk of injuries and infections in group care and we wanted to assess the infant/toddler item on the Checklist. Fifty-four percent of the children who attended the participating centers were receiving subsidies and thus, the majority of children were from low income households.

The CCHCs provided qualitative feedback on the project and the Checklist was user-friendly and easy to complete. The mean time to complete the Checklist was 2 hours and 15 minutes. Descriptive analyses by item and subscale were completed. The subscales with the lowest ratings (i.e., not able to meet the standards) were handwashing, toothbrushing, equipment safety outdoors and diapering infants. The subscales with the highest ratings (met standards) were supervision/ interaction/ activity, environmental health, and infant/toddler activity.

The psychometric analyses showed the alpha coefficients for internal consistency for the subscales ranged from weak to strong. There was a weak to moderate concurrent validity with the overall quality measures, the Infant Toddler Environmental Rating Scale-Revised (ITERS-R) or Early Childhood Environment Rating Scale-Revised (ECERS-R).

Based on the qualitative, process evaluation and quantitative psychometric statistics, the final Health and Safety Checklist was released in English and Spanish on the CCHP website ([www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)). The 124-item Checklist includes 72 CFOC3 standards and it was written at the 8<sup>th</sup> grade literacy level. The Health and Safety Checklist is being used in Alameda County, CA and Arizona's First Things First program to assess baseline health and safety in their QRIS Quality Counts programs.<sup>37</sup> The development of the Health and Safety Checklist and its psychometric properties was published in the *Maternal Child Health Journal* online in August 2015 (See Appendix – Checklist, User Manual, MCHJ electronic copy).

**The CCHP Health and Safety Policies Checklist** (2005) was modified from the UNC Quality Enhancement Project's *Child Care Evaluation Summary: Health Policy*. The CCHP Checklist includes 10 policies: exclusion of ill children, care of mildly ill children, administration of medications, daily health check, handwashing, sanitation, emergency preparedness, transportation safety, staff health, and inclusion of children with special needs. Each policy is rated as either present or not and if present, the quality of the policy is rated as excellent, good, fair or poor based on the number of CFOC standards are covered.

The **PA AAP/ECELS** is a nationally- acclaimed program of the PA Chapter, American Academy of Pediatrics. For over 25 years, PA AAP/ECELS has leveraged resources to improve early learning and school age child care programs in Pennsylvania. PA AAP/ECELS was used as a model by the federal government to encourage other states to establish statewide child care health and safety programs. Currently the program is a recipient of a federal, MCHB Early Childhood Comprehensive Systems (ECCS) grant assessing practices related to Infant Toddler Care as defined in 13 *Caring for Our Children* (CFOC3) standards.

**Caring for Our Children Basics (CFOCB)** as indicated earlier is the result of many documents and initiatives reviewed by ACF. One of the investigators, Richard Fiene, has worked for over 40 years in improving the early care and education delivery system in states, nationally, and internationally through the development of national health and safety standards. He is the original developer of the health and safety licensing key indicator and risk assessment statistical modeling widely used in state regulatory and licensing systems and these models have been used at the national (Head Start and National Early Childhood Program Accreditation) and international (several Provinces in Canada and the Cruise Industry) levels as well. He has worked with ACF, OCC, and ASPE on various licensing and white papers highlighting his research into differential monitoring, key indicators and risk assessment.

The National Association for Regulatory Administration (NARA) Licensing Curriculum highlights the Key Indicator, Risk Assessment and Differential Monitoring methodologies as important licensing tools and systems for state administrators. **Dr. Fiene** developed a series of generic key indicators (published as a research monograph by APSE) that have been used widely throughout *Caring for Our Children* and *Stepping Stones*, both in their third editions.

In addition to developing the key indicator, risk assessment and differential monitoring, Dr. Fiene has developed an innovative *Early Childhood Program Quality Improvement and Indicator Model (ECPQI2M4©)* now in its fourth edition which has helped to develop a frame of reference for validating and evaluating the cost efficiency and effectiveness of program monitoring which integrates licensing, professional development, training, technical assistance, accreditation, and quality rating and improvement systems in early care and education programs.

*CFOCB* and the resulting Checklist will go a long way in taking the above methodologies and having them coalesce into a national health and safety monitoring system for all early care and education.

## STUDY METHODS

### Sample and Setting

This project will include a convenience sample of centers and family child care homes. The CCHCs in this project will identify the ECE programs that meet the following enrollment criteria: state licensed, enroll children 0-5 years of age, and CCDF-funded. There will be a purposive sampling to include 50% centers and 50% family child care homes. Of the programs enrolled, the overall sample will include ~50% infant and toddler classrooms or family child care homes and ~50% preschool-age classrooms or family child care homes.

### Measures

**1. Child Care Center, Child, Director Demographics:** The CCHC will interview the directors to collect basic information on the center, child and director demographics. The information will include the type of program (Head Start, private, non-profit), hours of operation, licensing status, affiliation with a CCHC, # children enrolled by age in years, # children with CCDF funding or other subsidies, # staff both part-time and fulltime, and staff turnover. The director data includes sex, age, education, ethnic background, and time employed at the center and in the field. The child data includes the percent of children enrolled by ethnic/ racial background.

**3. The BASICS Health and Safety Checklist** will be an objective, observational instrument modified from the Health and Safety Checklist for ECE Programs and include all the Basics CFO3 standards. The **BASICS Health and Safety Checklist** will assess both written health policies<sup>39</sup>, immunization records, staff training records, and health and safety practices. The policies will be based on the *Model Child Care Health Policies*, 5<sup>th</sup> edition available on the PA AAP/ECELS website at [www.ecels-healthychildcarepa.org](http://www.ecels-healthychildcarepa.org). The new edition is a practical tool for adoption and implementation of best practices for health and safety in group care settings for young children. This tool is frequently used in Pennsylvania and nationally to help programs develop health and safety policies that correspond with the *Caring for Our Children* (CFO3) Standards.

### Data Collection Procedures

**1. To develop and establish the psychometric properties of a new BASICS Health and Safety Checklist for ECE programs as a mobile application.**

**A. Develop Checklist with items written at the 8<sup>th</sup> grade reading level.**

**B. Create the mobile application of the Checklist.**

**C. Establish psychometrics.** We will establish the validity of the NHS Checklist<sup>40</sup> in the following ways: (1) **Construct validity.** After the NHS Checklists are completed in 60 centers, we will establish the reliability of the BASICS Health and Safety Checklist in the following ways: (1) **Inter-rater reliability.** The CCHC will complete the Checklist alongside a gold standard (Dr. Alkon) until the CCHC achieves 90% agreement; Based on our past experience, we found that observing 2-3 centers was sufficient to obtain 90% agreement. (2) **Test-retest reliability.** The BASICS Health and Safety Checklist will be completed in 20 centers two weeks

apart to assess the stability of the measure over time. (3) **Internal consistency reliability.** The stability or reliability of the items within each subscale and total score will be computed using Cronbach's alpha coefficient. It will assess the consistency between items within each subscale and across the whole measure.

### **Statistical Approach**

**Establish psychometrics for the new BASICS Health and Safety Checklist.** To establish the psychometrics on the new NHS Checklist, analyses will be conducted as a sequence of steps to identify poorly performing items and subscales which will help us refine, update and finalize the BASICS Health and Safety Checklist. Based on the results of the psychometric analyses, poorly performing subscales or items will be deleted from the BASICS Checklist. This iterative process will provide a thorough evaluation of the BASICS Health and Safety Checklist and yield a final version of the BASICS Health and Safety Checklist that has high validity and reliability.

**Inter-Rater Reliability Analyses.** Inter-rater reliability will be assessed with each CCHC and Dr. Alkon, the 'gold standard', by completing the BASICS Health and Safety Checklist in the same site and calculating percent agreement on each BASICS Health and Safety Checklist item.

**Test-Retest Reliability.** Test-retest reliability will be assessed by correlating initial and 2-week follow-up BASICS Health and Safety Checklist subscales (n=20 centers).

**Internal Consistency Reliability Analyses.** For internal consistency reliability analyses for each subscale and the total BASICS Health and Safety Checklist, we will compute Cronbach's coefficient alpha. Items whose deletion results in a non-trivial increase in alpha will be removed from subscales, further strengthening those subscales.

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