Preface

This paper was originally written in 2000 as a chapter in the NARA Licensing Curriculum dealing with the subject of licensing tools and systems. Since then, many changes and refinements have occurred in the human services regulatory administration field related to measurement and program monitoring. This paper will address many of these updates within the context of the original NARA Licensing Curriculum chapter since many of those original concepts are still relevant today.

Since 2000, several original results related to regulatory compliance have been supported and enhancements to what was called inferential inspections and now is called differential monitoring have occurred. We have continued to see that key indicator/predictor rules have remained very constant over the past 15 years. The original 13 key indicators of licensing and quality have not changed a great deal – 10 of the original 13 are still present. An important question is, why is this the case, for example why is compliance with a rule related to proper immunization of children a key predictor rule discriminating between high and low overall compliant programs.

Another result that has held up over the years is the non-linear relationship between program compliance and program quality. This continues to be a controversial and troubling relationship from a public policy point of view.

Other areas that need further development is for validation studies to make certain that differential monitoring, risk assessment and key indicators work as intended. There is substantial anecdotal evidence but a solid empirical base needs to be established for these various licensing and monitoring system methodologies.
Introduction

Measurement within licensing and regulatory administration has changed dramatically over the past 40 years. In the 1970s it was more qualitative in nature rather than its quantitative nature today. The qualitative nature was depicted with long narratives obtained from in-depth observations and interviews that described a facility in detail with a listing of violations with specific rules. The observations used a running record format in which a detailed accounting of the facility was obtained. This qualitative system worked well when there were few facilities to be assessed. However, as the number of human care facilities increased and licensing agency administrators felt a greater need to understand compliance trends, movement to a more quantitative measurement system evolved.

This move to quantification of measurement began in earnest in the 1970’s. The notion of an instrument based program monitoring or licensing system began to be examined by licensing agencies. Checklists and rating scales were employed, with checklists being used predominantly because of the nature of regulatory compliance, an all or none phenomenon. However, a few states, provinces and cities have considered the use of rating scales to measure compliance with rules. More will be said about the differences between checklists and rating scales later.

By the early 1980s with severe federal cutbacks in funding, licensing administrators found themselves with an increasing number of facilities to license but fewer funds to perform these program monitoring and investigative functions. In response to this concern, more streamlined or abbreviated program monitoring systems were developed utilizing a differential monitoring format, such as the key indicator or indicator checklist methodology which utilized a shortened version of the comprehensive checklist approach used by many states. Key indicator systems have been developing over the past 40 years and in many states are key components of their monitoring and licensing functions as they form a basis for risk assessment regulatory analyses. The key indicator system along with risk assessment systems are two forms of what is known in the human service licensing/regulatory administration literature as differential monitoring inspections. For the interested reader, two federally produced publications, a white paper on program monitoring innovations published by the Assistant Secretary’s Office for Planning and Evaluation and a licensing brief on differential monitoring, risk assessment, and key indicators published by the Office of Child Care in the Administration for Children and Families are highly recommended. These two resources are cited in the resource section at the end of this document.
A related but very different technique that complements key indicator systems is the use of weighting or risk assessment systems to determine the relative risk for morbidity or mortality of specific rules related to non-compliance. The original reason for the development of weighting/risk assessment systems is the nature of regulatory compliance data. Because compliance data measure minimum health, safety and well-being rules, the data are highly skewed with very little variance. The use of risk assessment systems was to help to increase the amount of variance in the regulatory data sets. However, risk assessment systems over the past 40 years have taken on a life of their own and are used by many states as stand-alone abbreviated differential program monitoring systems. It is estimated that more states employ a risk assessment approach rather than a key indicator approach when applying differential monitoring.

The key indicator and risk assessment systems have not been limited to licensing and regulatory administration systems but have also been developed and used for other program quality endeavors, such as accreditation, quality rating and improvement systems, national and international standards setting.

**Definitions**

*Instrument based program monitoring* – a movement within licensing and regulatory administration from qualitative measurement to a very quantitative form of measurement that includes the use of checklists. This move to more quantitative has been encouraged as more and more states develop electronic data systems.

*Key indicator system* – a licensing measurement system utilizing a shortened or abbreviated version of a comprehensive checklist measuring compliance with rules through a statistical methodology. Only key predictor rules are included on an indicator checklist. It is a form of differential monitoring or inferential inspections where only a portion of the full set of rules is measured.

*Differential monitoring/inferential inspections* – an abbreviated inspection utilizing a select set of rules to be reviewed. A key indicator system or a risk assessment system are two examples of differential monitoring approaches. The use of differential monitoring/inferential inspections by licensing agencies was developed as a time saving technique and a technique to focus regulatory efforts on facilities that required additional inspections or technical assistance.

*Checklist* is a simple measurement tool that measures compliance with state rules in a yes/no nominal format. Either the facility is in compliance with rules or not in compliance. Generally, there is no partial compliance with checklists. Having regulatory compliance data being at a nominal measurement level creates limitations statistically in the types of tests that can be completed.
Rating scale is a more complex measurement tool in which a Likert type of rating is employed going from more to less or high to low. A rating scale is always used in the development of weighting/risk assessment systems. It is not used in measuring compliance with rules or at least it hasn’t been used in the past.

Risk Assessment/Weighting system is a Likert type of measurement that utilizes a modified Delphi technique to determine the relative risk to individuals if there are violations with specific rules. Risk assessment/weighting systems are developed by sending a survey to a selected sample of persons/stakeholders in order for them to rank the relative risk of violation with specific rules.

Outcome based systems are measurement systems based upon outcomes, not processes. A facility would be assessed by the outcomes it produced with individuals. For example, the number of consumers (children or adults) developing normally, free from abuse, not in placement, involved actively in the community, properly immunized, free from injuries, etc. are outcome based measures.

Instrument Based Program Monitoring

Instrument based Program Monitoring (IPM) is a particular approach to measurement and assessment. It is in contrast to a more qualitative type of assessment (case study is an example of this type of assessment). IPM is very quantitative and is characterized by the use of checklists (see the next section for a discussion of checklists). The advantages of instrument based program monitoring are the following: cost savings, improved program performance, improved regulatory climate, improved information for policy and financial decisions and the ability to make state/province comparisons.

IPM was a paradigm shift in conducting licensing inspections and licensing of facilities when it was first introduced in the late 1970s – early 1980s. More recently it has come under scrutiny to see if a more balanced approach employing a combination of quantitative and qualitative tools is more appropriate. With that said, IPM is an approach that lends itself to automation, it is objective and it is generally systems-oriented. The IPM approach came into its own in the 1970s and has been used predominantly since then as the primary licensing measurement approach. As stated, some state administrators have argued that the IPM approach is not as effective as the more qualitative, narrative case study approach although they can’t argue with its efficiency. A combination of IPM (quantitative approach) with a qualitative approach is probably most effective; however, this is very time consuming and a luxury that most state/province licensing agencies do not have, with more and more facilities to license and fewer and fewer staff to do the licensing.
Checklists

Checklists are the predominant means of collecting licensing data. It simplifies the process, making it very quantifiable. This is one of its strengths, but along with this simplification, a drawback is that some of the richness of the description of a particular facility is lost.

There are particular steps that need to be followed in the development of the checklist. Licensing administrators need to follow this four step process:

1) Make interpretations of the rules part of the overall manual for measurement of the comprehensive set of rules.
2) Identify the rules to be included in the checklist.
3) Consider the organization of the checklist – the flow of the investigation to the facility.
4) Decide what type of record keeping will be used – paper, tablet, laptop, etc.

Rating Scales

Rating scales will not be discussed in detail because their applicability to licensing measurement is rather limited. Only in cases where a licensing administrator was interested in some form of partial compliance would rating scales make sense. The NAEYC (National Association for the Education of Young Children) accreditation system is one example of the use of a rating scale of full, partial or non-compliance with accreditation standards. Many QRIS (Quality Rating and Improvement Systems) use rating scales through the ERS (Environment Rating Scales). While a partial compliance rating may be useful in accreditation standard measurement or QRIS standards measurement, it is generally not appropriate for use in licensing rule measurement.

Most licensing agencies do not use partial compliance, and the movement within the regulatory administration field is to consider partial compliance as being equivalent to non-compliance. Either a facility meets the rule or does not meet the rule. There is no middle ground.

Weighting/Risk Assessment Systems

Weighting/risk assessment systems and licensing indicator systems that are described in the next section are enhancements of the basic checklist (instrument based program monitoring) system. Weighting/risk assessment systems are used to increase the amount of various in licensing compliance data. Because licensing data are nominal data (‘yes’ or ‘no’ compliance) and are generally highly in compliance, there is little variance in the data set from any particular set of rules. In order to increase the variance in data, weighting/risk assessment are used so
that each rule does not have an equal weight. If you do not weight rules, by default, you have given an equal weight to each rule.

The remainder of this section describes the process for developing a licensing weighting/risk assessment system for use in the implementation of human care licensing rules, displays data from states that have used this approach and discusses the applicability of weighting/risk assessment system for all types of human service licensing.

A licensing weighting/risk assessment system is a regulatory administration tool designed for use in implementing human care licensing rules. A licensing weighting/risk assessment system assigns a numerical score or weight to each individual licensing rule or section of a rule, based upon the relative health, safety and welfare risk to the consumers if a facility is not in compliance with the rule. The type of license issued is based on the sum of the numerical weights for each rule that is not in compliance.

The specific objectives of a licensing weighting/risk assessment system are:

a) To standardize decision-making about the type of license to be issued.
b) To take into account the relative importance of each individual rule.
c) To ensure that rules are enforced consistently.
d) To improve the protection of consumers through more equitable and efficient application and enforcement of the licensing rules.

A licensing weighting/risk assessment system can and should be developed and implemented only if:

1) Regular or full licenses are issued with less than 100% compliance with all rules. If a regular license is not issued unless all violations are corrected at the time of license issuance, a weighting/risk assessment system is not necessary. A weighting/risk assessment system in useful if a facility is issued a license with outstanding violations (and a plan to correct the non-compliance areas) at the time of license issuance.

2) There is a large number of licensing rules with a variation of degrees of risk associated with various rules. If there are only a few rules with equal or similar risk associated with each rule, a weighting/risk assessment system is not necessary. A weighting/risk assessment system is useful if there are many rules with varying degrees of risk.

3) A standardized measurement system or inspection instrument is used to measure compliance with licensing rules. Before developing a weighting/risk assessment system, a standardized measurement instrument or tool should be developed and implemented.
Development of a Weighting/Risk Assessment System

This section will provide a step-by-step process in the development of a weighting/risk assessment system for licensing agency use.

1) The first step in developing a licensing weighting/risk assessment system is the development of a survey instrument. A licensing inspection instrument or measurement tool can be adapted into a survey tool…the survey should contain each rule or section of a rule, according to how it is measure in the inspection instrument. Survey instructions should explain the purpose of the survey and instructions for completing the survey instrument. It is suggested that survey participants rate each rule section from 1-8 based on risk to the health, safety and welfare of the clients if the rule is not met (1 = least risk; 8 = most risk). The survey participant should be instructed to circle their rating choice of 1, 2, 3, 4, 5, 6, 7, 8. An example of a survey question is:

Interior stairways, outside steps, porches and ramps shall have well-secured handrails.

Low Risk  1  2  3  4  5  6  7  8  High Risk

2) Surveys should be disseminated to at least 100 individuals. If a state has more than 3,000 licensed facilities in the type of service being surveyed, consideration for surveying more than 100 individuals should be given. Individuals surveyed should include providers of service; provider, consumer and advocacy associations; health, sanitation, fire safety, medical, nutrition and program area professionals; licensing agency staff including policy/administrative staff and inspectors; consumers of service; parents; and funding agency staff. In order to assure a higher survey return rate, persons selected as survey participants should be contacted prior to the survey to explain the weighting/risk assessment system and request their willingness to complete the survey.

3) Survey results from each survey should be collected and entered into a computer data base spreadsheet software package or an online survey software. After all survey data are recorded, means or average weights for each rule or section of a rule should be calculated. If there is sufficient variation in the means for each rule, the individual rule means can be rounded to the nearest whole number. Generally when comparing mean
weights among the various groups surveyed there should be a similarity in rating among the groups, supporting the use of the weights as a reliable measure of risk.

4) The next step is to either (a) pilot test the weights with new licensing data for about six months, or (b) apply the weights to a least 25% of historical data from the previous 12 months. The intent of the pilot application is to collect data to use as the database for determining statistical cut-off points for the issuance of specific types of licenses or for administration of various negative sanctions. A total weighted score for each facility based upon the combined weights of all violations should be calculated. Following is an example of how the scores should be calculated:

<table>
<thead>
<tr>
<th>Rule Violations</th>
<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule 1</td>
<td>7</td>
</tr>
<tr>
<td>Rule 2</td>
<td>6</td>
</tr>
<tr>
<td>Rule 3</td>
<td>-8</td>
</tr>
</tbody>
</table>

Sum of Weights = 21

Under the above example a perfect compliance score with no non-compliance areas would be a score of “0”. The higher the score, the lower the compliance would be. However, this is not congruent with the common usage of scores in which the higher score is associated with better compliance. In order to accommodate our familiarity with higher scores for the better facilities, the weighted score should be deducted from an arbitrary constant score of “100”. Thus a weighted non-compliance score of “20” will convert to a positive score of “80”. This is more intuitive to individuals as they think about scores and measurement.

Using the previous example, the final weighted score would be computed as follows:

<table>
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<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule 1</td>
<td>7</td>
</tr>
<tr>
<td>Rule 2</td>
<td>6</td>
</tr>
<tr>
<td>Rule 3</td>
<td>+8</td>
</tr>
</tbody>
</table>

Sum of Weights = 21

Final Calculation:

\[ 100 - 21 + 79 \]
5) The fifth step in the process is to compute and apply the standard deviation to the data. The mean and standard deviation of all weighted scores computed in the pilot application in step #4 should then be calculated. The mean and standard deviation of all final weighted scores computed in the pilot application in step #4 should then be calculated. Based upon experience with implementing licensing weighting/risk assessment systems, it is recommended that if a final weighted score is no more than one standard deviation below the mean, a regular license should be issued. If a score is between one standard deviation below the mean and two standard deviations below the mean, a provisional license should be issued (the length of the provisional license will vary based upon the severity of the non-compliance), or intermediate negative sanctions should be administered. If a score is less than two standard deviations below the mean, no license should be issued or a more severe negative sanction should be administered.

For example, if the standard deviation is 18 and the mean is 88, following is the distribution of the weighted scores used to determine the type of license to be issued:

- **Score of 100 — 70 = Regular license/no sanction**
- **Score of 69 — 52 = Provisional license/intermediate sanction such as warnings, administrative fines or restriction on admissions**
- **Score of 51 and below = No license/severe sanction such as revocation or administrative closure**

6) The final weighted scores from the pilot application should be applied to the standard deviation cut-off points to determine the type of license or negative sanction issued. These data should be studied to compare types of licenses or sanctions issued under pre-weighting vs weighting.

7) Before implementing the licensing weighting/risk assessment system the following additional licensing factors should be considered and incorporated as necessary into the licensing system.

   a) Repeated violations from the previous licensing inspection;
   b) Violation with high risk items (possibly a weight of 8.0);
   c) Discretion of licensing inspector to recommend variance from licensing weighting system.

8) Whenever licensing rules are amended, or at least every 5 years, the weights should be recomputed and the weighting system re-evaluated. The licensing weighting system as described here can be used to license any type of human care facility including child care, adult care, residential care and part-day care facilities. Licensing weighting/risk assessment systems have been developed in the majority of states.
Since the concept, development and implementation of weighting/risk assessment systems is relatively new to the field of licensing, the long term impact and benefits of weighting/risk assessment systems have not been fully realized through the use of validation studies (Please see the section on Future Research to address this concern). The potential of using weighting/risk assessment systems and modifications of weighting to help standardize the implementation and enforcement of licensing rules is an exciting area of research to pursue in the field of regulatory administration.

**Licensing Indicator Systems**

As mentioned in the weighting/risk assessment system section of this chapter, indicator checklists or licensing indicator systems are used to improve upon instrument based program monitoring (checklist) systems. The licensing indicator system is one method of assuring compliance with licensing rules in a time efficient manner. The concept has been developed and successfully implemented in several states and for different human service types. The licensing indicator system was originally developed in Pennsylvania in 1977 for use in licensing child care centers. The original intent was to develop an abbreviated licensing instrument in order to refocus licensing investigation time to assess and assist in quality enhancement activities.

From 1980-1984, the US Department of Health and Human Services funded a project to study and further develop a licensing indicator system for child day care facilities on a national level. The federally funded project, known as the Children’s Services Monitoring Transfer Consortium, organized researchers, state licensing administrators and professional staff from Pennsylvania, Michigan, West Virginia, Texas, New York City and California to review and refine the existing Pennsylvania system for possible use by other states.

The purpose of a licensing indicator system is to increase the efficiency and effectiveness of an existing licensing system by refocusing the emphasis of the licensing process. A licensing indicator system is intended to complement, and not replace, an existing licensing measurement system. Through use of the licensing indicator system, less time is spent conducting annual inspections of facilities with a history of high compliance with the licensing rules, and more time is spent a) providing technical assistance to help facilities comply with licensing rules and b) conducting additional inspections of facilities and agencies with low compliance with licensing rules.

The licensing indicator system is actually a shortened version of a comprehensive licensing inspection instrument. A small number of rules are selected based upon a statistical methodology designed for this specific purpose. The licensing indicator system uses a measurement tool, designed to measure compliance with a small number of rules that predicts high compliance with all the rules. If a facility is in complete compliance with all of the rules
measured in the licensing indicator system, high compliance with all the rules is statistically predicted. It is critical to understand that the rules for the licensing indicator system are selected statistically (the statistical technique is called the phi-coefficient and generally is set at a p value of .01 or higher) and not based upon value judgement (arbitrary assignment, no basis from research literature), risk assessment or frequent rule violations. The rules are selected based upon an SPSSPC+ computer software package that compares violations of facilities with high compliance versus facilities with low compliance. The rules that are most often out of compliance in low compliance facilities and in compliance in high compliance facilities will be the indicator or predictor rules.

**Prerequisites for implementing a licensing indicator system**

Before developing and implementing a licensing indicator system it is important that the existing licensing system is comprehensive and well established. The following are prerequisites to implementation of an indicator system:

1) Licensing rules must be comprehensive, well written and measurable. Rules are the building blocks for any licensing system. If the rules are not well written and measurable a licensing indicator system should not be pursued. Also, if the total number of rules is small, a shortened inspection tool is not valuable.

2) There must be a measurement tool designed to standardize the application and interpretation of the rules. A licensing inspection instrument designed to assure statewide consistency in the application of the rules is essential prior to implementing a licensing indicator system.

3) There should be a licensing weighting system designed to assess the relative risk to consumers if the rule is not met. This system may be a formal weighting system or a simple classification system which categorizes rules by degree of risk. An example of a high degree of risk to consumers would be the accessibility of heat sources or toxins. Having a signature in a record is an example of a low degree of risk to consumers.

4) At least one year of data on rule violations for individual facilities. These data are needed to enter into the computer software system in order to determine the rules that are the indicators or predictors of high compliance.

**How to develop a licensing indicator system**

The basic steps to developing a licensing indicator system include:

1) Select facilities to be used in determining the indicators. If the total number of licensed facilities is less than 200, all 200 facilities can be used. If the total number of licensed facilities exceeds 200, sampling must be done. Generally, a sample of 100 facilities or 10% is acceptable.
When selecting the sample, variables of size of facilities, geographic area, urban/rural, profit/non-profit, public/private and varied compliance levels or scores must be controlled.

2) Violation data for the sampled facilities is entered into a computer software system designed for this purpose (SPSSPC+ is recommended but other statistical packages will do the same).

3) A list of indicator or predictor rules, based on phi coefficients, that were the best indicators of high compliance will be calculated by the computer software system. These are the rules that are most often out of compliance in low compliance facilities and in compliance in high compliance facilities.

4) A small number of additional rules which are determined based on a licensing weighting system or relative risk are added to the statistically selected indicators. The purpose of this step is to assure face validity of the instrument. By adding a smaller number of carefully selected high risk rules to the instrument, the licensing agency can be assured that critical rules are always measured.

5) In order to assure that full compliance with all the rules is maintained, five items selected at random should also be applied as part of the licensing indicator system. The final licensing indicator system instrument contains the indicator rules, high-risk rules and random rules. The total number of rules on an indicator checklist will vary, but will range from 20-45 items.

6) Specific criteria for use of the licensing indicator system are developed.

**Criteria for use of the licensing indicator system**

The development of very specific criteria for use of the licensing indicator system is perhaps the most critical step of the design process. This is the step at which the determinations are made as to when the licensing indicator system will be used. The determination of use of the system should be standardized and not based upon licensing inspector discretion.

Each licensing agency must develop its own criteria based upon its own historical licensing data and experience. Following are some criteria that may be useful:

1) The facility has had a full or regular license and no negative sanctions have been administered, within the previous two (2) years.

2) The facility has had a score or percentage of compliance above a specified threshold for the previous year.

3) All previous violations have been corrected according to the facility’s plan of correction.

4) No significant validated complaints have been found within the past year.

5) The total number of consumers served has not increased by more than a specified percentage during the past year.
6) There has not been significant staff turnover at the facility/agency within the past year. This may be targeted to certain levels of staff turnover, such as direct care staff or facility directors, depending on which staff are particularly key for program stability.

7) A full inspection using the comprehensive licensing measurement instrument must be done at least every three (3) years.

**Revision of the licensing indicator system**

The licensing indicator system should be continually reevaluated for its effectiveness. The system should be completely revised at least every three years or upon a revision of the rules. In order to achieve the intended purpose of the licensing indicator system of refocusing the emphasis of licensing effort from facilities with high compliance to facilities with low compliance, constant review, evaluation and revision of the licensing indicator system is essential.

Other types of inferential inspection/differential monitoring systems, of which the licensing indicator system is only one, will not be addressed in this chapter because inferential systems/differential monitoring other than the licensing indicator system have not been determined to be statistically valid or reliable. As licensing administrators may potentially need to defend their actions in a court of law, it is essential that the methodology or technique utilized is scientifically sound. When it comes to inferential inspections only those instruments based upon an indicator or weighting/risk assessment methodology can stand up to this rigorous testing.

**Outcome Based Systems**

This is a relatively new phenomenon in the licensing and regulatory administration field. The emphasis in this new approach is to examine outcomes rather than processes. What are the ultimate outcomes for individuals? Determine this and the argument goes there is no need to measure processes directly.

Outcome measurement is appealing in many respects. It does focus on results, something the human services field has been short on demonstrating. However, there is a fallacy in this approach. Results are the end product, but we always have a process to get to the end product.

Another issue is that the purpose of licensing is to prevent harm to consumers. A purely outcome-based system would potentially harm consumers who were in the facilities later determined to “fail” the outcome test. Moreover, there are two other problems:

1. Insufficient (political) agreement on what are acceptable outcomes.
2. Some outcomes will not manifest for years and/or are contaminated by other variables related to other influences on later behavior.

What makes more sense is to tie outcomes to specific regulatory processes that appear to be in a causal or at least a correlational relationship. If licensing agencies were able to clearly link specific results (outcomes) to specific rules (processes), there would be the empirical ability to focus only on those rules that produced positive results for consumers and families and eliminate all other unnecessary rules that do not produce positive outcomes for consumers and families. Specific studies could be conducted and in fact have already been conducted by university researchers. In child care, for example, low staff:child ratios, pre-service and in-service training of staff, highly qualified staff and small group size are all examples of regulatory variables that have been identified as surrogates to program quality that produce positive outcomes for children.

Outcome based or results-oriented systems will impact licensing, but the research literature demonstrates how licensing agencies can clearly link outcomes to regulatory processes that produce the outcomes. This becomes a powerful argument to legislators when this roadmap of process to outcome can be provided.

**Relationship Between Rules and Instruments**

This section is included because this is one area that gets many licensing administrators into trouble. Not enough time is spent on making sure that the instruments developed are the exact reflection of the rules. This is where the interpretive rules that are part of any measurement instrument that accompanies the actual instrument should be placed. This helps to increase the reliability of the instrument and doesn’t hurt the overall validity of the tool either (more on reliability and validity in the next section). Readers who are interested in doing additional reading in this area should refer to the NARA Licensing Curriculum’s chapter on The Formulation of Rules, for additional information on the definition and development of interpretive and substantive rules.

When there is not a close link between instrument development and rule formulation this only leads to headaches for licensing agencies. It may take years and not be evident until you get called into a court of law to defend your licensing system but it will happen.

An analogy taken from the original 2000 manuscript of playing Russian Roulette may still be useful. As licensing administrators, you are never 100% certain that all your facilities are compliant with all the rules. However, there are certain management procedures and processes that you can put in place to help. A clear link between rules and measurement tools is one of them. Since you are never 100% sure of full compliance (in other words all six chambers of the revolver are not empty if they were, you wouldn’t have Russian Roulette), you
must make difficult decisions related to increasing or decreasing your chances in playing Russian Roulette. So you have the choice of having the management and procedural safeguards built in (one or two bullets in the revolver) or you don’t build in the procedural safeguards (four or five bullets in the revolver). It is obvious statistically where your chances are greater in surviving a potential mishap in a licensing system.

**Reliability and Validity**

The two concepts of reliability and validity are so critical to measurement, but are so often overlooked in the development of licensing measurement systems. In fact, it has been estimated that as many as 30 states may be using a type of differential monitoring/inferential inspection. But only a few states have followed the rigorous statistical methodology as outlined in the Licensing Indicator System section.

Very simply, validity deals with content of the particular tool or instrument does it serve the purpose for which it is to be used? Does it measure the rules accurately? Usually the answer to this question is easier for licensing administrators to answer. Since licensing measurement tools should be directly based upon rules, as explained in the previous section, there should not be much difficulty in establishing validity. When the tools are not based on the rules that is when validity can be and should be called into question.

Reliability deals with the administration of the tool or instrument. Does it measure the rules consistently and in an objective manner? The answer to this question is much more difficult for licensing administrators to answer affirmatively. This poses real problems if each administration of the licensing tool is not consistent and objective. Facilities will not have the rules applied in an equal and fair manner.

Reliability testing should be done methodologically and scientifically. Inter-rater reliability should be established for the tools/checklists that are to be used in the field by licensing field staff. This is a process that has been well documented in the psychological research. This has not been the case within licensing and regulatory administration. Generally checklists are designed quickly and are never tested for reliability. This creates a problem that many of us have heard—the rules are not applied uniformly across the state/province. The reason is that the tool that is used to measure compliance is not reliable.

In order to establish reliability, licensing inspectors need to go out to facilities in pairs assessing the same facility at the same time. They then need to compare their results. Do they agree on what is in compliance and out of compliance at the particular facility? If there is not at least 90% agreement for each rule then additional interpretation of that specific rule is needed. Establishing reliability is not overly difficult nor overly time consuming; however, it will add a bit
more time before staff are really ready to begin to license facilities (90% agreement on each rule and interpretative rule).

**Balance Between Compliance and Program Quality**

An interesting development in the past five years has been the emphasis on program quality as a result of pressure from consumers, families, advocates and the general public. Consumers and other interested persons are requesting licensing agencies to ensure not only the health, safety and well-being of individuals served in facilities, but also to be concerned advocates for the overall quality of services provided at these facilities.

This increased emphasis and concern for program quality is a difficult area to address for licensing agencies. The resources to complete program quality reviews and to advocate for quality within government are not commensurate with the expectations. However, there are some strategies that can be employed to assist licensing agencies. The first and foremost will be to save time on doing licensing inspections. The indicator system described in this chapter will provide such a tool for saving time. Studies conducted over the past two decades indicate that utilizing an indicator checklist approach saves up to 50% in the on-site inspection time.

The time saved in doing licensing inspections should be used to either:

a) Conduct additional licensing inspections in new or problem facilities  
b) Provide technical assistance  
c) Complete program quality reviews

This could be done by utilizing a tool from accreditation in observing classrooms, or utilizing a program quality tool from the research literature (for example, Early Childhood Environment Rating Scale). Licensing administrators need to be certain that they have a plan to utilize this extra time or the worst fears of licensing professionals could occur. Two potential scenarios could play out. One is that the time is used to do more and more licensing inspections utilizing the indicator system on more and more facilities. The worst scenario is that staffs are cut. If a state/province can complete all its inspections in half the time, then doesn’t it follow that only half the staff is needed? With a clearly articulated plan on how the licensing and program quality reviews will produce higher quality programs should help to prevent this cost cutting approach. However, this is always a fear that licensing administrators must face.

**Regulatory Compliance Theory**

A very important discovery which has now been replicated on several occasions is the relationship between regulatory compliance and program quality. The essence of the relationship forms the basic tenet for the use of a key indicator approach which states that
there is a non-linear relationship between regulatory compliance and program quality. In laymen’s terms, programs that score low on regulatory compliance also score low on program quality measures but when one looks at the full and substantial levels of regulatory compliance the program quality measure scores plateau out where it is difficult to discriminate between program quality. There appears to be a ceiling effect which makes it difficult to say that those programs that are 100% in compliance with all rules are also the best quality programs. This is not always the case and in fact, many times, those programs that are in substantial compliance have higher program quality scores.

From a public policy perspective this creates problems in requiring a hard line on full (100%) regulatory compliance. A more effective public policy would be to require substantial compliance identifying those rules that predict overall compliance and quality. This is the essence of the key indicator approach in identifying those predictive rules.

From a statistical perspective this is an important consideration because it leads us in the direction that the methods we should be using will be non-linear rather than linear. This may help to explain some of the reasons why we haven’t been finding significant relationships between program compliance and quality.

The above relationship has been replicated in several regulatory compliance studies and the predictive rules have been replicated in several regulatory compliance studies as well. On the basis of this relationship it makes possible for policymakers to consider more effective and efficient program monitoring and regulatory compliance strategies.

**Extreme Skewness of Licensing Data**

A very important facet of regulatory compliance data is that it is extremely skewed and not close to being normally distributed. Now, why is this important? It makes it very difficult to analyze skewed data because there is very little variance in the data. It becomes difficult to discriminate between levels of quality and regulatory compliance because only one or two rules that are non-compliant may separate 100s of programs. There is less chance that this will be the case when data are normally distributed, it is generally easier to distinguish between the top performers and the mediocre performers.

It was because of this problem that the concept of weighting of individual rules was introduced in order to enhance the differences amongst the various rules. This weighting of rules has led to the development and implementation of risk assessment systems as stand-alone systems for measuring regulatory compliance and the differential monitoring of programs.
Early Childhood Program Quality Improvement & Indicator Model (ECPQI2M4)

An outgrowth of the above approaches is a comprehensive model that can be used to help improve quality called the Early Childhood Program Quality Improvement and Indicator Model (ECPQI2M4). This model is in its 4th edition utilizing a risk assessment, key indicator and differential monitoring approach (DMLMA4). The reason for introducing these models is to provide an overall structure for states when attempting to develop their program monitoring systems. This model provides crosswalks from licensing and program compliance to more focused program quality improvement systems, such as Quality Rating and Improvement Systems (QRIS), professional development, early learning, and accreditation.

These models provide a paradigm shift in how we address the balance between program compliance and quality by focusing only on those standards that are proven to make a difference. In 20 years we will have fewer regulations and standards and better outcomes for children because the program monitoring system will be working smarter, not harder. Only those standards that empirically demonstrate a positive impact will be enforced, all others will go by the waste-side.

Methodological Issues

These are some of the key methodological issues that have surfaced over the past 40 years that will need to be addressed if we continue to use these methodologies:

1) The need for states to routinely conduct reliability testing is vitally important to make sure that their licensing staff/inspectors are consistently measuring rules.

2) The balancing between program compliance and program quality.

3) Determining the most effective and efficient threshold is critical because as one becomes more efficient a loss of effectiveness does occur which can lead to an increase in false positives and negatives. False positives are not as critical as false negatives because it would only involve inspecting programs with a comprehensive review that wasn’t necessary; but with a false negative a program could be missed that really did need a full comprehensive review rather than an abbreviated review. To solve this threshold issue will take a good deal of sensitivity analyses to determine the correct number of key indicator/predictor rules to be included. For example, it is important in selecting your p value since the more stringent you are, the fewer indicators will be able to make the threshold score. The less stringent your p value will produce more indicators making the threshold score. When the later occurs you will have fewer false negatives but could have more false positives occur.
Lessons Learned

Over the past 40 years here are some lessons learned which should help us as we move forward:

1) We have learned how to deal more effectively with very skewed data through dichotomization grouping of a high versus a low compliant groups.

2) Risk assessment only focuses on compliance and high risk rules which generally are always in compliance. This provides an interesting dilemma when thinking about the efficiency of this approach. One can’t argue with its effectiveness because you are monitoring for risk and the prevention of harm which is the essence of regulatory compliance. But is it really efficient to review rules that are generally in compliance. Isn’t it more efficient to monitor rules that discriminate between high vs low compliant programs to determine if a more comprehensive review needs to be done. Keep in mind that risk assessment is based upon weighting of rules which was never intended to be used as a stand alone system but rather one to enhance the key indicator methodology by creating more variance in the data. A validation study to determine if risk assessment systems really work in finding additional non-compliance is warranted as is the basic tenet of key indicator systems.

3) Key indicators focus on high and low compliance differences with these rules generally being somewhere in the middle range, not in compliance the majority of the time nor out of compliance the majority of the time.

4) It continues to be a fact that all rules are not created equal nor are they administered equally. This is very important concept for risk assessment systems as well as a measurement issue in that we are not dealing with equality in measuring each rule. This is where the weighting of each rule comes into play.

5) Most recently we have seen that when higher standards are applied, especially with Pre-K initiatives, this goes a long way in helping to discriminate the top performers from the mediocre performers. With licensing data which is very skewed this has been a real problem in discriminating between the best programs and those that are at a lower level. Because the data are so skewed all these high performer and mediocre programs are all grouped together. This is the nature of regulatory compliance data which does not do a good job of distinguishing between the best and the near best, what it is good at is determining the really poor performing providers.

6) With both risk assessment and key indicators being used over many years now and with the data being fairly consistent as evidence by the Stepping Stones and Thirteen Indicators of Quality publications we have seen the development of national standards in Caring for Our Children Basics (See Resource Section at the end of this document for citation listings).
Future Research

Here are some of the key research that needs to be accomplished in the near future related to human service licensing measurement, regulatory compliance, and program monitoring systems.

1) The crucial need for future research in the human services licensing and regulatory compliance area is for validation studies of the above approaches, Key Indicators and Risk Assessment methodologies to make certain that they are working as they should. This crucial need has been pointed out by other authors with the ASPE White Paper as the most poignant example of this suggestion.

2) Another validation study is needed regarding the relationship between program compliance and program quality. This is such an important finding about the plateau of program quality scores with increasing regulatory compliance as one moves from substantial compliance with all rules to full compliance with all rules.

3) A clear delineation needs to occur to establish appropriate thresholds for the number of key indicator/predictor rules that provide a balance between efficiency and effectiveness that can diminish the number of false positives and especially false negatives.

Conclusion

The original NARA Licensing Curriculum chapter provided a brief overview to the major issues confronting licensing administrators when they consider licensing tools and measurement systems. The emphasis upon quantitative systems was reflected in this chapter because of the need to develop cost effective and efficient licensing systems as the number of facilities continues to grow with shrinking resources. Also there is a compounding effect with higher expectations on licensing agencies to be concerned more about program quality.

The chapter showed the various types of measurement tools that apply to licensing and regulatory administration. It is clear that given the nature of licensing there are certain tools more suited than others, such as checklists versus rating scales. A very detailed description of both licensing weighting /risk assessment and indicator systems was provided. The reason for this emphasis is that these are two very valid and reliable tools that can be used by licensing administrators in making their agencies more effective and efficient. The licensing measurement field is changing constantly as new approaches are introduced. For example, within the program evaluation field there is a move to have a better balance between quantitative and qualitative analyses. It will not be long before this initiative has its impact on the licensing measurement field as well.
This paper has provided a much needed update to what is occurring within the human service licensing and regulatory compliance area. It reviewed what has been in place for several decades but also provided new material to consider in future research, methodological issues, and lessons learned. To summarize what we know about human service licensing measurement, regulatory compliance, and program monitoring:

- The relationship between regulatory compliance and quality is not linear.
- Regulatory compliance has difficulty in distinguishing the best programs from the mediocre programs.
- Regulatory compliance is very effective at identifying the worse programs.
- There still is the need to balance regulatory compliance with quality indicators.
- There is the need to validate differential monitoring approaches, such as risk assessment and key indicators.
- What is the ideal threshold for the number of key indicator/predictor rules so that we can maintain a balance of program monitoring effectiveness and efficiency.
- Risk assessment rules are usually in compliance because they place children at such risk of mortality or morbidity.
- More recent risk assessment systems have two components: severity and probability of occurrence.
- Key indicator/predictor rules are not usually in compliance but are not out of compliance a great deal.
- What is it about key indicator/predictor rules that make them so effective in discriminating between high and low performing programs.
- Licensing data are very skewed and because of this there is the need to dichotomize the data.
- There is very little variance in licensing data with generally only 20 rules separating the top compliant programs from the lowest compliant programs.
- The majority of programs (60%+) are in substantial or full compliance with rules.
- There is a balance between being effective and efficient that needs to be identified because as the system becomes more efficient it becomes less effective.
- As a system becomes more efficient it also can produce additional false positives and negatives which results in lessened effectiveness in program monitoring.
- Higher standards (as applied through Pre-K or QRIS) help to distinguish between the best and mediocre programs.
- Caring for Our Children Basics is a major step forward for the ECE field in establishing national standards.
- ASPE and OCC have published two very important papers on program monitoring which provides best practices and states that have successfully used the various methodologies.
- Key indicators represent 10% of all rules; risk assessment represent 20% of all rules.
Resources

For the interested reader, please consult the following excellent publications by the Assistant Secretary's Office for Planning and Evaluation, the Office of Child Care, and the National Resource Center for Health and Safety in Child Care that will provide additional insights into program monitoring in general, differential monitoring in particular, risk assessment and key indicator systems:

**ACF/Caring for Our Children Basics:**

**NRC/Stepping Stones to Caring for Our Children:**

**ASPE/Thirteen Key Indicators of Quality:**
http://aspe.hhs.gov/basic-report/13-indicators-quality-child-care

**ASPE/Monitoring White Paper:**
http://aspe.hhs.gov/hsp/15/ece_monitoring/rpt_ece_monitoring.cfm

**OCC/Differential Monitoring, Risk Assessment and Key Indicators:**

This website provides many additional websites, reports and examples based upon the above papers and many of the references listed below:

**RIKI Website for additional publications and websites:**
http://rikinstitute.wikispaces.com
References


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*For additional information about this paper, please contact:*

Richard Fiene, Ph.D., Research Psychologist
Research Institute for Key Indicators  [http://rikinstitute.wikispaces.com](http://rikinstitute.wikispaces.com)
National Association for Regulatory Administration  [http://naralicensing.org](http://naralicensing.org)
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DIFFERENTIAL MONITORING LOGIC MODEL (DMLM©): A NEW EARLY CHILDHOOD PROGRAM QUALITY INDICATOR MODEL (ECPQIM4©) FOR EARLY CARE AND EDUCATION REGULATORY AGENCIES

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DIFFERENTIAL MONITORING LOGIC MODEL (DMLM©): A NEW EARLY CHILDHOOD PROGRAM QUALITY INDICATOR MODEL (ECPQIM©) FOR EARLY CARE AND EDUCATION REGULATORY AGENCIES

ABSTRACT

A new Early Childhood Program Quality Indicator Model (ECCPQIM©) is described which utilizes targeted program monitoring (Differential Monitoring) via two licensing methodologies: Key Indicators and Risk Assessments. The theoretical and conceptual framework as well as a logic model are presented along with a scoring protocol that can be utilized to compare state/province and national organizations on how they are designing and implementing their program monitoring systems. A state/province/national framework/plan is presented as well as results from five (5) states (Georgia, Kansas, Illinois, Colorado, and New York) and a national organization (Office of Head Start). The five states and national organization are then compared using the Differential Monitoring Scoring Protocol (DMSP©). The Head Start program monitoring system scored a perfect 10 out of 10 in utilizing the DMSP©. Suggestions are made in how the scoring protocol could be used for making comparisons internationally and for future research in comparing various approaches.

Key Words: Program Monitoring, Differential Monitoring, Program Quality, Licensing.
**Background**

This paper will introduce a Differential Monitoring Logic Model (DMLM©) which provides a new Early Childhood Program Quality Indicator Model (ECPQIM⁴©) in which the major monitoring systems in early care and education are integrated conceptually so that the overall early care and education system can be assessed and validated. With this new model, it is now possible to compare results obtained from licensing systems, quality rating and improvement systems (QRIS), risk assessment systems, key indicator systems, technical assistance, and child development/early learning outcome systems (see Figures 1 & 2 for a graphical depiction of the theoretical underpinnings and actual design & logic model for the ECPQIM⁴©/DMLM).

The DMLM© can be used by early care and education state/province agencies, Federal agencies, and large provider organizations where an economy of scale is required. This model can be used with state as well as national standards, such as state licensing rules/regulations and *Caring for Our Children (AAP, 2012)*. Most states and Federal agencies have either some or all of the key elements of this model in their overall monitoring systems. The purpose of this model is to alter a one-size fits all monitoring system to one that is targeted, spending more time with problem programs who need additional assistance. This is a cost neutral model that is both cost effective and efficient and re-allocates resources from the compliant programs to the non-compliant programs. Presently there is not a measurement rubric for making comparisons within the USA or internationally when it comes to measuring the effectiveness and efficiency of child care and
early care program monitoring systems. This can become a very important tool as the USA begins implementation of the re-authorization of the Child Care and Development Block Grant.

The ECPQIM©/DMLM© is based very heavily in translational research and implementation science as a means of building an ongoing program monitoring system based upon the latest empirical demonstrations in the early care and education research literature. It is at the intersection of child care public policy, early care and education interventions, and empirical research. The ECPQIM©/DMLM© along with the scoring protocol introduced in this paper could provide a framework for making comparisons amongst states/provinces, national organizations, and countries in how they have designed and implemented their respective program monitoring of child care and early care & education systems similar to how Child Care Aware has developed a reporting format for the USA in comparing states on regulatory and oversight functions. The author reported on such a comparison in a previous study in an earlier edition of this journal (Fiene, 2013). The DMLM© framework and scoring protocol could provide a similar measurement tool for assessing child care and early childhood education program monitoring systems.
DMLM© Key Elements (see Figure 2): **CI** = state or federal child care standards, usually rules or regulations that measure health and safety - *Caring for Our Children* (AAP, 2012) will be applicable here. **PQ** = Quality Rating and Improvement Systems (QRIS) standards at the state level; process quality measures. **RA** = risk assessment tools/systems in which only the most critical rules/standards are measured. *Stepping Stones* (NRC, 2013) is an example of this approach. **KI** = key indicators in which only predictor rules/standards are measured. The *Thirteen Indicators of Quality Child Care* (Fiene, 2002) is an example of this approach. **DM** = differential monitoring decision making in which it is determined if a program is in compliance or not and the number of visits/the number of rules/standards are ascertained from a scoring protocol. **PD** = technical assistance/training and/or professional development system which provides targeted assistance to the program based upon the DM results. **CO** = child outcomes which assesses how well the children are developing which is the ultimate goal of the system.

Once the above key elements are in place, it is then possible to look at the relationships (this is depicted by the arrows that go from one box to another) amongst them to determine if the system is operating as it was intended; in other words, to determine if the DM system is improving the health, safety, program quality and ultimately the overall development of the children it serves.
In the Methodology section, a scoring protocol (DMSP© - Differential Monitoring Scoring Protocol©) is introduced which attempts to quantify these relationships and to give us a means for making measurements and comparisons across various types of organizations.

The DMLM© provides a cross-cutting methodology that can be used in all child care/early care and education delivery systems as well as in other human services. In the past many of these monitoring systems have functioned in silos. The DMLM© integrates all these various monitoring systems together so that the overall monitoring system can be validated as being cost effective and efficient. This can be an important development as available funds become more scarce in the future as international organizations deal with fewer and fewer resources.

Methods

National/State/Provincial Agency Plan for implementing a Differential Monitoring System:

The first step in utilizing the DMLM© for a state/province/nation is to take a close look at its Comprehensive Licensing Tool (CI) that it uses to collect violation data on all rules with all facilities in its respective state/province/nation. If the state/province/nation does not utilize a tool or checklist or does not review all violation data than it needs to consider these changes because the DMLM© is based upon an Instrument Based Program Monitoring System (IPM)(Fiene & Nixon,1985) which utilizes tools/checklists to collect data on all rules.

The second step for the state/province/nation is to compare their nation’s/state’s/province’s rules
with the National *Health and Safety Performance Standards (Caring for Our Children)* (AAP, 2012) or an equivalent international set of standards to determine the overlap and coverage between the two.

The **third step** for the state/province/nation if it utilizes a Risk Assessment (RA) tool is to assess the relationship between this tool and *Stepping Stones* (NRC, 2013) or an equivalent international set of targeted standards to determine the overlap and coverage between the two.

The **fourth step** for the state/province/nation is to compare the results from the CI with the RA tools.

In the **fifth step**, if a state/province/nation is fortunate enough to have a QRIS – Quality Rating and Improvement System in place and has sufficient program quality (PQ) data available then they will have the ability to compare results from their CI tool with their PQ tool and validate outputs by determining the relationship between compliance with health and safety rules (CI) and program quality (PQ) measures that measure process quality. This is a very important step because very few empirical demonstrations appear in the research literature regarding this relationship.

The **sixth step** is for the state/province/nation to generate a Key Indicator (KI) tool from the CI data base. Please see Fiene & Nixon (1985) and Fiene & Kroh (2000) for a detailed explanation
of the methodology for generating a KI tool. If a state/province/nation did not want to use the KI methodology, a direct comparison could be drawn from The *Thirteen Indicators of Quality Child Care* (Fiene, 2002).

The **seventh step** for the state/nation is to use the RA and KI tools together to determine overall compliance of facilities and how often and which rules will be monitored for future visits. This is the basic component of a Differential Monitoring (DM) approach. Also, this step should drive decisions within the technical assistance/training/professional development (PD) system in what resources are allocated to a particular facility.

The **eighth and final step** for the state/nation is to compare the results from the various monitoring tools (CI, PQ, RA, KI) with any child development outcome (CO) data they collect. This is a relatively new area and few, if any, states/provinces/nations at this point have this capability on a large scale. However, as Early Learning Networks/Systems and Standards (ELS) are developed, this will become more common place.

The ECPQIM®DMLM© is presented without two additional items that were present in the 2012/2013 versions which are important to note. The algorithm (Fiene, 2012, 1013) and validation framework (Zellman & Fiene, 2012) are not presented because the author felt that these two components took away from a more direct presentation of differential monitoring. For those interested readers, please refer to my previous abstracts (Fiene, 2012, 2013) which
included the algorithm and validation frameworks.

Just another brief word about the Theoretical Underpinnings for ECPQIM⁴. This graphic (Figure 1) attempts to provide the relationships amongst public policy, interventions, and empirical evidence through the lens of translational research, implementation science, and program monitoring. In constructing the ECPQIM⁴ concepts were borrowed from each area and integrated them in a model for monitoring early care and education programs. The graphic provides a means for displaying the relationships and potential intersections as well as the content that is important to each scientific/research field.

Figure 3 is provided as additional information regarding differential monitoring conceptually without all the details as in figure 2; and figure 4 is provided to demonstrate the impact that a state’s/provincial/national licensing law can have on using the Key Indicators and Risk Assessment methodologies.

Insert Figures 3 & 4

Also, taking Figure 2 and attempting to quantify these relationships, a scoring protocol is proposed as depicted in Table 1. This can provide a numerical means of comparing various
differential monitoring systems and their relative comprehensiveness. This protocol could be a useful tool in future research for determining which combinations work best.

Insert Table 1

The next section provides the results from a national organization and five states who used the above methodology to implement their respective differential monitoring systems.

**Results and Discussion**

The Early Childhood Program Quality Indicator Model (ECPQIM©) and its latest iteration presented as a logic model: Differential Monitoring Logic Model (DMLM©) have been written about extensively by this author (Fiene & Nixon, 1985; Griffin & Fiene, 1996; Fiene & Kroh, 2000; Fiene, 2013). Several states and Head Start have used the model in order to re-align their program monitoring systems. This paper presents the results of those new program monitoring systems through the lenses of the ECPQIM©/DMLM© logic model display. Each particular approach used various components of the overall comprehensive national model and have been highlighted by connecting arrows. It is proposed that this approach could be applied at an international level as well.
The interested reader should obtain a copy of the Office of Child Care’s *Licensing Brief on Differential Monitoring, Risk Assessment, and Key Indicators* published by the National Center on Child Care Quality Improvements which gives additional details regarding these approaches and methodologies as well as other state examples. Please go to the following URL website: (https://childcareta.acf.hhs.gov/sites/default/files/1408_differential_monitoring_final_1.pdf). In fact, this paper builds upon that excellent *Licensing Brief*.

Let’s start with Figure 5 which provides the Comprehensive National Example that depicts all the possible interconnections and gives national examples from the research literature. As one will see, it is possible for a national organization or a state/provincial agency to select the various components from the model based upon what is available in their particular organization. All do have the program compliance/licensing component (PC) but not all have fully functional program quality initiatives (PQ) or do not have the data to draw from the program quality initiatives.

The next level of components are the key indicator (KI) and risk assessment (RA) approaches or methodologies which organizations or state agencies can use alone or in tandem. One limitation in the key indicator methodology is not to use it with program initiatives if the data are not severely skewed in their data distribution as is the case with licensing data.

The last component is the resulting differential monitoring (DM) approach based upon the results
from using the key indicator and risk assessment methodologies either alone or in tandem. This is the ultimate revision of the program monitoring system in which how often and what is reviewed are answered.

All the components are highlighted (this is indicated by the arrows going from one box to another) in Figure 5 because all are possibilities to be used by a national or state agency. The examples in Figure 5 are drawn from the national research literature so *Caring for Our Children* (AAP, 2012) is the example for Program Compliance, Licensing, and the Health & Safety Comprehensive Instrument (CI). The following examples in Figures 6-11 will show some differences in how national and state agencies have developed their respective differential monitoring systems through their use of key indicator (KI) and risk assessment (RA) methodologies, and linking their licensing/program compliance (PC) and program quality (PQ) initiatives. Tables 1-3 explain the scoring protocol and provide results from the national Head Start program and five states geographically dispersed around the USA (New York, Georgia, Illinois, Kansas, and Colorado). Also see the end of the paper for an explanation of Notes a,b,c in Figure 5.
Figure 6 provides an example from New York (NY) where the state agency is attempting to restructure their early care and education program monitoring system to have a better balance between licensing and key program quality indicators. The plan is to have licensing staff collect data from both areas which means a need to save time in the licensing reviews via key indicators and to only identify indicators of quality through a risk assessment approach. The results from these two methodologies will then be combined into a Quality Indicators Instrument to be used by licensing staff in their annual reviews.

________________________________________

Insert Figure 6

________________________________________

Figure 7 provides an example from Georgia (GA) in which the driving methodology is a risk assessment core rule review system that results in a differential monitoring system called the Annual Compliance Determination Worksheet (ACDW) approach. Key indicators are not used directly but were used as part of the risk assessment core rule development. Please note how the relationship amongst the various components is different from the NY approach delineated in Figure 6. There is a link to their program quality initiatives which proved very significant in the validation studies performed on their Core Rule differential monitoring system.
Figure 8 presents a very different approach from the previous two approaches. In Kansas’s (KS) case, the state agency was only interested in developing a key indicator approach and was not interested in risk assessment nor had the capability to tie data together from their program quality initiatives. This is noted by the arrow connections which is more minimal in this depiction. As one can see, this still is a viable option for developing a differential monitoring approach.

Figure 9 depicts the use of both key indicator and risk assessment methodologies in Illinois (IL) with their licensing system but no data interaction with their program quality initiatives. It is proposed that both methodologies will be used together in future licensing reviews of programs which will constitute their differential monitoring system approach.
Figure 10 depicts the new aligned differential monitoring system being employed in Head Start (HS). Head Start has a very comprehensive system that employs various aspects from all the components in their system. The Head Start Performance Standards are very comprehensive, CLASS is used as a major process quality measure and both a key indicator (Head Start Key Indicator – Compliance (HSKI-C)) and risk assessment (Selected Compliance Measures) are utilized in their program monitoring system. The Head Start new Aligned Program Monitoring system comes closest to the comprehensive national model.

In Figure 11 a very different scenario played out in the state of Colorado (CO) in which key indicators were developed for their QRIS system rather than for their licensing system. As mentioned earlier, when applying the key indicator methodology to Quality Initiatives one needs to be very cautious if the data distribution is not exceptionally skewed as is the case with licensing data. Some of the data were sufficiently skewed to be able to be used in generating
quality key indicators but there were limitations noted.

Insert Figure 11

The above results clearly demonstrate how agencies can take very different approaches to designing and implementing their differential monitoring system. The next research question is to determine if agencies that have higher scores (more than 6) if they are more effective and efficient than those agencies that have lower scores (less than 5).

**Conclusion**

This paper presents the latest examples of national and state agencies differential monitoring approaches. It clearly demonstrates that there are many different approaches to developing and implementing differential monitoring. A key research question for the future as more states utilize the different approaches is to study if one approach is better than the next or a combination works better than most. From 40+ years of experience as a researcher and state policy analyst I would suggest that a more comprehensive approach which employs the full menu of program quality initiatives similar to the Head Start or the New York approaches will be most effective.
As mentioned in the introduction of this paper in describing the Comprehensive National Example of the DMLM© Model Tables 1-3 present a Differential Monitoring Scoring Protocol (DMSP©) that can potentially be used to compare states on how in depth their differential monitoring system is. Table 1 describes the DMSP© in narrative terms delineating the various systems that need to be in place in order to get a particular score. A score of 0 means no systems are in place or do not intersect while a score of 10 means that all of the systems are in place and intersect or are linked. Table 2 gives the points assigned to the specific systems that are part of a differential monitoring system. And Table 3/Figure 12 give the actual points assigned to the state & national examples that have been presented in this paper for New York (NY), Georgia (GA), Head Start (HS), Kansas (KS), Illinois (IL), and Colorado (CO). The total points assigned to the comprehensive model are also provided as a point of context.

There are a couple of important things to note about the DMSP© in Table 2, such as: if Key Indicators (KI) and Risk Assessment (RA) are linked, it negates KI and RA being scored separately. If KI and RA are developed separately, it is very improbable that they will not be linked but that is always a possibility, so it is listed as so. Linking Program Compliance/Licensing (PC) and Program Quality (PQ) Initiatives is a highly desirable event and is assigned a high score (4 points). Linking KI and RA is also considered a highly desirable event and is assigned a high score (4 points).
For future research, it will be interesting to see if this ECPQIM\textsuperscript{4}/DMLM\textsuperscript{©} model has applicability from an international perspective. Some of the key elements present in USA state systems are organized very differently in other countries and would have to be adjusted. Also, it will be interesting to see if the DMSP\textsuperscript{©} can be developed as a scoring systems similar to the Child Care Aware Report Card Benchmarks protocol where it will be possible to make comparisons across state and national agencies.
Endnotes a, b, c:

The arrows going from Key Indicators (KI) and Risk Assessment (RA) to Differential Monitoring (DM) can be configured in the following ways: only KI (Kansas); only RA (don’t have an example of this as of this writing) or a combination of KI and RA (Illinois) but this configuration could mean all of the KI and RA rules which would be more rules than if only KI or RA rules were selected or only those rules that overlap (KI+RA) which would be a much reduced number of rules. Or a different configuration determined by the state agency.
References


Figure 1

The Theoretical Underpinnings for ECPQIM: Early Childhood Program Quality Indicator Model©
Figure 2

Early Childhood Program Quality Indicator Model (ECPQIM©): Differential Monitoring Logic Model (DMLM©)
Comprehensive National Example

<table>
<thead>
<tr>
<th>Program Compliance (PC)</th>
<th>Program Quality (PQ) Initiatives:</th>
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<tbody>
<tr>
<td>Full Licensing Visit</td>
<td>Quality Rating &amp; Improvement (QRIS)</td>
</tr>
<tr>
<td>Comprehensive Instrument/Tool (CI)</td>
<td>Professional Development (PD)</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>Early Learning System (ELS)</td>
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<tr>
<td>Structural Quality</td>
<td>Process Quality</td>
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<tr>
<td><em>Eg: Caring for Our Children (CFOC)</em></td>
<td><em>Eg: Classroom Assessment Scoring System</em></td>
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<table>
<thead>
<tr>
<th>Key Indicators (KI) – Abbreviated Visit</th>
<th>Risk Assessment (RA) – Abbreviated Visit</th>
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<tbody>
<tr>
<td>Statistical predictor rules/standards that predict overall compliance with rules or standards.</td>
<td>Weighting of Rules or Standards</td>
</tr>
<tr>
<td><em>Eg: 13 Indicators of Quality Child Care</em></td>
<td>Places children at greatest risk of mortality or morbidity if non-compliance found.</td>
</tr>
<tr>
<td><em>Eg: Stepping Stones to CFOC</em></td>
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</tbody>
</table>

**Differential Monitoring (DM):** How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
Figure 3
Licensing Rules, Compliance Reviews, Differential Monitoring, Abbreviated Tools, Risk Assessment, and Key Indicators

All Licensing Rules – Full Compliance Reviews

Differential Monitoring

How Often to Visit? What is Reviewed?

Frequency

More Often Less Often

Abbreviated Tool

Risk Assessment Weights

Key Indicators Predictors

RESEARCH INSTITUTE FOR KEY INDICATORS (RIKI)
Figure 4
When Key Indicators and Risk Assessments Can Be Used

The Licensing Law:
All Rules that are promulgated based upon the Law

Compliance Decision:
100% compliance with all rules all the time.

Key Indicators are ok to use.
Risk Assessment CANNOT be used.

Compliance Decision:
Substantial (96-99%) but not 100% compliance with all rules all the time.

Key Indicators are ok to use.
Risk Assessment ok to use.
Early Childhood Program Quality Indicator Model (ECPQIM4©): Differential Monitoring Logic Model (DMLM©) Comprehensive National Scoring Protocol Example (Maximum of 10 Points) Figure 5

Program Compliance (PC)
- Full Licensing Visit
- Comprehensive Instrument (CI)
- Health & Safety
- Structural Quality
  *Eg: Caring for Our Children (CFOC)*

Key Indicators (KI) – Abbreviated Visit
- Statistical predictor rules/standards that predict overall compliance with rules or standards.
  *Eg: 13 Indicators of Quality Child Care*

Program Quality (PQ) Initiatives:
- Quality Rating & Improvement (QRIS)
- Professional Development (PD)
- Early Learning System (ELS)
- Process Quality
  *Eg: Early Childhood Environment Rating Scale*

Risk Assessment (RA) – Abbreviated Visit
- Weighting of Rules or Standards
- Places children at greatest risk of mortality or morbidity if non-compliance found.
  *Eg: Stepping Stones to CFOC*

Differential Monitoring (DM): How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
(ECPQIM4©)(DMLM©): New York Example (NY)
Figure 6

**Program Compliance (PC)**
- Full Licensing Visit
- Comprehensive Instrument (CI)
- Health & Safety
- Structural Quality
  - *Eg: New York Licensing Rules*

**Program Quality (PQ) Initiatives:**
- Quality Rating & Improvement (QRIS)
- Professional Development (PD)
- Early Learning System (ELS)
- Process Quality
  - *Eg: Early Childhood Environment Rating Scale*

**Key Indicators (KI)** – Abbreviated Visit
- Statistical predictor rules/standards that predict overall compliance with rules or standards.
  - *Eg: New York Key Indicators*

**Risk Assessment (RA)** – Abbreviated Visit
- Weighting of Rules or Standards
- Places children at greatest risk of mortality or morbidity if non-compliance found.
  - *Eg: Selected Quality Indicators*

**Differential Monitoring (DM):** How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
(ECPQIM4©)(DMLM©): Georgia Example (GA)

Figure 7

**Program Compliance (PC)**
- Full Licensing Visit
- Comprehensive Instrument (CI)
- Health & Safety
- Structural Quality
  *Eg: Georgia Licensing Rules*

**Program Quality (PQ) Initiatives:**
- Quality Rating & Improvement (QRIS)
- Professional Development (PD)
- Early Learning System (ELS)
- Process Quality
  *Eg: Early Childhood Environment Rating Scale*

**Key Indicators (KI)** – Abbreviated Visit
- Statistical predictor rules/standards that predict overall compliance with rules or standards.
  *Eg: 13 Indicators of Quality Child Care*

**Risk Assessment (RA)** – Abbreviated Visit
- Weighting of Rules or Standards
- Places children at greatest risk of mortality or morbidity if non-compliance found.
  *Eg: Core Rules*

**Differential Monitoring (DM):** How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
  *Eg: Annual Compliance Determination Worksheet (ACDW)*
(ECPQIM©)(DMLM©): Kansas Example (KS)

**Figure 8**

**Program Compliance (PC)**
- Full Licensing Visit
- Comprehensive Instrument (CI)
- Health & Safety
- Structural Quality
  *Eg: Kansas Licensing Rules*

**Program Quality (PQ) Initiatives:**
- Quality Rating & Improvement (QRIS)
- Professional Development (PD)
- Early Learning System (ELS)
- Process Quality

**Key Indicators (KI)** – Abbreviated Visit
- Statistical predictor rules/standards that predict overall compliance with rules or standards.
  *Eg: Kansas Key Indicators*

**Risk Assessment (RA)** – Abbreviated Visit
- Weighting of Rules or Standards
  Places children at greatest risk of mortality or morbidity if non-compliance found.

**Differential Monitoring (DM):**
- How often to visit – More or Less?
- And what is reviewed – More or Less?
  Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
Program Compliance (PC)
Full Licensing Visit
Comprehensive Instrument (CI)
Health & Safety
Structural Quality
*Eg: Illinois Licensing Rules*

Program Quality (PQ) Initiatives:
Quality Rating & Improvement (QRIS)
Professional Development (PD)
Early Learning System (ELS)
Process Quality

Key Indicators (KI) – Abbreviated Visit
Statistical predictor rules/standards that predict overall compliance with rules or standards.
*Eg: Illinois Key Indicators*

Risk Assessment (RA) – Abbreviated Visit
Weighting of Rules or Standards
Places children at greatest risk of mortality or morbidity if non-compliance found.
*Eg: Illinois Weighting Consensus*

Differential Monitoring (DM): How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
(ECPQIM©)(DMLM©): Head Start Example (HS)

**Program Compliance (PC)**
- Full Review Visit
- Comprehensive Instrument (CI)
- All Compliance Measures
- Structural Quality
  
  *Eg: Head Start Performance Standards*

**Program Quality (PQ) Initiatives:**
- Professional Development (PD)
- Early Learning System (ELS)
- Process Quality
  
  *Eg: Classroom Assessment Scoring System*

**Key Indicators (KI) – Abbreviated Visit**
- Statistical predictor rules/standards that predict overall compliance with rules or standards.
  
  *Eg: Head Start Key Indicators-Compliance*

**Risk Assessment (RA) – Abbreviated Visit**
- Weighting of Rules or Standards
- Places children at greatest risk of mortality or morbidity if non-compliance found.
  
  *Eg: Selected Compliance Measures*

**Differential Monitoring (DM):** How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
**Program Compliance (PC)**
- Full Licensing Visit
- Comprehensive Instrument (CI)
- Health & Safety
- Structural Quality

**Program Quality (PQ) Initiatives:**
- Quality Rating & Improvement (QRIS)
- Professional Development (PD)
- Early Learning System (ELS)
- Process Quality
  - *Ea: Early Childhood Environment Rating*

**Key Indicators (KI) – Abbreviated Visit**
- Statistical predictor rules/standards that predict overall compliance with rules or standards.
  - *Eg: Colorado Quality Key Indicators*

**Risk Assessment (RA) – Abbreviated Visit**
- Weighting of Rules or Standards
- Places children at greatest risk of mortality or morbidity if non-compliance found.

**Differential Monitoring (DM):** How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.
DMSP© SCORING PROTOCOL WITH STATE AND NATIONAL AGENCIES AS EXAMPLES

Figure 12

10 POINTS
ALL SYSTEMS IN PLACE AND LINKED.
Example
HEAD START

8 POINTS
KI & RA IN PLACE BUT NOT LINKED; AND PC & PQ LINKED.
Example
Georgia

6 POINTS
KI & RA IN PLACE & LINKED.
Example
Illinois
New York

4 POINTS
KI & RA IN PLACE BUT NOT LINKED OR PC & PQ LINKED.
Example
Colorado
Kansas

2 POINTS
KI OR RA IN PLACE.
Example
Kansas

0 POINTS
NO SYSTEMS

SCORING

KI = Key Indicators; RA = Risk Assessment; PC = Licensing; PQ = Program Quality Initiatives
Table 1: Differential Monitoring Scoring Protocol (DMSP)

<table>
<thead>
<tr>
<th>Score</th>
<th>Systems Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systems in place.</td>
</tr>
<tr>
<td>2</td>
<td>KI or RA in place and not linked.</td>
</tr>
<tr>
<td>4</td>
<td>(KI &amp; RA in place but not linked) or (PC + PQ are linked).</td>
</tr>
<tr>
<td>6</td>
<td>(KI &amp; RA in place) &amp; (KI + RA are linked)</td>
</tr>
<tr>
<td>8</td>
<td>(KI &amp; RA in place but not linked) &amp; ((PC + PQ) are linked).</td>
</tr>
<tr>
<td>10</td>
<td>All systems in place and linked.</td>
</tr>
</tbody>
</table>

*KI (Key Indicators); RA (Risk Assessment); PC (Program Compliance/Licensing); PQ (Program Quality Initiatives)*
Table 2: Differential Monitoring Scoring Protocol (DMSP)© Point Assignment

<table>
<thead>
<tr>
<th>Score</th>
<th>Systems Present and Point Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systems in place.</td>
</tr>
<tr>
<td>2</td>
<td>(KI (1)) &amp; (KI -&gt; DM (1)) or ((RA (1)) &amp; (RA -&gt; DM (1))</td>
</tr>
<tr>
<td>4</td>
<td>(PC + PQ (4)) or (KI (1) &amp; (KI -&gt; DM (1)) &amp; (RA (1) &amp; (RA -&gt; DM (1))</td>
</tr>
<tr>
<td>6</td>
<td>(KI + RA -&gt; DM (4)) &amp; (KI (1)) &amp; (RA (1))</td>
</tr>
<tr>
<td>8</td>
<td>(KI (2) &amp; RA (2)) &amp; (PC + PQ (4)).</td>
</tr>
<tr>
<td>10</td>
<td>(KI + RA -&gt; DM (4)) &amp; (KI (1)) &amp; (RA (1)) &amp; (PC + PQ (4))</td>
</tr>
</tbody>
</table>

KI (Key Indicators); RA (Risk Assessment); PC (Program Compliance/Licensing); PQ (Program Quality Initiatives)
Table 3: DMLM© SCORING PROTOCOL WITH STATE EXAMPLES

<table>
<thead>
<tr>
<th>SYSTEMS (pts)</th>
<th>MODEL</th>
<th>GA</th>
<th>NY</th>
<th>HS</th>
<th>IL</th>
<th>KS</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>KI (1)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RA (1)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KI + RA -&gt; DM (4)</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KI + RA (2)</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PC + PQ (4)</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KI -&gt; DM (1)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RA -&gt; DM (1)</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL (10)</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

GA (Georgia); NY (New York); HS (Head Start); IL (Illinois); KS (Kansas); CO (Colorado)
The purpose of this report is to present to the Office of Head Start (OHS) Key Indicators of their Head Start Performance Standards (HSPS) that have the ability to statistically predict substantial compliance with all Compliance Measures and ultimately the majority of HSPS's. The analytical and methodological basis of this approach is based upon a *Differential Monitoring Logic Model and Algorithm (DMLMA©)* (Fiene, 2012) (see Appendix 3). The DMLMA© is the 4th generation of an Early Childhood Program Quality Indicator Model (ECPQIM)(Fiene & Nixon, 1985; Griffin & Fiene, 1995; Fiene & Kroh, 2000). Only a portion of the DMLMA© model was utilized in this report which focused on key indicators, risk assessment, and program quality.

**Definitions:**

*Risk Assessment (RA)* - a differential monitoring approach that employs using only those rules, standards, or regulations that place children at greatest risk of mortality or morbidity if violations/citations occur with the specific rule, standard, or regulation.

*Key Indicators (KI)* - a differential monitoring approach that employs using only those rules, standards, or regulations that statistically predict overall compliance with all the rules, standards, or regulations. In other words, if a program is 100% in compliance with the Key Indicators the program will also be in substantial to full compliance with all rules, standards, or regulations. 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, standards, or regulations.

*Differential Monitoring (DM)* - this is a relatively new approach to determining the number of visits made to programs and what rules, standards, or regulations are reviewed during these visits. There are two measurement tools that drive differential monitoring, one is Weighted Risk Assessment tools and the other is Key Indicator checklists. Weighted Risk Assessments determine how often a program will be visited while Key Indicator checklists determine what rules, standards, or regulations will be reviewed in the program. Differential monitoring is a very powerful approach when Risk Assessment is combined with Key Indicators because a program is reviewed by the most critical rules, standards, or regulations and the most predictive rules, standards, or regulations. See Appendix 3 which presents a Logic Model & Algorithm for Differential Monitoring (DMLMA©)(Fiene, 2012).

*Program Quality (PQ)* - for the purposes of this study this was measured via the CLASS – Classroom Assessment Scoring System. The CLASS has three sub-scales (ES = Emotional Support, CO = Classroom Organization, and IS = Instructional Support). The CLASS is a tool that is identified in the research literature as measuring classroom quality similar to the ERS tools.
Early Childhood Program Quality Indicator Model (ECPQIM) – these are models that employ a key indicator or dashboard approach to program monitoring. Major program monitoring systems in early care and education are integrated conceptually so that the overall early care and education system can be assessed and validated. With these models, it is possible to compare results obtained from licensing systems, quality rating and improvement systems (QRIS), risk assessment systems, key indicator systems, technical assistance, and child development/early learning outcome systems. The various approaches to validation are interposed within this model and the specific expected correlational thresholds that should be observed amongst the key elements of the model are suggested.

Key Elements of the model are the following (see Appendix 3 for details): CI = state or federal standards, usually rules or regulations that measure health and safety - Caring for Our Children or Head Start Performance Standards will be applicable here. PQ = Quality Rating and Improvement Systems (QRIS) standards at the state level; ERS (ECERS, ITERS, FDCRS), CLASS, or CDPES (Fiene & Nixon, 1985). RA = risk assessment tools/systems in which only the most critical rules/standards are measured. Stepping Stones is an example of this approach. KI = key indicators in which only predictor rules/standards are measured. The Thirteen Indicators of Quality Child Care is an example of this approach. DM = differential monitoring decision making in which it is determined if a program is in compliance or not and the number of visits/the number of rules/standards are ascertained from a scoring protocol. PD = technical assistance/training and/or professional development system which provides targeted assistance to the program based upon the DM results. CO = child outcomes which assesses how well the children are developing which is the ultimate goal of the system.

The organization of this report is as follows:

1) **The first section** will provide an overall analysis the Head Start (HS), Early Head Start (EHS), and Head Start/Early Head Start (HS/EHS) programs;

2) **The second section** will provide analyses of the various content areas (CA) within the HSPS;

3) **The third section** will provide analyses of the relationship between the HSPS as measured by compliance with the Compliance Measures (CM) and the program quality scores (CLASS scores);

4) **The fourth and final section** will provide the analyses that produced the key indicators (KI) and recommendations in how it could be used.

The source of data for this report is all the Tri-Annual On-Site Monitoring visits for 2012 which consisted of 422 reviews of programs across the country. There were 191 Head Start (HS) only programs, 33 Early Head Start (EHS) only programs, and 198 Head Start/Early Head Start (HS/EHS) programs reviewed. This is a representative sample of Head Start and Early Head Start programs nationally representing approximately 25% of the total number of Head Start programs.

Before proceeding with the results of this study, a few clarifying and definitional terms need to be highlighted. In the 2012 edition of OHS On-Site Review Protocol and the 2013 OHS Monitoring Protocol, Compliance Indicators (CI) and Key Indicators (KI) are respectively mentioned. In the licensing literature, when the term “Indicators” is used it refers to standards/rules that are predictive of overall compliance with all rules/standards. However, as defined by OHS, indicators (CI/KI) are used within the context of risk assessment which means that these indicators are the standards which are most important/critical
to the OHS in their monitoring reviews. These indicators therefore are not predictive in essence. That is the focus of this report/study which is to determine which of these indicators are predictive of overall compliance with all the compliance/key indicators. This is a common misconception in the human service regulatory field where risk assessment tools and key indicator tools purposes are confused. As we move forward please keep the definitions in mind related to the distinctions and functionality of risk assessment and key indicators.

For the purposes of this study, 131 Compliance Measures (CM), organized into seven (7) Content Areas (CA), were reviewed and analyzed. The seven content areas are the following: Program Governance; Management Systems; Fiscal Integrity; Eligibility, Recruitment, Selection, Enrollment, and Attendance; Child Health and Safety; Family and Community Engagement; Child Development and Education. Ten CM’s were from Program Governance (GOV), 10 were from Management Systems (SYS), 22 were from Fiscal Integrity (FIS), 11 were from Eligibility, Recruitment, Selection, Enrollment, and Attendance (ERSEA), 34 were from Child Health and Safety (CHS), 16 were from Family and Community Engagement (FCE), and 28 were from Child Development and Education (CDE).

Section 1 - Head Start (HS), Early Head Start (EHS), and Head Start/Early Head Start (HS/EHS) programs

In order to determine if analyses needed to be performed separately on Head Start (HS), Early Head Start (EHS), and Head Start/Early Head Start (HS/EHS) combined programs, the first series of analyses were performed to determine if any statistically significant differences existed amongst these three groups. This is a very important first analysis because it will help to determine the stability of the sample selected and of the overall system. In other words, is there a good deal of consistency across all service types: HS, EHS, and HS/EHS.

Based upon Table 1, no statistically significant differences were determined amongst the three groups (HS, EHS, HS/EHS) with Compliance Measures (CM) or CLASS (ES, CO, IS) Scores indicating that using the full 422 sample and not having to do separate analyses for the three groups was the correct analytical framework. However, where it is appropriate, any statistically significant differences amongst the various program types will be highlighted.

Table 1 – Head Start, Early Head Start, & Head Start/Early Head Start With CM and CLASS/ES, CO, IS

<table>
<thead>
<tr>
<th>Program Type</th>
<th>CM(N)</th>
<th>CLASS/ES(N)</th>
<th>CLASS/CO(N)</th>
<th>CLASS/IS(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Start (HS)</td>
<td>3.72(191)</td>
<td>5.88(186)</td>
<td>5.43(186)</td>
<td>2.97(186)</td>
</tr>
<tr>
<td>Early Head Start (EHS)</td>
<td>2.67(33)</td>
<td>-----*</td>
<td>-----*</td>
<td>-----*</td>
</tr>
<tr>
<td>Head Start (HS/EHS)</td>
<td>3.07(198)</td>
<td>5.91(198)</td>
<td>5.47(198)</td>
<td>3.00(198)</td>
</tr>
<tr>
<td>Totals</td>
<td>3.33(422)</td>
<td>5.89(384)</td>
<td>5.45(384)</td>
<td>2.98(384)</td>
</tr>
</tbody>
</table>

Statistical Significance NS NS NS NS

CM = Compliance Measures (Average Number of Violations)
CLASS/ES = CLASS Emotional Support Average Score
CLASS/CO = CLASS Classroom Organization Average Score
CLASS/IS = CLASS Instructional Support Average Score
NS = Not Significant
N = Number of Programs

*CLASS data were not collected in EHS.
The average number of violations with the Compliance Measures for Head Start (3.72), Early Head Start (2.67) and Head Start/EHS (3.07) was not significant in utilizing a One-Way ANOVA. There were 191 Head Start (HS) programs, 33 Early Head Start (EHS) programs, and 198 Head Start (HS/EHS) programs.

Comparisons were also made with Head Start and Head Start/EHS on the various CLASS sub-scales (ES = Emotional Support, CO = Classroom Organization, and IS = Instructional Support) and no significant differences were found between these two groups. The EHS (n = 33) was not used because CLASS data were not collected in these programs.

The practical implication of the above results is that the same monitoring tools and the resulting Head Start Key Indicator (HSKI) to be developed as a result of this study can be used in the three main types of programs: Head Start, Early Head Start, and Head Start/EHS. There is no need to have separate tools.

Section 2 - Content Areas

The second series of analyses was to look more closely at the 7 content areas (CA) to measure demographically any differences amongst the various areas. In order to do this a weighted average had to be determined in order to compare the various areas because of the differences in the number of Compliance Measures (CM) used in each content area. Table 2 provides the results of these analyses. For the total sample of 422 sites, Management Systems (SYS) Content Area (CA) had the highest number of violations with the Compliance Measures (CM) with 359. The SYS/CA also had the highest average number of violations with 35.90 because there were only 10 CM. For the total sample of 422 sites, the lowest number of violations was in the Family and Community Engagement (FCE) Content Area (CA) with 48 violations with CM. It also had the lowest average number of violations with 3.00.

For the Head Start only sites (n = 191), a similar distribution as with the total sample (n = 422) is depicted in which Management Systems (SYS) Content Area (CA) had the highest number of violations with the Compliance Measures (CM) with 192. The SYS/CA also had the highest average number of violations with 19.20 because again there were only 10 CM. The lowest number of violations was in the Family and Community Engagement (FCE) Content Area (CA) with 20 violations with CM. It also had the lowest average number of violations with 1.25.

For the Early Head Start only (n = 33) and the Head Start/Early Head Start (n = 198) sites, the ranking of the various Content Areas changed somewhat with the total number of violations and the average number of violations from the Total Sample (n = 422) and the Head Start only (n = 191) sites but not dramatically. For example, the Family and Community Engagement (FCE); Child Development and Education (CDE); and the Eligibility, Recruitment, Selection, Enrollment, and Attendance (ERSEA) Content Areas switched rankings in which it had the fewest total violations and the average number of violations (see Table 2).
Table 2 – Comparing Content Areas and Program Types

<table>
<thead>
<tr>
<th>Content Areas</th>
<th>TOT</th>
<th>HS</th>
<th>EHS</th>
<th>HS/EHS</th>
<th>Average # of Violations/(Rank)</th>
<th>CM</th>
<th>Total Violations/(Rank)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TOT</td>
<td>HS</td>
<td>EHS</td>
<td>HS/EHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCE</td>
<td>48(1)</td>
<td>20(1)</td>
<td>2(1)</td>
<td>26(2)</td>
<td>3.00(1) 1.25(1) 0.125(1) 1.63(2)</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>ERSEA</td>
<td>62(2)</td>
<td>37(2)</td>
<td>6(3)</td>
<td>19(1)</td>
<td>5.64(3) 3.36(3) 0.545(3) 1.73(3)</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>CDE</td>
<td>91(3)</td>
<td>43(3)</td>
<td>5(2)</td>
<td>43(3)</td>
<td>3.25(2) 1.54(2) 0.179(2) 1.54(1)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>GOV</td>
<td>150(4)</td>
<td>94(4)</td>
<td>6(3)</td>
<td>50(4)</td>
<td>15.00(6) 9.40(6) 0.600(4) 5.00(5)</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>FIS</td>
<td>255(5)</td>
<td>114(5)</td>
<td>23(7)</td>
<td>118(5)</td>
<td>11.59(5) 5.18(5) 1.045(6) 5.36(6)</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td>333(6)</td>
<td>151(6)</td>
<td>22(6)</td>
<td>160(7)</td>
<td>9.79(4) 4.44(4) 0.647(5) 4.71(4)</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>SYS</td>
<td>359(7)</td>
<td>192(7)</td>
<td>20(5)</td>
<td>147(6)</td>
<td>35.90(7) 19.20(7) 2.000(7) 14.70(7)</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

**CONTENT AREAS (CA):**
- FCE = FAMILY and COMMUNITY ENGAGEMENT
- ERSEA = ELIGIBILITY, RECRUITMENT, SELECTION, ENROLLMENT, and ATTENDANCE
- CDE = CHILD DEVELOPMENT AND EDUCATION
- GOV = PROGRAM GOVERNANCE
- FIS = FISCAL INTEGRITY
- CHS = CHILD HEALTH AND SAFETY
- SYS = MANAGEMENT SYSTEMS

**TOT = TOTAL NUMBER OF SITES, FULL SAMPLE OF 422 SITES**

**HS = HEAD START ONLY PROGRAMS**

**EHS = EARLY HEAD START ONLY PROGRAM**

**HS/EHS = HEAD START AND EARLY HEAD START COMBINED PROGRAMS**

**CM = NUMBER OF COMPLIANCE MEASURES**

**TOTAL VIOLATIONS = ALL THE VIOLATIONS FOR A SPECIFIC CONTENT AREA.**

**AVERAGE # OF VIOLATIONS = THE TOTAL VIOLATIONS FOR A SPECIFIC CA DIVIDED BY THE NUMBER OF COMPLIANCE MEASURES FOR THAT SPECIFIC CONTENT AREA.**

**RANK = HOW EACH CONTENT AREA COMPARES TO THE OTHER CONTENT AREAS FOR THE RESPECTIVE PROGRAM TYPE.**

For the total sample (n = 422), other CA’s had different configurations between the total number of violations and the average number of violations as demonstrated by CHS – Child Health and Safety in which there was a total of 333 violations but the average number of violations was 9.79 because there were 34 Compliance Measures (CM). Program Governance (GOV) had 150 total violations and a weighted-average of 15 violations with 10 CM. Child Development and Education (CDE) had 91 total violations and a weighted-average of 3.25 violations. Fiscal Integrity (FIS) had 255 total violations and a weighted-average of 11.59 violations. And lastly, Eligibility, Recruitment, Selection, Enrollment, and Attendance (ERSEA) had 62 total violations and a weighted-average of 5.64 violations.

The Head Start only (HS = 191), Early Head Start only (EHS = 33), and the Head Start/Early Head Start (HS/EHS = 198) programs followed a similar pattern as with the total sample (n = 422). This indicates a great deal of consistency in the sample drawn. See Appendix 4 for violation data for all 131 Compliance Measures.

The practical implication of the above findings is that certain Content Areas (SYS, GOV, FIS) may need additional exploration by OHS because of their high rates of non-compliance with the Compliance Measures.
Section 3 – Program Quality

This section provides comparisons between the Compliance Measures (CM) data and the CLASS (ES, CO, IS) data. This is a very important section because there is always the concern that compliance with the HSPS has no relationship to program quality as measured by the CLASS. In Table 3, correlations were run between the CM data and the CLASS scores for Emotional Support (ES), Classroom Organization (CO), and Instruction Support (IS) for the Head Start only and the Head Start/Early Head Start programs. The EHS only programs were not included because CLASS data are not collected on these programs. The results are very positive and statistically significant in most cases. It is also important to note the very positive correlation between the Head Start Key Indicators (HSKi) and CLASS. This result supports using the HSKI in monitoring Head Start.

Table 3 – Relationship Between Compliance Measures (CM), KI, and CLASS (ES, CO, IS) Scores

<table>
<thead>
<tr>
<th>Class</th>
<th>CM</th>
<th>FCE</th>
<th>ERSEA</th>
<th>CDE</th>
<th>GOV</th>
<th>FIS</th>
<th>CHS</th>
<th>SYS</th>
<th>KI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class/ES</td>
<td>.22*</td>
<td>.13*</td>
<td>.15*</td>
<td>.15*</td>
<td>.11*</td>
<td>.05</td>
<td>.23*</td>
<td>.17*</td>
<td>.27**</td>
</tr>
<tr>
<td>Class/CO</td>
<td>.19*</td>
<td>.13*</td>
<td>.11*</td>
<td>.16*</td>
<td>.04</td>
<td>.06</td>
<td>.21*</td>
<td>.15*</td>
<td>.25**</td>
</tr>
<tr>
<td>Class/IS</td>
<td>.20*</td>
<td>.10</td>
<td>.12*</td>
<td>.12*</td>
<td>.13*</td>
<td>.06</td>
<td>.18*</td>
<td>.11*</td>
<td>.17**</td>
</tr>
</tbody>
</table>

CM Violations = Total Compliance Measure Violations

** CONTENT AREAS (CA):**
FCE = FAMILY and COMMUNITY ENGAGEMENT
ERSEA = ELIGIBILITY, RECRUITMENT, SELECTION, ENROLLMENT, and ATTENDANCE
CDE = CHILD DEVELOPMENT AND EDUCATION
GOV = PROGRAM GOVERNANCE
FIS = FISCAL INTEGRITY
CHS = CHILD HEALTH AND SAFETY
SYS = MANAGEMENT SYSTEMS

** CLASS/IS = Average CLASS IS (Instructional Support) Score**
** CLASS/ES = Average CLASS ES (Emotional Support) Score**
** CLASS/CO = Average CLASS CO (Classroom Organization) Score**

** KI = Key Indicators Total Score**

* p < .05
** p < .01

See Appendix 6 & 6A for the inter-correlations amongst all the Content Areas, HSKI, and Total Compliance with Compliance Measures.

These results are very important but it is equally important to look more specifically at the distribution of the Compliance Measures (CM) scores and their relationship to the CLASS data (see Appendix 5 for detailed graphic distributions and Appendix 6 & 6A for the inter-correlations amongst all the CA). When this is done a very interesting trend appears (see Table 3a) in which a definite plateau occurs as the scores move from more violations or lower compliance with the Compliance Measures (25-20 to 3-8 CM Violations) to fewer violations or substantial compliance with the Compliance Measures (1-2 CM Violations) and full compliance with the Compliance Measures (Zero (0) CM Violations).
Table 3a – Aggregate Scores Comparing CM Violations with CLASS Scores

<table>
<thead>
<tr>
<th>CM Violations</th>
<th>IS</th>
<th>ES</th>
<th>CO</th>
<th>Number/Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Full Compliance)</td>
<td>3.03</td>
<td>5.99</td>
<td>5.59</td>
<td>75/19%</td>
</tr>
<tr>
<td>1-2 (Substantial Compliance)</td>
<td>3.15</td>
<td>5.93</td>
<td>5.50</td>
<td>135/35%</td>
</tr>
<tr>
<td>3-8 (Mid-Compliance)</td>
<td>2.87</td>
<td>5.85</td>
<td>5.37</td>
<td>143/40%</td>
</tr>
<tr>
<td>9-19 (Lower Compliance)</td>
<td>2.65</td>
<td>5.71</td>
<td>5.32</td>
<td>28/6%</td>
</tr>
<tr>
<td>20-25 (Lowest Compliance)</td>
<td>2.56</td>
<td>5.52</td>
<td>4.93</td>
<td>3/1%</td>
</tr>
</tbody>
</table>

Significance: $F = 4.92; p < .001$  $F = 4.918; p < .001$  $F = 4.174; p < .003$

CM Violations = Compliance Measure Violations (lower score = higher compliance)(higher score = lower compliance)
IS = Average CLASS IS (Instructional Support) Score
ES = Average CLASS ES (Emotional Support) Score
CO = Average CLASS CO (Classroom Organization) Score
#/% = Number of programs and Percent of programs at each level of compliance

When comparing these groupings in Table 3a the results from a One Way ANOVA were significant ($F = 4.92; p < .001$) for the CLASS/IS Scores. The average CLASS/IS Score when there were no CM Violations was 3.03. The average CLASS/IS Score when there were 1-2 CM Violations was 3.15. The average CLASS/IS Score when there were 3-8 CM Violations was 2.87. The average CLASS/IS Score when there were 9-19 CM Violations was 2.65. And finally, the average CLASS/IS Score when there were 20-25 violations was 2.56. The results were very similar with the CLASS/ES and CLASS/CO scores as well in which the results from a One Way ANOVA were statistically significant for the CLASS/ES ($F = 4.918; p < .001$) and for the CLASS/CO ($F = 4.174; p < .003$). These results clearly demonstrate that being in full or substantial compliance with the Compliance Measures correlates with more positive scores on the CLASS. Approximately 55% of the Head Start programs are at the full or substantial compliance level.

The practical implication of the above findings is that placing equal emphasis on full as well as substantial compliance with the Compliance Measures could be an acceptable public policy decision.

Section 4 – Head Start Key Indicators (HSKI)

The fourth and final section of this report is in some ways the most important since this is the focus of the study: developing statistically predictive Key Indicator (KI) Compliance Measures (CM) – the Head Start Key Indicators (HSKI).

These are the statistically predictive Key Indicators based upon the KI methodology, correlations with the CLASS/ES, CO, IS, and correlations with the CM Total Violation scores. Table 4 lists the results while Appendix 1 has the specific KI’s content specified. Appendix 2 depicts the KI Formula Matrix. Only those Compliance Measures (CM) that had significant results on three of the five correlations were selected to be Head Start Key Indicator Compliance Measures (HSKI).

The methodology used to generate the Compliance Measure Key Indicators sorted the top 20% of programs in compliance and compared this group to the bottom 27% of programs in compliance. The middle 53% of programs were not used in order to determine the Key Indicators. These cut off points
were determined by the compliance distribution in which 20% of the programs were in 100% compliance while 27% of the programs had compliance scores of 95% or less.

Table 4 – Head Start Key Indicator (HSKI) Compliance Measures (CM) and CLASS and Total Violations

<table>
<thead>
<tr>
<th>HSKI/CM (2013)</th>
<th>Phi</th>
<th>CLASS/ES</th>
<th>CLASS/CO</th>
<th>CLASS/IS</th>
<th>Total Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDE4.1</td>
<td>.28***</td>
<td>.10*</td>
<td>ns</td>
<td>ns</td>
<td>.30***</td>
</tr>
<tr>
<td>CHS1.1</td>
<td>.39***</td>
<td>.15**</td>
<td>.16**</td>
<td>.10*</td>
<td>.39***</td>
</tr>
<tr>
<td>CHS1.2</td>
<td>.33***</td>
<td>.18**</td>
<td>.15**</td>
<td>ns</td>
<td>.39***</td>
</tr>
<tr>
<td>CHS2.1</td>
<td>.49***</td>
<td>.18**</td>
<td>.15**</td>
<td>ns</td>
<td>.54***</td>
</tr>
<tr>
<td>CHS3.10</td>
<td>.39***</td>
<td>.11*</td>
<td>.11*</td>
<td>ns</td>
<td>.24***</td>
</tr>
<tr>
<td>GOV2.1</td>
<td>.31***</td>
<td>.11*</td>
<td>ns</td>
<td>ns</td>
<td>.46***</td>
</tr>
<tr>
<td>SYS2.1</td>
<td>.47***</td>
<td>.15**</td>
<td>.16**</td>
<td>.14**</td>
<td>.55***</td>
</tr>
<tr>
<td>SYS3.4</td>
<td>.58***</td>
<td>.13*</td>
<td>.10*</td>
<td>ns</td>
<td>.36***</td>
</tr>
</tbody>
</table>

Phi = the phi coefficient which statistically predicts compliance with the full set of CM’s.

CLASS/ES = correlations between the specific CM and this specific scale of the CLASS.
CLASS/CO = correlations between the specific CM and this specific scale of the CLASS.
CLASS/IS = correlations between the specific CM and this specific scale of the CLASS.

Total Violations = correlations between the specific CM and the total number of CM violations for each program.

*   p < .05
**  p < .01
*** p < .001
ns = not significant

Separate Key Indicators were run for just Head Start only and Head Start/Early Head Start programs but the key indicators were only a subset of the above list, albeit a shorter list in each case. Based upon those phi coefficients, it was determined that using the above list for all Head Start only, Early Head Start, and Head Start/Early Head Start was a more efficient and effective way to monitor all the programs with one list of indicators rather than having separate key indicators for program types. The separate phi coefficients run for Head Start only and Head Start/Early Head Start programs did not show any significant differences because they were sub-samples of the overall sample drawn.

Section 4A – Suggested Use of the HSKI for Head Start Program Monitoring

Now that Key Indicators have been generated, the next question is how to use HSKI in the program monitoring of Head Start. A possible way in which the HSKI could be used would be the following (see Figure 1) in which a differential monitoring approach could be used:

All programs would be administered the HSKI. If there is full (100%) compliance with the Head Start Key Indicators (HSKI) then the next scheduled review of the program would be an Abbreviated Monitoring Visit (AMV). If there is not 100% compliance with the Head Start Key Indicators (HSKI) then the next scheduled review of the program would be a Full Monitoring Visit (FMV) in which all Compliance Measures are reviewed. Based upon the results of the FMV a determination could be made regarding a compliance or non-compliance decision (see Figure 1) and how often the program will be visited.
Figure 1 – Head Start Key Indicator (HSKI) Compliance Measures Differential Monitoring Model

**Compliance Decisions:**

**Head Start Key Indicators (HSKI)** – this becomes a screening tool to determine if a program receives an AMV OR FMV visit.

**HSKI (100%)** = For the next visit, an Abbreviated Monitoring Visit (AMV) is conducted. Every 3-4 yrs a full Monitoring is conducted.

**HSKI (not 100%)** = For the next visit, a Full Monitoring Visit (FMV) is conducted and all CMs are reviewed.

**Compliance** = 98%+ with all CMs which indicates substantial to full compliance and 100% with HSKI. For the next visit, an Abbreviated Monitoring Visit (AMV) is conducted.

**Non-compliance** = less than 98% with all CMs which indicates low compliance. For the next visit a Full Monitoring Visit (FMV) is conducted.

Moving to a differential monitoring system could provide a cost effective and efficient model for Head Start program monitoring. This revision to the Head Start program monitoring system would combine a risk assessment and key indicator approach (see Appendix 3) in determining what compliance measures to review, how often, and how comprehensive a review should be utilized. It would continue to focus on the most critical compliance measures that statistically predict overall compliance with the full complement of compliance measures.

See Appendix 7 – Figure 2 for how the above differential monitoring system could impact the present Head Start Tri-Annual Review Monitoring System. In this appendix, a cost neutral monitoring system is proposed based upon the above DMLMA/Key Indicator Model.
References


Footnotes

1) PIR Dashboard Key Indicators could not be generated because the PIR data demonstrated little statistical predictive ability to be useful for discriminating between high and low compliant programs or program quality with the exception of staff having CDA’s.

2) The correlation between Compliance Measures (CM) and the statistically predictive Key Indicators (HSKI) was .77 which exceeds the expected correlation threshold.

3) The correlations between the CLASS/ES, CO, IS and Key Indicators were the following: .27, .25, .17 respectively. The correlations between KI and ES, CO were higher than the correlations between CM and ES, CO as reported earlier in this report. The correlation between IS and CM was higher .20 than KI and IS (.17).

4) Because this study spans the 2012 Review Protocol and 2013 Monitoring Protocol, Compliance Indicators and Compliance Measures are used interchangeably with a preference given to using Compliance Measures (CM) in this report. There are 139 Compliance Indicators; 115 Compliance Measures, but for the purposes of this study 131 Compliance Measures were available in the 2012 Head Start data base drawn for this study.

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February 2013 (revised March, April 2013)
## Appendix 1 – Head Start Key Indicators (HSKI) Compliance Measures Content

<table>
<thead>
<tr>
<th>CM</th>
<th>Content</th>
<th>Regulations/Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS1.1</td>
<td>The program engages parents in obtaining from a health care professional a determination of whether each child is up to date on a schedule of primary and preventive health care (including dental) and assists parents in bringing their children up to date when necessary and keeping their children up to date as required.</td>
<td>1304.20(a)(1)(ii), 1304.20(a)(1)(ii)(A), 1304.20(a)(1)(ii)(B)</td>
</tr>
<tr>
<td>CHS1.2</td>
<td>The program ensures that each child with a known, observable, or suspected health, oral health, or developmental problem receives follow-up and further testing, examination, and treatment from a licensed or certified health care professional.</td>
<td>1304.20(a)(1)(iii), 1304.20(a)(1)(iv), 1304.20(c)(3)(ii)</td>
</tr>
<tr>
<td>CHS2.1</td>
<td>The program, in collaboration with each child’s parent, performs or obtains the required linguistically and age-appropriate screenings to identify concerns regarding children within 45 calendar days of entry into the program, obtains guidance on how to use the screening results, and uses multiple sources of information to make appropriate referrals.</td>
<td>1304.20(a)(2), 1304.20(b)(1), 1304.20(b)(2), 1304.20(b)(3)</td>
</tr>
<tr>
<td>CHS3.10</td>
<td>Maintenance, repair, safety of facility and equipment</td>
<td>1304.53(a)(7)</td>
</tr>
<tr>
<td>GOV2.1*</td>
<td>Members of the governing body and the Policy Council receive appropriate training and technical assistance to ensure that members understand 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>
<tr>
<td>SYS2.1</td>
<td>The program established and regularly implements a process of ongoing monitoring of its operations and services, including delegate agencies, in order to ensure compliance with Federal regulations, adherence to its own program procedures, and progress towards the goals developed through its Self-Assessment process.</td>
<td>1304.51(i)(2), 641A(g)(3)</td>
</tr>
<tr>
<td>SYS3.4</td>
<td>Prior to employing an individual, the program obtains a: Federal, State, or Tribal criminal record check covering all jurisdictions where the program provides Head Start services to children; Federal, State, or Tribal criminal record check as required by the law of the jurisdiction where the program provides Head Start services; Criminal record check as otherwise required by Federal law</td>
<td>648A(g)(3)(A), 648A(g)(3)(B), 648A(g)(3)(C)</td>
</tr>
</tbody>
</table>

Appendix 2: Key Indicator Formula Matrix for HSKI – Head Start Key Indicators

<table>
<thead>
<tr>
<th>Providers In Compliance</th>
<th>Programs Out Of Compliance</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Low Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>W</td>
<td>X</td>
</tr>
</tbody>
</table>

Key Indicator Statistical Methodology (Calculating the Phi Coefficient):

\[ \phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}} \]

\[ A = \text{High Group + Programs in Compliance on Specific Compliance Measure.} \]
\[ B = \text{High Group + Programs out of Compliance on Specific Compliance Measure.} \]
\[ C = \text{Low Group + Programs in Compliance on Specific Compliance Measure.} \]
\[ D = \text{Low Group + Programs out of Compliance on Specific Compliance Measure.} \]
\[ W = \text{Total Number of Programs in Compliance on Specific Compliance Measure.} \]
\[ X = \text{Total Number of Programs out of Compliance on Specific Compliance Measure.} \]
\[ Y = \text{Total Number of Programs in High Group.} \]
\[ Z = \text{Total Number of Programs in Low Group.} \]

\[ \text{High Group} = \text{Top 20\% of Programs in Compliance with all Compliance Measures.} \]
\[ \text{Low Group} = \text{Bottom 27\% of Programs in Compliance with all Compliance Measures.} \]

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include on HSKI</td>
</tr>
<tr>
<td>(.25) – (0)</td>
<td>Too Easy</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(0) – (-.25)</td>
<td>Too Difficult</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>
Appendix 3

DIFFERENTIAL MONITORING LOGIC MODEL AND ALGORITHM (Fiene, 2012) DMLMA© Applied to the Office of Head Start Program Monitoring Compliance System

CI + PQ => RA + KI => DM

Head Start Examples:

CI = Head Start Performance Standards (HSPS)
PQ = CLASS ES, IS, CO (CLASS)
RA = Compliance Measures (CM)
KI = Key Indicators (generated from this study = Head Start Key Indicators (HSKI))
DM = Not Applicable at this time (NA) but see Figure 1 for a proposed model

DMLMA© Thresholds:

High Correlations (.70+) = CI x KI.
Moderate Correlations (.50+) = CI x RA; RA x DM; RA x KI; KI x DM.
Lower Correlations (.30+) = PQ x CI; PQ x RA; PQ x KI.
## Appendix 4: Content Areas and Compliance Measures

<table>
<thead>
<tr>
<th>Content Areas and Compliance Measures</th>
<th>Percent (%) Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CDE - CHILD DEVELOPMENT AND EDUCATION</strong></td>
<td></td>
</tr>
<tr>
<td>1.1.2.2 The program implements a curriculum that is aligned with the Head Start Child Development and Early Learning Framework...</td>
<td>99%</td>
</tr>
<tr>
<td>1.2 The program implements a curriculum that is evidence-based...</td>
<td>99%</td>
</tr>
<tr>
<td>1.3.2.1 The curriculum is comprehensive...</td>
<td>99%</td>
</tr>
<tr>
<td>2.1 The program implements an infant/toddler curriculum...</td>
<td>99%</td>
</tr>
<tr>
<td>2.2 The program develops secure relationships in out of home care settings for infants and toddlers...</td>
<td>100%</td>
</tr>
<tr>
<td>2.3 The program implements an infant/toddler curriculum that encourages trust...</td>
<td>100%</td>
</tr>
<tr>
<td>2.4 The program encourages the development of self-awareness, autonomy...</td>
<td>100%</td>
</tr>
<tr>
<td>2.5 The program fosters independence...</td>
<td>100%</td>
</tr>
<tr>
<td>2.6 The program enhances each child’s strengths by encouraging self control...</td>
<td>99%</td>
</tr>
<tr>
<td>2.7 The program plans for routines and transitions...</td>
<td>99%</td>
</tr>
<tr>
<td>2.9 The program encourages respect for others feelings and rights...</td>
<td>99%</td>
</tr>
<tr>
<td>2.10 The program provides opportunities for children to engage in child-initiated...</td>
<td>100%</td>
</tr>
<tr>
<td>2.11 Nutrition services contribute to children’s development and socialization...</td>
<td>100%</td>
</tr>
<tr>
<td>3.1 The program uses information from screenings, ongoing observations...</td>
<td>99%</td>
</tr>
<tr>
<td>3.2 The programs’ nutrition program is designed and implemented to meet the nutritional needs...</td>
<td>98%</td>
</tr>
<tr>
<td>3.4(CHS4.5) Meal and snack periods are appropriately scheduled...</td>
<td>99%</td>
</tr>
<tr>
<td>3.5(CHS4.2) Services provided to children with identified disabilities are designed to support...</td>
<td>100%</td>
</tr>
<tr>
<td>3.6(CHS3.3) The program designates a staff member or consultant to coordinate services for children w/disabilities...</td>
<td>100%</td>
</tr>
<tr>
<td>3.7(CHS3.4) The program has secured the services of a mental health professional...</td>
<td>97%</td>
</tr>
<tr>
<td>3.8(CHS3.5) The program’s approach to CDE is developmentally and linguistically appropriate...</td>
<td>99%</td>
</tr>
<tr>
<td>4.1 The program establishes goals for improving school readiness...</td>
<td>98%</td>
</tr>
<tr>
<td>4.2 The program uses self assessment information on school readiness goals...</td>
<td>99%</td>
</tr>
<tr>
<td>4.3 The program demonstrates that children who are dual language learners...</td>
<td>100%</td>
</tr>
<tr>
<td>5.1(CHS4.1) The program hires teachers who have the required qualifications, training, &amp; experience.</td>
<td>92%</td>
</tr>
<tr>
<td>5.2 The program ensures that family child care providers have the required qualifications...</td>
<td>100%</td>
</tr>
<tr>
<td>5.3 The program ensures that all full time Head Start employees who provide direct education...</td>
<td>96%</td>
</tr>
<tr>
<td>5.4 The program ensures that home visitors have the required qualifications, training...</td>
<td>99%</td>
</tr>
<tr>
<td>5.5 When the majority of children speak the same language...</td>
<td>99%</td>
</tr>
<tr>
<td><strong>CHS - CHILD HEALTH AND SAFETY</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 The program engages parents in obtaining from a health care professional a determination of whether each child...</td>
<td>89%</td>
</tr>
<tr>
<td>1.2 The program ensures that each child with a known, observable, or suspected health, oral health......</td>
<td>92%</td>
</tr>
<tr>
<td>1.3 The program involves parents, consulting with them immediately when child health or developmental problems......</td>
<td>100%</td>
</tr>
<tr>
<td>1.4 The program informs parents and obtains authorization prior to all health procedures...</td>
<td>98%</td>
</tr>
<tr>
<td>1.5 The program has established procedures for tracking the provision of health services...</td>
<td>97%</td>
</tr>
<tr>
<td>1.6 The EHS program helps pregnant women, immediately after enrollment in the program, access through referrals...</td>
<td>100%</td>
</tr>
<tr>
<td>1.7 Program health staff conduct a home visit or ensure that a health staff member visits each newborn within 2 weeks of birth...</td>
<td>97%</td>
</tr>
<tr>
<td>2.1 The program, in collaboration with each child’s parent, performs or obtains the required screenings...</td>
<td>84%</td>
</tr>
<tr>
<td>2.2 A coordinated screening, assessment, and referral process for all children...</td>
<td>98%</td>
</tr>
<tr>
<td>2.3 The program, in partnership with the LEA or Part C Agency, works to inform and engage parents in all plans for screenings...</td>
<td>99%</td>
</tr>
<tr>
<td>3.1 Facilities used for center based program options comply with state and local licensing...</td>
<td>100%</td>
</tr>
<tr>
<td>3.2 The program ensures that sufficient equipment, toys, materials, and furniture are provided...</td>
<td>97%</td>
</tr>
<tr>
<td>3.3 Precautions are taken to ensure the safety of children...</td>
<td>99%</td>
</tr>
<tr>
<td>3.4 The program ensures that medication is properly stored and is not accessible to children...</td>
<td>98%</td>
</tr>
<tr>
<td>3.5 The program ensures that no hazards are present around children...</td>
<td>89%</td>
</tr>
<tr>
<td>3.6 The program ensures that sleeping arrangements for infants do not use soft bedding materials.</td>
<td>99%</td>
</tr>
<tr>
<td>3.7 All infant and toddler toys are made of non-toxic materials and sanitized regularly.</td>
<td>99%</td>
</tr>
<tr>
<td>3.8 The program has adequate usable indoor and outdoor space.</td>
<td>99%</td>
</tr>
<tr>
<td>3.9 Outdoor play areas are arranged to prevent children from getting into unsafe or unsupervised areas...</td>
<td>100%</td>
</tr>
<tr>
<td>3.10 The program provides for maintenance, repair, safety, and security of all Head Start facilities and equipment...</td>
<td>85%</td>
</tr>
<tr>
<td>3.11 The program’s facilities provide adequately for children with disabilities...</td>
<td>100%</td>
</tr>
<tr>
<td>4.1 Staff, volunteers, and children wash their hands with soap and running water.</td>
<td>98%</td>
</tr>
<tr>
<td>4.2 Spilled bodily fluids are cleaned up and disinfected immediately...</td>
<td>100%</td>
</tr>
<tr>
<td>4.3 The program adopts sanitation and hygiene practices for diapering...</td>
<td>99%</td>
</tr>
</tbody>
</table>
The financial records of the grantee are sufficient to allow verification that non-
Federal share contributions are necessary and reasonable. Grantees that entered into a mortgage or other loan agreement using collateral property complied with Federal regulations.
The program meets property management standards for equipment purchased using Head Start grant funds. For grantees that own facilities purchased or constructed using Head Start grant funds, documentation is available.

The program has a systematic process for establishing selection criteria and ensuring that no child's enrollment or participation in the Head Start program is contingent on payment of a fee.

The program has taken steps to establish ongoing collaborative relationships with community organizations.

The program's financial management systems provide for effective control and accountability. Program staff are familiar with the backgrounds of families and children.

The program has a systematic process for establishing selection criteria and ensuring that no child's enrollment or participation in the Head Start program is contingent on payment of a fee.

The program has taken steps to establish ongoing collaborative relationships with community organizations.

The program ensures that facilities are available for proper refrigerated storage and handling of breast milk and formula.

The program ensures that the children are released only to a parent or other person designated by the parent.

The program ensures that persons employed to drive vehicles receive the required behind-the-wheel training.

The program ensures that persons employed to drive vehicles receive the required behind-the-wheel training.

The program ensures that facilities are available for proper refrigerated storage and handling of breast milk and formula.

The program has taken steps to establish ongoing collaborative relationships with community organizations.

The program ensures that facilities are available for proper refrigerated storage and handling of breast milk and formula.
<table>
<thead>
<tr>
<th>OHS KEY INDICATOR PROJECT REPORT</th>
<th>2013</th>
</tr>
</thead>
</table>

1.1 The program has a governing body.... 98%
1.2 The program has established a policy council.... 98%
2.1 Policy council and policy committee members are supported by the program.... 99%
2.2 The program has policies and procedures in place to ensure that member of the governing body & PAC are free..... 97%
3.1(2.1) Members of the governing body and the PAC receive appropriate training and TA..... 94%
3.2(2.2) The governing body performs required activities and makes decisions pertaining to program administration.... 95%
3.3 The governing body approves financial management, accounting, and reporting policies..... 99%
3.4 The governing body reviews and approves all of the program’s major policies..... 95%
3.5(2.4) The PAC approves and submits decisions about identified program activities to the governing body. 98%
4.1(3.1) Governing body and PAC members regularly receive and use information about program planning..... 88%

**SYS – MANAGEMENT SYSTEMS** 91%

1.1 The program routinely engages in a process of systematic planning that utilizes the results of the community assessment.... 97%
1.2(5.1) At least annually, the program conducts a self assessment of program effectiveness.... 97%
2.1(5.2) The program established and regularly implements a process of ongoing monitoring of its operations and services.... 86%
2.2 The program established and maintains a record keeping system regarding children, families, and staff.... 92%
2.3 The program publishes and makes available to the public an annual report..... 88%
3.1 The program has established an organizational structure that provides for adequate supervision..... 97%
3.2 The program develops and implements written standards of conduct..... 97%
3.3 The program ensures that each staff member completes an initial health examination..... 90%
3.4 Prior to employing an individual, the program obtains: criminal record check.... 66%
4.1 The program has mechanisms for regular communication among all program staff.... 98%
Appendix 5 – Histograms of Total Compliance Measure Violations, CLASS (IS, ES, CO) Scores and Head Start Key Indicator (HSKI) Scores

Total Compliance Measure Violations

Mean = 3.33
Std. Dev. = 3.769
N = 422
CLASS ES Scores

Mean = 5.8935
Std. Dev. = .3578
N = 384
CLASS CO Scores

Mean = 5.4506
Std. Dev. = .4905
N = 384
CLASS IS Scores

Mean = 2.9933
Std. Dev. = .7030
N = 384
Head Start Key Indicators (HSKI) Scores

Mean = 1.00
Std. Dev. = 1.365
N = 422
Appendix 6 -

CONTENT AREA (CA)
CORRELATIONS

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th>ERSEA</th>
<th>FCE</th>
<th>FIS</th>
<th>GOV</th>
<th>SYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDE</td>
<td>.33**</td>
<td>.26**</td>
<td>.06</td>
<td>.14**</td>
<td>.13*</td>
<td>.33**</td>
</tr>
<tr>
<td>CHS</td>
<td></td>
<td>.29**</td>
<td>.18**</td>
<td>.09</td>
<td>.25**</td>
<td>.51**</td>
</tr>
<tr>
<td>ERSEA</td>
<td></td>
<td></td>
<td>.15**</td>
<td>.10*</td>
<td>.27**</td>
<td>.38**</td>
</tr>
<tr>
<td>FCE</td>
<td></td>
<td></td>
<td></td>
<td>.01</td>
<td>.17**</td>
<td>.23**</td>
</tr>
<tr>
<td>FIS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.13*</td>
<td>.23**</td>
</tr>
<tr>
<td>GOV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.38**</td>
</tr>
</tbody>
</table>

* P < .05  
** P < .01

CONTENT AREAS (CA):  
FCE = FAMILY and COMMUNITY ENGAGEMENT  
ERSEA = ELIGIBILITY, RECRUITMENT, SELECTION, ENROLLMENT, and ATTENDANCE  
CDE = CHILD DEVELOPMENT AND EDUCATION  
GOV = PROGRAM GOVERNANCE  
FIS = FISCAL INTEGRITY  
CHS = CHILD HEALTH AND SAFETY  
SYS = MANAGEMENT SYSTEMS

Appendix 6A – Total Compliance with Compliance Measures, HSKI, and Content Area Correlations

<table>
<thead>
<tr>
<th></th>
<th>TOT</th>
<th>HSKI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDE</td>
<td>.51**</td>
<td>.42**</td>
</tr>
<tr>
<td>CHS</td>
<td>.70**</td>
<td>.81**</td>
</tr>
<tr>
<td>ERSEA</td>
<td>.49**</td>
<td>.33**</td>
</tr>
<tr>
<td>FCE</td>
<td>.30**</td>
<td>.22**</td>
</tr>
<tr>
<td>FIS</td>
<td>.50**</td>
<td>.14**</td>
</tr>
<tr>
<td>GOV</td>
<td>.57**</td>
<td>.37**</td>
</tr>
<tr>
<td>SYS</td>
<td>.78**</td>
<td>.72**</td>
</tr>
</tbody>
</table>

TOT = Total Compliance with all Compliance Measures.  
HSKI = Total Compliance with the Head Start Key Indicators.
Appendix 7 – Figure 2 – DMLMA Potential Impact on Tri-Annual Head Start Program Reviews

Present Head Start Monitoring System:

All programs receive the same Tri-Annual Reviews regardless of Compliance History:

- Present Head Start Monitoring System:
  - Tri-Annual Review – all 131 CM’s
  - Tri-Annual Review – all 131 CM’s
  - Tri-Annual Review – all 131 CM’s

Proposed DMLMA System with Key Indicators (KI):

100% Compliance with the Head Start Key Indicators (HSKI):

- Proposed DMLMA System with Key Indicators (KI):
  - HSKI 8 KI CM’s
  - HSKI 8 KI CM’s
  - HSKI 8 KI CM’s
  - HSKI 8 KI CM’s
  - FULL REVIEW OF ALL 131 CM’S APPLIED
  - HSKI 8 KI CM’s
  - HSKI 8 KI CM’s

If less than 100% with the Head Start Key Indicators (HSKI):

- If less than 100% with the Head Start Key Indicators (HSKI):
  - Full Review – all 131 CM’s applied
  - Full Review – all 131 CM’s applied
  - Full Review – all 131 CM’s applied
  - Full Review – all 131 CM’s applied
The above proposed change is cost neutral by re-allocating monitoring staff from doing only Tri-Annual Reviews on every program to doing abbreviated monitoring via the HSKI on the highly compliant programs with periodic comprehensive full monitoring less frequently (this would change if a program did not continue to be 100% in-compliance with the HSKI), and only doing more comprehensive full monitoring on those programs with low compliance with the Compliance Measures and/or less than 100% compliance with the HSKI. Once a program was in the high compliance group they would be eligible for the HSKI abbreviated monitoring.

However, the real advantage in this proposed change is the increased frequency of targeted or differential monitoring of all programs.

**DMLMA Algorithm with Key Indicators applied to Head Start Tri-Annual Reviews:**

Six (6) Years example:

**Present Head Start Monitoring System:**

(Tri-Annual Visits)(Compliance Measures)(Percent of Programs(%)) = Total Effort
(3)(131)(100) = 39300
Total Effort = **39300**

**Revised Head Start Monitoring DMLMA with Key Indicators System:**

100% Compliance with HSKI:
(Number of Monitoring Visits)(Compliance Measures)(Percent of Programs*(%)) = Total Effort
Abbreviated Monitoring Visits using Key Indicators: (6)(8)(43*) = 2064
Full, Comprehensive Monitoring Visit using all Compliance Measures: (1)(131)(43*) = 5633

Less than 100% Compliance with HSKI:
(Number of Monitoring Visits)(Compliance Measures)(Percent of Programs**(%) = Total Effort
Full, Comprehensive Monitoring Visits using all Compliance Measures: (4)(131)(57**) = 29868

100% Compliance with HSKI + Less than 100% Compliance with HSKI = Total Effort:
Total Effort = 2064 + 5633 + 29868 = **37565**

*This was the actual percent of Head Start Programs that met the criteria of 100% compliance with HSKI in this study.
**This was the actual percent of Head Start Programs that did not meet the criteria of 100% compliance with HSKI in this study.

It would be expected that the total population of Head Start programs would have a similar percent as was found in this representative sample (43% = 100% compliance with HSKI and 57% = less than 100% compliance with HSKI). This representative sample for this study constituted approximately 25% of all Head Start programs nationally.
Georgia Child Care Licensing Study: Validating the Core Rule Differential Monitoring System

Executive Summary

Richard Fiene, Ph.D.

The purpose of this study was to validate Georgia’s process for determining if a state-regulated child care facility is compliant with basic state health and safety requirements. The process was developed by staff at Bright from the Start: Georgia Department of Early Care and Learning (DECAL). Currently Georgia utilizes a “Core Rule” risk assessment approach in which the health and safety rules deemed most crucial to ensure children’s health and safety are used to compute a program’s compliance status.

This validation study utilized a unique analytical model that compared licensing data with previous key indicator (for readers not familiar with this term, please see the definitions on page 4 of the report) research and ascertained if the Core Rules accurately indicated a program’s overall compliance with the total population of licensing rules.

Additional statistical analyses examined if the mathematical formula used to compute compliance was an appropriate configuration of the data that discerned between those programs that adequately met basic health and safety rules (compliant) and those that did not (non-compliant). Also licensing data were compared to a representative sample of quality data collected as part of a different study to examine the correlation between compliance and quality. A Differential Monitoring Logic Model/Algorithm (DMLMA©) (Fiene, 2012) and a previous validation framework (Zellman & Fiene, 2012) were used in the research.

One hundred and four child care centers (104 CCC) and 147 family child care (FCC) homes were assessed. Licensing data over a four-year period (2008-2012) and matching program quality data from a two-year period (2007-2008) were used in this study.

The study focused on three research questions:

1. Do the Core Rules CCCs and FCC homes serve as overall Key Indicators of compliance?
2. Does the Annual Compliance Determination Worksheet (ACDW) appropriately designate programs as compliant or non-compliant related to health and safety?
3. Are the Core Rules related to program quality?

The analysis demonstrated that the Core Rules did serve as key indicators, and these key indicators were identified for both center based and home based child care. The second analysis concluded that the ACDW computation did distinguish between compliant and non-compliant programs. Finally, the expected correlation between compliance and quality was found but only for state-funded Pre-K classrooms, not for family child care nor for preschool classrooms that were not part of the state-funded Pre-K.
Georgia Child Care Licensing Study: Validating the Core Rule Differential Monitoring System

Richard Fiene, Ph.D.

February 1, 2014

This study was made possible by a grant from Bright from the Start: Georgia Department of Early Care and Learning. All opinions expressed in the report reflect the opinions of the author, not necessarily those of the Department of Early Care and Learning.

ABSTRACT

The purpose of this study was to validate Georgia’s process for determining if a state-regulated child care facility is compliant with basic state health and safety requirements. The process was developed by staff at Bright from the Start: Georgia Department of Early Care and Learning (DECAL). Currently Georgia utilizes a “Core Rule” risk assessment approach in which the health and safety rules deemed most crucial to ensure children’s health and safety are used to compute a program’s compliance status. This validation study utilized a unique analytical model that compared licensing data with previous key indicator (for readers not familiar with this term, please see the definitions on page 4 of the report) research and ascertained if the Core Rules accurately indicated a program’s overall compliance with the total population of licensing rules. Additional statistical analyses examined if the mathematical formula used to compute compliance was an appropriate configuration of the data that discerned between those programs that adequately met basic health and safety rules (compliant) and those that did not (non-compliant). Also, licensing data were compared to a representative sample of quality data collected as part of a different study to examine the correlation between compliance and quality. A Differential Monitoring Logic Model/Algorithm (DMLMA©) (Fiene, 2012) and a previous validation framework (Zellman & Fiene, 2012) were used in the research. Child care centers (CCC) and family child care (FCC) homes were assessed. The analysis demonstrated that the Core Rules did serve as key indicators, though this list should be reexamined. The second analysis concluded that the computation could be simplified. Finally, the expected correlation between compliance and quality was found but only in state-funded Pre-K classrooms; it was not found in preschool classrooms and could not be validated. Family child care could not be validated either. As a result of the study, recommendations were made to strengthen Georgia’s child care licensing system.

Acknowledgements:

Special thanks are extended to DECAL staff who had the vision to conduct this validation study: Bobby Cagle, Commissioner; Kay Hellwig, Assistant Commissioner for Child Care Services; Kristie Lewis, Director of Child Care Services; and Dr. Bentley Ponder, Director of Research & Evaluation. Also, researchers at the University of North Carolina, Chapel Hill, Frank Porter Graham Child Development Institute, Dr. Donna Bryant and Dr. Kelly Maxwell who made this study so much more significant by sharing program quality data from earlier studies they completed in Georgia.
INTRODUCTION

Background of Georgia’s Compliance Determination System

Similar to other states, Georgia has a licensing and monitoring system that oversees a diverse population of early care and learning programs across the state. The licensing and monitoring system of early care and learning programs is charged to Bright from the Start: Georgia Department of Early Care and Learning (DECAL), a state early education department that also oversees and administers Georgia’s Pre-K Program, Child Care and Development Block Grant, the Child and Adult Care Food Program, and the Summer Food Service Program. In 2012, DECAL’s licensing and monitoring system regulated approximately 6,300 early care and learning programs. The crux of this regulation is determining if the programs meet Georgia’s health and safety rules. Programs that meet these rules are determined to be compliant.

In the mid 2000’s, Georgia began experimenting with a process that determined whether or not a program was designated as compliant with the state’s health and safety regulations by focusing on key Core Rules. These are health and safety rules deemed crucial to minimizing risk related to children’s health and safety. Seventy-four rules out of the 456 that programs must follow were classified as Core Rules1. Core Rules are cited by severity (low, medium, high, extreme). It is important to note that this entails a risk assessment theoretical approach rather than a Key Indicator statistical approach. This means that the Core Rules were determined by content analysis rather than by a statistical procedure.

Though this system has undergone some slight revisions, this basic methodology is still in place:
1. All programs receive at least one full licensing study and one monitoring visit. At the licensing study all applicable rules are examined. At the monitoring visit, only Core Rules (or any rule that was not met at the licensing study) are examined.
2. If additional visits are conducted, the Core Rules are examined again at that time.
3. At the end of the fiscal year (June 30), each program receives a compliance determination. This determination is based on all visits (licensing study, monitoring visit, and other reviews). A standardized worksheet, Annual Compliance Determination Worksheet (ACDW), is used to make the computation that determines the designation.
4. The compliance status remains until the next determination one year later. Programs do not have an opportunity to contest the compliance determination, though programs have numerous opportunities to contest any citation.
5. At the conclusion of Fiscal Year 2012, approximately 91% of the programs were classified as compliant. A program’s eligibility for certain services, acceptance into Quality Rated and Georgia’s Pre-K Program, is impacted by the program’s compliance determination.

Background of this Study

Since the compliance determination system has been used for several years, key policymakers at DECAL requested an external review to validate if the system was operating as intended. Are the Core Rules a sufficient subsample to measure a program’s overall regulation with the state’s health and safety regulations? Furthermore, does the compliance determination formula appropriately differentiate compliant programs from non-compliant programs? In other words, is the computation a viable way to make this designation? And finally, does compliance determination serve as a sufficient indicator for other aspects of quality not addressed in Georgia’s health and safety rules?

The purpose of this study was to validate the aforementioned compliance determination process. This validation process utilized a unique analytical model that compared licensing data with previous key indicator research and ascertained if the Core Rules are an indication of a program’s overall compliance with the total population of licensing rules. Second, additional statistical analyses examined if the mathematical formula used to compute compliance was an appropriate configuration of the data that differentiated between those programs that adequately met basic health and safety rules (compliant) and those that did not (non-compliant). Finally, licensing data were

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1 The number of Core Rules was expanded in 2012 to include increased enforcement and sanctions regarding transportation. The new Core Rules were not part of this analysis.
Georgia Child Care Licensing Validation Study

compared to a representative sample of quality data collected as part of a different study to examine the correlation between compliance and quality (see a further explanation of the sample in the Limitations Section of this report).

Specifically, the study addressed the following research questions:

1. Do the Core Rules for child care centers (CCC) and family child care (FCC) homes serve as overall Key Indicators of compliance?
2. Does the Annual Compliance Determination Worksheet (ACDW) appropriately designate programs as compliant or non-compliant related to health and safety?
3. Are the Core Rules related to program quality?

The following definitions are used in the study:

**Core Rules** = the rules determined to be of greatest importance and place children at greatest risk if not complied with. This approach is defined in the licensing literature as a risk assessment approach. Core Rules cover 12 regulatory areas and 74 specific rules. The Core Rules were the focal point of this validation study and are addressed in the first approach to validation – Standards and the first research question.

**ACDW** = Annual Compliance Determination Worksheet, the compliance decision-making system based on the Core Rules that can be used to determine the number of visits made to programs. The ACDW was the secondary focal point of this validation study and is addressed in the second approach to validation – Measures and the second research question.

**Key Indicators** = a differential monitoring approach that uses only those rules that statistically predict overall compliance with all the rules. In other words, 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. In this study, eight Key Indicators rules were identified for CCC and nine Key Indicators rules for FCC (See Tables 9-12 and Figure 2 on pages 15-16 for the specific indicators and additional detail about the methodology). These are in addition to the Core Rules.

**Rule Violations or Citations** = occurs when a program does not meet a specific rule and is cited as being out of compliance with that rule. These individual rule violations/citations are summed to come up with total violation/citation scores on the Core Rules and on the Licensing Studies.

**Differential Monitoring** = a relatively new approach to determining the number of licensing visits made to programs and to what rules are reviewed during these visits. Two measurement tools drive differential monitoring: one is a Weighted Risk Assessment, and the other is a Key Indicator checklist. Weighted Risk Assessments determine how often a program will be visited while Key Indicator checklists determine what rules will be reviewed in the program. Differential monitoring is a powerful approach when Risk Assessment is combined with Key Indicators because a program is reviewed by the most critical rules and the most predictive rules. See Figure 1 which presents a Logic Model & Algorithm for Differential Monitoring (*DMLMA©*) (Fiene, 2012).

**Licensing Study** = a comprehensive review of a program where all child care rules are reviewed.

**Monitoring Visit** = an abbreviated form of a visit and review in which only a select group (Core Rules) of child care rules are reviewed.

**Program Quality** = for the purposes of this study, quality was measured in child care centers by the *Early Childhood Environment Rating Scale-Revised (ECERS-R)*, *Infant Toddler Environment Rating Scale-Revised (ITERS-R)* and in family child care homes by the *Family Child Care Environment Rating Scale-Revised (FCCERS-R)*. The program quality measures were used as part of the third approach to validation – Outputs and the third research question.
Scoring for Licensing Variables/Data Collection Protocols:

Licensing Study = the total number of rule violations for a specific facility.

Core Rules = the total number of core rule violations.

ACDW/Compliance Designation = the annual compliance determination taken from the Annual Compliance Determination Worksheet. Compliant [C] was coded as “1” in the data base; Non-Compliant [NC] was coded as “0” in the data base.

Key Indicators = these were generated by a statistical methodology based upon the ability of the specific rule to predict full compliance with all the rules. Data from the Licensing Studies were used to make this determination of key indicator rule status.

METHODOLOGY AND ANALYTICAL FRAMEWORK

Licensing data over a four-year period (2008-2012) and matching program quality data from a two-year period (2007-2008) were used in this study. Specifically, data from 104 child care centers and 147 family child care homes were analyzed. Data from licensing studies (all rules) and monitoring visits (selected rules) were utilized. Program quality data were provided by researchers from the FPG Child Development Institute at the University of North Carolina at Chapel Hill (FPG), and the FPG research team matched these data points with the licensing data provided by DECAL. (See the following website for the specific reports - http://decal.ga.gov/BftS/ResearchStudyOfQuality.aspx). All the data were analyzed by the Research Institute for Key Indicators.

Two models were used to frame the analysis: a Validation Framework that uses four approaches (Zellman & Fiene, 2012) to validating quality rating and improvement systems (QRIS) being applied to licensing systems; and a Differential Monitoring Logic Model and Algorithm (DMLMA©)(Fiene, 2012) were employed to answer the three research questions for this Validation Study. The validation approaches are described below; the DMLMA© is described at the beginning of the Findings Section of this report.

The first validation approach deals with examining the validity of key underlying concepts by assessing if basic components and standards are the right ones by examining levels of empirical and expert support. For this study, this approach used Key Indicators to validate the Core Rules since Risk Assessment and Key Indicators are differential monitoring approaches. This answers the first research question.

The second validation approach deals with examining the measurement strategy and the psychometric properties of the measures used by assessing whether the verification process for each rule is yielding accurate results. Properties of the key rules can be measured through inter-rater reliability on observational measures, scoring of documentation, and inter-item correlations to determine if measures are psychometrically sound. Cut scores can be examined to determine the most appropriate ways to combine measures into summary ratings. For this study, the second validation approach validates the use of the ACDW and Core Rules by comparing compliance decisions with the Licensing Studies. This answers the second research question.

The third validation approach deals with assessing the outputs of the licensing process by examining the variation and patterns of program level ratings within and across program types to ensure that the ratings are functioning as intended. The approach examines the relationship of program level ratings to other more broadly based program quality measures and examines alternate cut points and rules to determine how well the ratings distinguish different levels of quality. For this study, this approach used data from Core Rules and Licensing Studies and data from earlier program quality studies (Maxwell, et al., 2009a,b; 2010) for validation. This answers the third research question.

Out of the four validation approaches (See Table 8), only three were utilized in this study. The fourth validation approach deals with how ratings are associated with children’s outcomes. This approach examines the relationship
between program level ratings and selected child outcomes to determine whether higher program ratings are associated with better child outcomes. This approach did not have data that could be used in this study.

**FINDINGS**

The DMLMA© (See Figure 1) provides the conceptual model for assessing the overall effectiveness of Georgia’s approach using Core Rules. In the model, the two main tools are Risk Assessment and Key Indicator measurements, which are created from a statistical analysis of the comprehensive licensing tool. The comprehensive licensing tool measures compliance with all rules. For the purposes of this study the Licensing Study represents the comprehensive licensing tool while the Core Rules represent a Risk Assessment tool. For the Program Quality tools, the ECERS-R, ITERS-R and FCCERS-R were utilized from an earlier program quality study by FPG Child Development Institute at the University of North Carolina at Chapel Hill (Maxwell, et al., 2009a,b; 2010). Georgia currently does not use a Key Indicator tool (see Table 1). With the DMLMA© analytical methodology, specific correlational thresholds are expected (please refer to Figure 1 on page 14).

**TABLE 1**

<table>
<thead>
<tr>
<th>DMLMA© Terminology</th>
<th>Georgia Examples and Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Tool</td>
<td>Licensing Study</td>
</tr>
<tr>
<td>Program Quality Tool</td>
<td>ECERS-R and ITERS-R for CCC; FCCERS-R for FCC</td>
</tr>
<tr>
<td>Risk Assessment Tool</td>
<td>Core Rules</td>
</tr>
<tr>
<td>Key Indicators Tool</td>
<td>Not Present (Generated as part of this Study-see Tables 9/10)</td>
</tr>
<tr>
<td>Differential Monitoring Tool</td>
<td>ACDW Compliance Determination</td>
</tr>
</tbody>
</table>

Before presenting the findings for the validation approaches, some basic descriptive statistics are provided regarding the major variables in this study: Licensing Study, ACDW, Core Rules, and Key Indicators (see Table 2). The data are provided for both child care centers and family child care homes. It is clear from these basic descriptive statistics that the data distributions are very skewed in a positive fashion which means that there is very high compliance with all the major licensing variables for this study. In other words, the majority of programs are in substantial compliance with all the licensing rules and receive a compliant determination.

**TABLE 2**

<table>
<thead>
<tr>
<th>Licensing Variable</th>
<th>Mean</th>
<th>Range</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensing Study (CCC)</td>
<td>5.51</td>
<td>25</td>
<td>5.26</td>
<td>1.47</td>
<td>2.11</td>
</tr>
<tr>
<td>ACDW (CCC)</td>
<td>0.75</td>
<td>1</td>
<td>0.44</td>
<td>-1.17</td>
<td>-0.64</td>
</tr>
<tr>
<td>Core Rules (CCC)</td>
<td>4.47</td>
<td>22</td>
<td>4.72</td>
<td>1.81</td>
<td>3.60</td>
</tr>
<tr>
<td>Key Indicators (CCC)</td>
<td>1.68</td>
<td>6</td>
<td>1.61</td>
<td>0.90</td>
<td>0.073</td>
</tr>
<tr>
<td>Licensing Study (FCC)</td>
<td>5.85</td>
<td>33</td>
<td>5.71</td>
<td>1.56</td>
<td>3.37</td>
</tr>
<tr>
<td>ACDW (FCC)</td>
<td>0.87</td>
<td>1</td>
<td>0.34</td>
<td>-2.23</td>
<td>3.03</td>
</tr>
<tr>
<td>Core Rules (FCC)</td>
<td>1.61</td>
<td>11</td>
<td>1.75</td>
<td>1.99</td>
<td>6.61</td>
</tr>
<tr>
<td>Key Indicators (FCC)</td>
<td>2.37</td>
<td>8</td>
<td>2.13</td>
<td>0.63</td>
<td>-0.57</td>
</tr>
</tbody>
</table>

Licensing Study Mean = the average number of total rule violations.
ACDW Mean = the average score for a determination of compliance (1) or non-compliance (0).
Core Rules Mean = the average number of core rule violations.
Key Indicators Mean = the average number of key indicator violations.

The findings are presented by the three validation approaches of Standards, Measures, and Outputs as well as the three research questions related to Key Indicators, Core Rules, and Program Quality.

1) Validation of Standards (First Approach to Validation) for answering the first research question: *Do the Core Rules for child care centers (CCC) and family child care (FCC) homes serve as overall key indicators of compliance?*

In this first approach to validation which focuses on Standards, Key Indicators were generated from the Licensing Studies because Core Rules (a Risk Assessment tool) and Key Indicators are both Differential Monitoring approaches (see Figure 1). The Core Rules were compared to the Key Indicators generated by the licensing data base and there was a .49 correlation for CCC (n = 104) and .57 correlation for FCC (n = 147) which indicates a
relationship between the Core Rules and Key Indicators at a p < .0001 significance level (Table 3). Also, the Key Indicators were correlated with the Licensing Study data and significant results were determined with r values of .78 (p < .0001) for CCC (n = 104) and .87 (p < .0001) for FCC (n = 147). These results clearly met the expected DMLMA© thresholds between the key indicator rules with core rules (.50+) and licensing studies (.70+).

<table>
<thead>
<tr>
<th>Key Indicators with Core Rules and Licensing Study</th>
<th>r</th>
<th>p</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Indicators and Core Rules (CCC)</td>
<td>.49</td>
<td>.0001</td>
<td>104</td>
</tr>
<tr>
<td>Key Indicators and Licensing Study (CCC)</td>
<td>.78</td>
<td>.0001</td>
<td>104</td>
</tr>
<tr>
<td>Key Indicators and Core Rules (FCC)</td>
<td>.57</td>
<td>.0001</td>
<td>147</td>
</tr>
<tr>
<td>Key Indicators and Licensing Study (FCC)</td>
<td>.87</td>
<td>.0001</td>
<td>147</td>
</tr>
</tbody>
</table>

Table 3 begins to demonstrate how the Georgia Child Care Licensing system is utilizing the DMLMA© terminology from Table 1. With the generation of Key Indicators from this study, all the key elements within a differential monitoring system are present. This crosswalk to the DMLMA© will continue in Tables 4 & 5.

2) Validation of Measures (Second Approach to Validation) for answering the second research question: Is the Annual Compliance Determination Worksheet (ACDW) a valid measure in determining the overall health and safety compliance of Georgia’s early care and learning programs?

The Core Rules and the ACDW were compared to the Licensing Study data and compliance designation to determine the validation of the ACDW scoring protocol. There was a high correlation between the number of violations on the Core Rules and the total licensing violations on the Licensing Studies (r = .69; p < .0001)(Table 4). This result helps to validate that the ACDW is actually discriminating between high compliant and low compliant providers for CCC. For FCC, there was also a high correlation between the number of violations on the Core Rules and the total licensing violations on the Licensing Studies (r = .74; p < .0001). These results meet the DMLMA© thresholds of .50+ for Licensing Studies and Core Rules.

When Core Rules were correlated with the ACDW compliance decisions, there was a significantly high correlation for CCC (r = .76; p < .0001) and for FCC (r = .70; p < .0001). The key element of the ACDW scoring protocol is that the Core Rules distinguish between high and low compliant providers. The CCC/Core Rules and ACDW have been validated, as well as the FCC/Core Rules and ACDW because both the correlations were above the expected DMLMA© threshold (.50+).

<table>
<thead>
<tr>
<th>Core Rules with Licensing Studies and ACDW</th>
<th>r</th>
<th>p</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Rules and Licensing Studies (CCC)</td>
<td>.69</td>
<td>.0001</td>
<td>104</td>
</tr>
<tr>
<td>Core Rules and ACDW (CCC)</td>
<td>.76</td>
<td>.0001</td>
<td>104</td>
</tr>
<tr>
<td>Core Rules and Licensing Studies (FCC)</td>
<td>.74</td>
<td>.0001</td>
<td>147</td>
</tr>
<tr>
<td>Core Rules and ACDW (FCC)</td>
<td>.70</td>
<td>.0001</td>
<td>147</td>
</tr>
</tbody>
</table>

3) Validation of Outputs (Third Approach to Validation) for answering the third research question: Are the Core Rules correlated with program quality?

For this approach, programs were divided into those that had an ITERS-R score, an ECERS-R score for a preschool class, and an ECERS-R score for a Georgia’s Pre-K class; and those that had only an ITERS-R score and an ECERS-R score for preschool. The sample was evenly divided. Since Georgia has placed substantial resources into its Pre-K program, it was thought that this analysis might suggest if there was anything different between programs with a Georgia’s Pre-K class and those without.

When the Core Rules for CCC’s were compared with program quality data (ECERS-R/PS + ITERS-R), a significant correlation was not found between CCC (r = .27) for programs with only preschool classrooms but was found for programs with Pre-K classrooms (ECERS-R/PK + ITERS-R) (r = .60). When Core Rules for FCC’s were compared...
to the FCC program quality data (FCCERS-R), the correlations were at a much lower level (r = .17) (See Table 5). However, these results are constrained by the limited range of the data; see the Limitation Section that follows this section.

Upon closer inspection of the correlations in Table 5 for CCC, it would appear that the CCC compliance system is more valid with the state-funded Pre-K programs (.48) than with the preschool programs (.21) because the correlations between the various Environment Rating Scales (ECERS-R + ITERS-R) are significant only when compared to the respective compliance with all rules on the Licensing Studies in the programs that have Pre-K programs. In making these comparisons, programs that had both ECERS-R and ITERS-R were combined and compared to the respective Licensing Study data (these data were reversed scored in which the number of violations were subtracted from a perfect score of 100). The differences are even more significant when you compare the Environment Rating Scales and the Core Rules where the Pre-K programs’ correlation between the compliance with Core Rules and Environment Rating Scales is .60 and preschool programs is .27 while the FCC is .17.

Program quality data refer to data collected in earlier studies by researchers from FPG (Maxwell, et al., 2009a,b; 2010) in which FPG collected Environment Rating Scales (ECERS-R; ITERS-R; FCCERS-R) data on a representative sample of CCC and FCC (See [http://decal.ga.gov/BftS/ResearchStudyOfQuality.aspx]). In comparing the program compliance and program quality data, the analyses supported the validation of the CCC for Pre-K only programs (DMLMA© threshold = .30+) but it was weaker for the FCC programs and not significant for preschool programs and therefore could not be validated. See Table 13 on page 17 for a further explanation of the CCC data distribution.

**TABLE 5**

<table>
<thead>
<tr>
<th>Program Compliance and Quality Comparisons</th>
<th>r</th>
<th>p</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECERS-R/PK + ITERS-R and Licensing Studies</td>
<td>.48</td>
<td>.001</td>
<td>45</td>
</tr>
<tr>
<td>ECERS-R/PK + ITERS-R and Core Rules</td>
<td>.60</td>
<td>.0001</td>
<td>45</td>
</tr>
<tr>
<td>ECERS-R/PS + ITERS-R and Licensing Studies</td>
<td>.21</td>
<td>ns</td>
<td>45</td>
</tr>
<tr>
<td>ECERS-R/PS + ITERS-R and Core Rules</td>
<td>.27</td>
<td>ns</td>
<td>45</td>
</tr>
<tr>
<td>FCCERS-R and Licensing Studies</td>
<td>.19</td>
<td>.04</td>
<td>146</td>
</tr>
<tr>
<td>FCCERS-R and Core Rules</td>
<td>.17</td>
<td>.03</td>
<td>146</td>
</tr>
</tbody>
</table>

**LIMITATION**

The sampling for this study was based on previous studies (Maxwell, 2009a,b; 2010) completed by FPG in which program quality data were collected and analyzed. This study employed a subset of sites that were a representative sample of Georgia’s child care licensing system. Not all of these sites could be used for this study because some had closed or some did not have the necessary data to make comparisons. So the sample at this point is one of convenience; however, 104 of the 173 CCC and 146 of the 155 FCC were used in this study, a significant number of the original representative sample. Also, when the Environment Rating Scales (ECERS-R, ITERS-R, FCCERS-R) scores were compared with the CCC and FCC samples, there were no significant differences (average difference was .01-.03) between the two study samples (See Table 6).

**TABLE 6**

<table>
<thead>
<tr>
<th>Environment Rating Scale Scores</th>
<th>FPG</th>
<th>This Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECERS-R Pre-K Total Scale Scores</td>
<td>4.16</td>
<td>4.15</td>
</tr>
<tr>
<td>ECERS-R Preschool Total Scale Scores</td>
<td>3.39</td>
<td>3.42</td>
</tr>
<tr>
<td>ITERS-R Total Scale Scores</td>
<td>2.74</td>
<td>2.72</td>
</tr>
<tr>
<td>FCCERS-R Total Scale Scores</td>
<td>2.50</td>
<td>2.49</td>
</tr>
</tbody>
</table>
CONCLUSION

The CCC differential monitoring through the Core Rules/ACDW has been validated on the three approaches (Standards, Measures, and Outputs (Pre-K Program only)) and three research questions (Key Indicators, Core Rules, Program Quality (Programs with Georgia Pre-K only)) (See Table 7). The FCC differential monitoring through the Core Rules/ACDW was validated on the first validation approach (Standards) and first research question (Key Indicators); validated on the second validation approach (Measures) and second research question (Core Rules); but not validated on the third validation approach (Outputs) and third research question (Program Quality).

TABLE 7

<table>
<thead>
<tr>
<th>Validation Approach/Research Question</th>
<th>CCC Actual (Expected*)</th>
<th>FCC Actual (Expected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 STANDARDS/Key Indicators</td>
<td>VALIDATED</td>
<td>VALIDATED</td>
</tr>
<tr>
<td>Key Indicators x Core Rules</td>
<td>.49 (.50+)</td>
<td>.57 (.50+)</td>
</tr>
<tr>
<td>Key Indicators x Licensing Studies</td>
<td>.78 (.70+)</td>
<td>.87 (.70+)</td>
</tr>
<tr>
<td>2 MEASURES/Core Rules/ACDW**</td>
<td>VALIDATED</td>
<td>VALIDATED</td>
</tr>
<tr>
<td>Core Rules x Licensing Studies</td>
<td>.69 (.50+)</td>
<td>.74 (.50+)</td>
</tr>
<tr>
<td>Core Rules x ACDW</td>
<td>.76 (.50+)</td>
<td>.70 (.50+)</td>
</tr>
<tr>
<td>3 OUTPUTS/Program Quality</td>
<td>NOT VALIDATED</td>
<td></td>
</tr>
<tr>
<td>Licensing Studies x ERS/**/PK</td>
<td>.48 (.30+)</td>
<td>.19 (.30+)</td>
</tr>
<tr>
<td>Core Rules x ERS/PS</td>
<td>.60 (.30+)</td>
<td>.17 (.30+)</td>
</tr>
<tr>
<td>Licensing Studies x ERS/PS</td>
<td></td>
<td>.21 (.30+)</td>
</tr>
<tr>
<td>Core Rules x ERS/PS</td>
<td></td>
<td>.27 (.30+)</td>
</tr>
</tbody>
</table>

* DMLMA© Expected r Value Thresholds in Order to be Validated (Also see Figure 1 for additional details):  
High correlations (.70+) = Licensing Studies x Key Indicators.  
Moderate correlations (.50+) = Licensing Studies x Core Rules; Core Rules x ACDW; Core Rules x Key Indicators; Key Indicators x ACDW.  
Lower correlations (.30+) = Program Quality Tools x Licensing Studies; Program Quality x Core Rules; Program Quality x Key Indicators.  

Program Quality Tools = ECERS-R, ITERS-R, FCCERS-R.  
**ERS = ECERS-R + ITERS-R  
PK = Pre-K program  
PS= Preschool program

A confounding of data occurred with the first two validation approaches because the Core Rules were influenced a great deal by the National Child Care Key Indicators (NCCKI) (Fiene, 2002) where 10 of the 13 Core Rules overlapped significantly with the NCCKI. This helped to increase the correlation between the Core Rules and the Licensing Studies because the Core Rules represented both risk assessment and key indicator rules. Using both risk assessment and key indicator rules together is an ideal differential monitoring approach (Fiene, 2012). Most states use one or the other but generally not together. By including the newly generated key indicators from this study where there is also overlap with the NCCKI, it should enhance the differential monitoring approach utilized by DÉCAL.

2. ACDW decisions were compared with using severity as a factor and not using it as a factor in the scoring system with Core Rules. No significant differences were found between the two scoring systems; therefore, the results in this study represent Core Rule scores without severity included since this is the simpler model.
**RECOMMENDATIONS**

The following recommendations\(^3\) can be made from this Licensing Differential Monitoring Validation Study.

1) **First research question/validation recommendation**: Revise the worksheet determination scoring relative to the visiting protocol by combining the Core Rules with a Key Indicator approach so that if any of the Core Rules or Key Indicators are out of compliance, then a full compliance review (Licensing Study) should be used. The present worksheet determination scoring protocol is overly complex. Just moving to a more comprehensive review (Licensing Study) based on non-compliance with the Core Rules will simplify the scoring protocol and make determinations more straightforward. If there is full (100%) compliance with the Core Rules and Key Indicators, then the next scheduled review of the program would be an abbreviated Monitoring Visit. If there is not 100% compliance with the Core Rules and Key Indicators, then the next scheduled review of the program would be a Licensing Study reviewing all child care rules. Based upon the compliance/non-compliance scores of the Licensing Study will determine how often the program will be visited. A revised Georgia Differential Monitoring System could potentially look like the following:

![Diagram of Monitoring Process]

**Compliance Decisions:**

- **Core Indicators** = Core Rules + Key Indicators – this becomes a screening tool to determine if a program receives a Licensing Study reviewing all child care rules or an abbreviated Monitoring visit continuing to review key indicator and core rules for their next visit.
- **Core Indicators (100%)** = the next visit is a Monitoring Visit. Every 3-4 years a full Licensing Study is conducted.
- **Core Indicators (not 100%)** = The next visit is a Licensing Study where all rules are reviewed.
- **Compliance** = 96%+ with all rules and 100% with Core Indicators. The next visit is a Monitoring Visit.
- **Non-compliance** = less than 96% with all rules. The next visit is a Licensing Study.

2) **Second research question/validation recommendation**: Follow the development of weighted risk assessment tools as outlined by Fiene & Kroh (2000) in the NARA Licensing Chapter for CCC and FCC. It has been over 20 years since Core Rules were weighted. It is recommended that Core Rules be weighted every 10 years. Doing a weighted risk assessment would help confirm that the present Core Rules are the highest risk rules.

3) **Third research question/validation recommendation**: Confirm the CCC (ERS/PS) and FCC results by conducting a more recent program quality study that reflects all the changes made within the CCC and FCC systems. Although FCC program quality and Licensing Study and Core Rules reached statistical significance, the overall correlation was too low (Licensing Studies = .19; Core Rules = .17). With the CCC system the Pre-K program demonstrated significant correlations between ERS/PK and Licensing Study (.48) & Core Rules (.60) but not the Preschool program (ERS/PS: Licensing Studies = .21; Core Rules = .27).

\(^3\) These recommendations are drawn from the data in this study and previous studies conducted by the author in which the empirical evidence led to similar recommendations.
REFERENCES

Fiene (2012). *Differential monitoring logic model and algorithm (DMLMA®)*. Middletown, PA: Research Institute for Key Indicators.


**TABLE 8 - FOUR APPROACHES TO VALIDATING A QRIS (Zellman & Fiene, 2012)**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Activities and Purpose</th>
<th>Typical Questions Approach Addresses</th>
<th>Issues and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Examine the validity of key underlying concepts</td>
<td>Assess whether basic QRIS quality components and standards are the “right” ones by examining levels of empirical and expert support.</td>
<td>Do the quality components capture the key elements of quality? Is there sufficient empirical and expert support for including each standard?</td>
<td>Different QRISs may use different decision rules about what standards to include in the system.</td>
</tr>
<tr>
<td>2. Examine the measurement strategy and the psychometric properties of the measures used to assess quality</td>
<td>Examine whether the process used to document and verify each indicator is yielding accurate results. Examine properties of key quality measures, e.g., inter-rater reliability on observational measures, scoring of documentation, and inter-item correlations to determine if measures are psychometrically sound. Examine the relationships among the component measures to assess whether they are functioning as expected. Examine cut scores and combining rules to determine the most appropriate ways to combine measures of quality standards into summary ratings.</td>
<td>What is the reliability and accuracy of indicators assessed through program administrator self-report or by document review? What is the reliability and accuracy of indicators assessed through observation? Do quality measures perform as expected? (e.g., do subscales emerge as intended by the authors of the measures?) Do measures of similar standards relate more closely to each other than to other measures? Do measures relate to each other in ways consistent with theory? Do different cut scores produce better rating distributions (e.g., programs across all levels rather than programs at only one or two levels) or more meaningful distinctions among programs?</td>
<td>This validation activity is especially important given that some component measures were likely developed in low-stakes settings and have not been examined in the context of QRIS.</td>
</tr>
<tr>
<td>Approach</td>
<td>Activities and Purpose</td>
<td>Typical Questions Approach Addresses</td>
<td>Issues and Limitations</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------</td>
<td>---------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>3. Assess the outputs of the rating process</td>
<td>Examine variation and patterns of program-level ratings within and across program types to ensure that the ratings are functioning as intended.</td>
<td>Do programs with different program-level ratings differ in meaningful ways on alternative quality measures?</td>
<td>These validation activities depend on a reasonable level of confidence about the quality components, standards and indicators as well as the process used to designate ratings.</td>
</tr>
<tr>
<td></td>
<td>Examine relationship of program-level ratings to other quality indicators to determine if ratings are assessing quality in expected ways.</td>
<td>Do rating distributions vary by program type, e.g., ratings of center-based programs compared to ratings of home-based programs? Are current cut scores and combining rules producing appropriate distributions across rating levels?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examine alternate cut points and rules to determine how well the ratings distinguish different levels of quality.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Examine how ratings are associated with children’s outcomes.</td>
<td>Examine the relationship between program-level ratings and selected child outcomes to determine whether higher program ratings are associated with better child outcomes.</td>
<td>Do children who attend higher-rated programs have greater gains in skills than children who attend lower-quality programs?</td>
<td>Appropriate demographic and program level control variables must be included in analyses to account for selection factors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Studies could be done on child and program samples to save resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Findings do not permit attribution of causality about QRIS participation but inferences can be made about how quality influences children’s outcomes.</td>
<td></td>
</tr>
</tbody>
</table>
A very important concept in this validation study is that the system employed by DECAL is a risk assessment approach rather than a key indicator methodology which is based upon predictor rules. The DMLMA© is a new methodology assessing the effectiveness and efficiency of Differential Monitoring systems being used by state regulatory agencies and provides the conceptual model for this study.

**DMLMA© Thresholds:**

- **High Correlations (.70+) = CI x KI.**
- **Moderate Correlations (.50+) = CI x RA; RA x DM; RA x KI; KI x DM.**
- **Lower Correlations (.30+) = PQ x CI; PQ x RA; PQ x KI.**
### Table 9 - Listing of Key Indicators for Georgia Child Care Centers with Phi Coefficients

591-1-1-25 (3) requires that the center and surrounding premises be clean, free of debris and in good repair. (Phi = .49)

591-1-1-.25 (13) requires that hazardous equipment, materials and supplies be inaccessible to children. (Phi = .46)

591-1-1-.26 (6) requires that outdoor equipment be free of hazards such as lead-based paint, sharp corners, rust and splinters. (Phi = .44)

591-1-1-.26 (8) requires the playground to be kept clean, free of litter and hazards. (Phi = .59)

591-1-1.26 (7) requires that a resilient surface be provided and maintained beneath the fall zone of climbing and swinging equipment. (Phi = .57)

591-1-1-.36 (6)(a-c) requires the center to maintain on the vehicle current information for each child including a) center and passenger information; b) emergency medical information and c) a passenger checklist. (Phi = .49)

591-1-1-.14 (1) requires that at least 50% of the caregiver staff have current first aid and CPR training. (Phi = .49)

591-1-1-.08 (a)-(f) requires the center to maintain a file for each child while such child is in care and for one year after that child is no longer enrolled…. (Phi = .44)

### Table 10 - Listing of Key Indicators for Georgia Family Child Care Homes with Phi Coefficients

290.2.3-.11(2)(C) requires that fire drills be practiced monthly and shall be documented and kept on file for one year. (Phi = .51)

290-2-3-.11 (2)(f) requires that poisons, medicines, cleaning agents and other hazardous materials be in locked areas or inaccessible to children. (Phi = .61)

290-2-3-.11 (1)(f) requires the family day care home and any vehicle used to have a first aid kit….. (Phi = .57)

290-2-3-.07 (4) requires that the provider obtain ten clock hours of training in child care issues from an approved source within the first year and thereafter on an annual basis. (Phi = .58)

290-2-3-.08 (1)(a) requires the family day care home to maintain a file for each child that includes the child’s name, birth date, parents or guardian’s name, home and business addresses and telephone numbers. (Phi = .63)

290-2-3-.08 (1)(b) requires that the record for each child contain the names(s), address(es) and telephone number(s) of person(s) to contact in emergencies when the parent cannot be reached. (Phi = .57)

290-2-3-.08 (1)(b) requires the family day care home to maintain a file for each child that includes the name, address and telephone number of the child’s physician to contact in emergencies. (Phi = .55)

290-2-3-.08 (1)(f) requires the family day care home to maintain a file for each child that includes known allergies, physical problems, mental health disorders, mental retardation or developmental disabilities which would limit the child’s participation in the program. (Phi = .51)

290-2-3-.08 (1)(c) requires the family day care home to maintain a file for each child that includes evidence of age appropriate immunizations or a signed affidavit against such immunizations; enrollment in the home may not continue for more than 30 days without such evidence. (Phi = .72)
Table 11 - Key Indicator Formula Matrix for Generating Key Indicators*

<table>
<thead>
<tr>
<th></th>
<th>Providers In Compliance on Rule</th>
<th>Programs Out Of Compliance on Rule</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Group</strong></td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Low Group</strong></td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

(* This computation occurred for each licensing rule)

\[
A = \text{High Group} + \text{Programs in Compliance on Specific Rule.}
\]

\[
B = \text{High Group} + \text{Programs out of Compliance on Specific Rule.}
\]

\[
C = \text{Low Group} + \text{Programs in Compliance on Specific Rule.}
\]

\[
D = \text{Low Group} + \text{Programs out of Compliance on Specific Rule.}
\]

\[
W = \text{Total Number of Programs in Compliance on Specific Rule.}
\]

\[
X = \text{Total Number of Programs out of Compliance on Specific Rule.}
\]

\[
Y = \text{Total Number of Programs in High Group.}
\]

\[
Z = \text{Total Number of Programs in Low Group}
\]

**High Group = Top 25% of Programs in Compliance with all Rules.

***Low Group = Bottom 25% of Programs in Compliance with all Rules.

Figure 2 - Key Indicator Statistical Methodology (Calculating the Phi Coefficient)

\[
\phi = \frac{(A)(D) - (B)(C)}{\sqrt{(W)(X)(Y)(Z)}}
\]

Table 12 – Phi Coefficient Decision Table

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>
### Table 13 - Comparison of the Pre-K and Preschool Programs

<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Pre-K ECERS-R** (N)</th>
<th>Preschool ECERS-R*** (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>4.88 (4)</td>
<td>3.40 (15)</td>
</tr>
<tr>
<td>99</td>
<td>4.13 (6)</td>
<td>4.35 (7)</td>
</tr>
<tr>
<td>98</td>
<td>4.38 (6)</td>
<td>3.89 (13)</td>
</tr>
<tr>
<td>97</td>
<td>3.99 (4)</td>
<td>3.15 (9)</td>
</tr>
<tr>
<td>96</td>
<td>4.36 (2)</td>
<td>3.16 (13)</td>
</tr>
<tr>
<td>95</td>
<td>4.60 (2)</td>
<td>3.53 (5)</td>
</tr>
<tr>
<td>90</td>
<td>3.43 (2)</td>
<td>2.56 (5)</td>
</tr>
<tr>
<td>80</td>
<td>2.56 (1)</td>
<td>2.38 (2)</td>
</tr>
</tbody>
</table>

*Compliance Level = the number of child care rule violations subtracted from 100.

100 = Full Compliance with Rules
99-98 = Substantial Compliance with Rules
97-90 = Medium Level of Compliance with Rules
80 = Low Level of Compliance with Rules

**Pre-K ECERS-R = average score of Pre-K Program classrooms as compared to the respective compliance levels. (N) = Sample Size.

***Preschool ECERS-R = average score of Preschool Program classrooms as compared to the respective compliance levels. (N) = Sample Size.

From this comparison there is more of a linear relationship between compliance levels and ECERS-R average scores for Pre-K Program classrooms than with the Preschool Program classrooms where there is more of a curvilinear or plateau effect at the upper end of compliance levels (Full Compliance). In order to attain the necessary correlational thresholds (+.30+) for validation for the third approach to validation, having a linear relationship rather than curvilinear will enhance this occurring. When a curvilinear or plateau effect occurs there is too great a likelihood that programs at a medium level of quality will be introduced into the highest (full) level of compliance. From a public policy standpoint this is an undesirable result.

The other item to note with the data distributions is that the Preschool ECERS-R data are more restricted than the Pre-K Program ECERS-R data. In other words, there is less variance in the Preschool Program ECERS-R data than in the Pre-K Program ECERS-R data.

There is an important limitation in these data that the reader must be aware of in not drawing any conclusions that the presence of a Pre-K Program classroom in any way is causing the change in licensing compliance. There is a relationship between the two but there is no assumption of causality.
Georgia Licensing Validation Technical Elements Appendix

Because of the nature of this report being a state’s first attempt at fully validating it’s Child Care Licensing Core Rule Differential Monitoring Approach utilizing the Zellman & Fiene (2012) Validation Framework and Fiene’s DMLMA (2012) Model, certain questions surfaced regarding the terminology and the methodology being used in this report. This Technical Elements Appendix provides answers to specific questions that have been raised regarding these methodologies.

1. **How were the multiple years of data handled?**

   The Licensing Study data used to make the comparisons are the facility reports that were the earliest facility observations so that these data would be closest to when the program quality data were collected. The other more recent Licensing Studies were not used in this comparison.

2. **If the Core Rules, Key Indicator, and Licensing Study values are counts of violations, how was the fact that different sites had different numbers of visits handled?**

   Because only the earliest Licensing Study data was used, the number of visits were not an issue in the scoring.

3. **If the Core Rules, Key Indicator, and Licensing Study values are counts of violations, were all levels of violation risk (low, medium, high, extreme) handled the same?**

   Yes, there were very few occurrences of high and extreme in the data base and also no significant differences were found when a sample of the rule violations with and without the levels of violation risk were compared. Therefore the simpler formula in which levels of violation risk were not used was selected.

4. **How did you determine the minimum correlations (DMLMA thresholds) for each analysis? Was this computed separately for this analysis or are the minimum correlations based on previous work?**

   The DMLMA thresholds were determined from previous research work conducted by the author of this study on this model over the past 30 years. These were the average correlational thresholds that have been proposed for making validation determinations. The reason for utilizing the DMLMA model and thresholds is that the Zellman & Fiene (2012) Framework provides guidance in how to select specific validation approaches, what are the specific questions answered by the approach and what are the limitations of the particular approach. The DMLMA model builds upon this but provides a suggested scoring protocol by comparing correlational thresholds in a specific state to historical trends.

5. **Was Phi calculated for every rule in the licensing study? Can the full list be added to the appendix?**

   Yes, Phi was calculated for every rule in the licensing study but most of them could not be computed because there was so few rule violations in the majority of the rules. This is typical of state licensing data sets and the full Phi comparisons are not depicted because it does not add any information to the state report.
6. **How did you determine which of the Licensing Study rules should be counted as Key Indicators?**

The Key Indicator statistical methodology based upon a specific cut off point for the Phi Coefficient in which the p values were .0001 or less. This is a very stringent cut off point but it has been found historically that the p values needed to be lowered as the data distributions became more skewed with programs overall compliance levels increasing over time.

7. **How were sites that had no infant/toddler (i.e., no ITERS score) handled for the third validation approach? How were sites that had only a GA Pre-K (no preschool) handled?**

For scoring purposes only those facilities that had both the ECERS and ITERS scores were used in making comparisons with the licensing data related to the third approach to validation. The GA Pre-K were scored and compared in the same way.

8. **On Table 13, why is the number of violation subtracted from 100 (rather than from the maximum possible)?**

Generally this scoring is done because it is more intuitive to think in terms of 100% in compliance as a score of “100” rather than a score of “0”. This conversion is used in all state licensing reports that involve the DMLMA, Key Indicators and Risk Assessment Methodologies/Models.
FOR ADDITIONAL INFORMATION REGARDING THIS REPORT AND STUDY:

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Qualistar Rating Key Indicator Study

Richard Fiene, Ph.D.

June 17, 2014

ABSTRACT

This report provides an analysis of Colorado’s quality rating system, the Qualistar Rating, for generating key indicators. Key indicators have been used a great deal in the licensing literature but this is a first time analysis in utilizing this methodology in a QRS (Quality Rating System) or a QRIS (Quality Rating and Improvement System). The key indicator methodology is described in detail applying it to QRS/QRIS. The results clearly indicate that the strongest key indicators are within the Family Partnerships component of the Qualistar Rating; however there are some major limitations to utilizing this methodology with QRS/QRIS.

INTRODUCTION

The Qualistar Rating, administered by Qualistar Colorado, is one of the longest continuously running QRS in the United States. Presently over 50% of states have QRS/QRIS and the research on these program quality rating & improvement systems has increased over the years. One area of research that has been gaining momentum most recently is ascertaining the most effective and efficient delivery system for a QRS/QRIS as the number of early care and education programs participating in QRS/QRIS continues to increase. This report provides an overview to the topic and introduces an option that has been used in the human services/child care licensing field in identifying key indicators of overall compliance with standards. The purpose of the key indicator methodology is to focus monitoring visits on those standards that have the ability to predict overall compliance with the full set of QRS/QRIS standards. The key indicator methodology is part of a program monitoring approach called Differential Program Monitoring which was developed to help streamline the program monitoring of early care and education programs (please see the Appendix for two graphics which help to depict this relationship (Figures 8/9). It was first applied in child care licensing (Fiene & Nixon, 1985) but has been used in many other service types, such as: Head Start Performance Standards (Fiene,
2013a), National Accreditation (Fiene, 1996), and child and adult residential programs (Kroh & Melusky, 2010). The methodologies are based upon statistical protocols that have been developed in the tests and measurements literature in which an abbreviated set of items is used to statistically predict as if the full test was applied. This methodology has been used in regulatory analysis and is now being proposed for use in Quality Rating and Improvement Systems (Fiene, 2013b). This study and report is the first demonstration of its use with QRS.

TECHNICAL ASPECTS OF THE KEY INDICATOR METHODOLOGY

This section provides the technical and statistical aspects of the key indicator methodology. It will provide the specific methodology for generating the key indicators for the Qualistar Rating.

One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. In very large states such as Colorado this is done on a sampling basis. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each item within the specific assessment tool (see Figure 1). An example from the Qualistar Rating database is provided in Figure 2 (see Figure 2).

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level (top 20-25%)</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td>Lowest level (bottom 20-25%)</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td>Column Total</td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

Because of the differences in the data distribution for the Qualistar Rating, the above cutoff points had to be more stringent with the respective cutoff points for the high and low groups because the majority of the programs were at the Star 2 and 3 levels. In comparing these data to past licensing distributions (see Fiene, 2013d), it would be expected that the majority of programs would be at a Star 1 level, but that was not the case with this sample. Rather than using a 20-25% cut off point, it was changed to 10% to accommodate this difference. Figure 2 depicts that all programs that were in the top 10% were in the highest rating while the bottom 10% were in the lowest rating. The data depicted in Figure 2 are taken from the Family
Engagement Standard 5 – The program provides opportunities for staff and families to get to know one another. The reason for selecting this particular standard is that it demonstrates a perfect Phi Coefficient in discriminating between the highest level and the lowest level.

<table>
<thead>
<tr>
<th>Figure 2: Criterion 5 Family Partnerships</th>
<th>Providers In Compliance or Top 10%</th>
<th>Programs Out Of Compliance or Bottom 10%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Star level</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Lowest Star level</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Column Total</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 3) is used to determine if the standard is a key indicator or not by calculating its respective Phi Coefficient. Please refer back to Figure 1 for the actual placement within the cells and Figure 2 for the data within the cells. The legend (Figure 4) below the formula shows how the cells are defined.

**Figure 3 – Formula for Phi Coefficient**

\[
\phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}}
\]

**Figure 4 – Legend for the Cells within the Phi Coefficient**

- \( A \) = High Group + Programs in Compliance on Specific Compliance Measure.
- \( B \) = High Group + Programs out of Compliance on Specific Compliance Measure.
- \( C \) = Low Group + Programs in Compliance on Specific Compliance Measure.
- \( D \) = Low Group + Programs out of Compliance on Specific Compliance Measure.
- \( W \) = Total Number of Programs in Compliance on Specific Compliance Measure.
- \( X \) = Total Number of Programs out of Compliance on Specific Compliance Measure.
- \( Y \) = Total Number of Programs in High Group.
- \( Z \) = Total Number of Programs in Low Group.

Once the data are run through the formula in Figure 3, the following chart (Figure 5) can be used to make the final determination of including or not including the item as a key indicator. Based
upon the chart in Figure 5, it is best to have a Phi Coefficient approaching +1.00 since the data are more normally distributed than is the case with licensing data.

Continuing with the chart in Figure 5, a Phi Coefficient between +.75 and -.25 indicates that the indicator is unpredictable in being able to predict overall compliance with the quality rating assessment tool. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance. This can occur with Phi Coefficients above +.75 but it becomes unlikely as they approach +1.00, although there is always the possibility that other standards/rules/regulations could be found to be out of compliance (this was demonstrated in a study conducted by the author (Fiene, 2013c). Another solution is to increase the number of key indicators to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Phi Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the desired. The indicator would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously undesirable.

**Figure 5 – Thresholds for the Phi Coefficient (Fiene & Nixon, 1983, 1985)(Fiene, 2014)**

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.76)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.75) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

The key indicators should then only be used with those programs that have attained the highest rating. It is not intended for those programs that have attained lower ratings. However, even with those programs that have attained the highest rating, periodically a full, comprehensive review using the full set of standards for Qualistar Colorado should occur (see Figure 6 for a graphical depiction). It is intended that a re-validation of the key indicators occur on a periodic basis to make certain that the key indicators have not changed because of differences in compliance with standards history. This is an important and necessary step for the program to engage in to ascertain the overall validity and reliability of the assessment system. Also there should not have been any major changes in the program while the key indicators are being administered, such as the director leaving or a large percentage of teachers leaving or enrollment increasing significantly, or a change in the licensing or accreditation status of the program.
Figure 6 - Proposed DMLMA System with Key Indicators (KI)

Use of Qualistar Rating Key Indicators (QRKI) for Monitoring with a Full Review every 4th Year for Star 4

This model is taken from the licensing literature and as will be pointed out in the Limitations and Conclusion Sections may not necessarily be appropriate for QRS/QRIS systems depending on a state’s QRS/QRIS data distribution. It is provided for illustrative purposes.

RESULTS

The results reported in this section are based upon a sample selected from the overall Qualistar Rating database from its most recent monitoring reviews (N = 117). This was a representative sample of the program’s QRS.

There are five components of the Qualistar Rating: Learning Environment, Family Partnerships, Training and Education, Adult to Child Ratios and Group Size, and Accreditation. See Figures 10-14 in the Appendix for the graphical depictions of the data distributions for the five major criteria. The data distributions are provided because a pre-requisite for calculating the key indicator Phi Coefficients is the dichotomization of data with a skewed data distribution. Figures 10-14 display how much the data are skewed.

The Qualistar Rating is a zero-to-4 star system, with 4 stars indicating the highest level of quality. Eleven programs were rated at the Star 1 level, 19 programs were rated at the Star 2 level, 77 programs were rated at the Star 3 level, and 10 programs were rated at the Star 4 level for a total of 117 programs included in these analyses. There were no programs in the sample that earned less than one star.

Based upon the key indicator methodology described in the previous section, the only Qualistar Rating standards that reached key indicator designation were the following: Family Partnership Standard/Criterion 5 = The program provides opportunities for staff and families to get to know one another; Family Partnership Standard/Criterion 7 = Families receive information on their child’s progress on a regular basis, using a formal mechanism such as a report or parent conference and Family Partnership Standard/Criterion 8 = Families are included in planning and decision making for the program.
Figure 7 – Key Indicators with Phi Coefficients

<table>
<thead>
<tr>
<th>Standard/Criterion</th>
<th>Phi</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Partnership</td>
<td>1.00</td>
<td>.001</td>
</tr>
<tr>
<td>Family Partnership</td>
<td>.86</td>
<td>.001</td>
</tr>
<tr>
<td>Family Partnership</td>
<td>.83</td>
<td>.001</td>
</tr>
</tbody>
</table>

There were many other significant correlations (Family Partnerships and Adult-to-Child Ratios and Group Sizes) obtained but none reached the cutoff threshold of .76+ for the Phi calculations. These other correlations are reported in the Appendix after the descriptive graphical displays in Figures 15, 15a, 15b. The Phi Coefficients for the other Criteria (Learning Environment, Training and Education, and Program Accreditation) were not calculated because the data distributions were not skewed as was the case with Family Partnerships and Adult-to-Child Ratios and Group Sizes (see Figures 10-14).

LIMITATIONS

There are two major limitations to this study, 1) the first deals with the statistics being used to generate the key indicators; 2) the second deals with the key indicator methodology.

The first limitation has to do with dichotomization of data which should only be used with very skewed data. Data skewness always occurs with licensing data because of the nature of the data, health and safety protections (the majority of programs are always in compliance with the respective rules). However, this appears to not always be the case with QRS/QRIS data which deals with more program quality aspects of facilities and shows greater variation in the data. If this is the case then dichotomization of data is not appropriate and should not be utilized in order to generate key indicators.

The second limitation of this study is if the key indicator methodology and differential monitoring approaches are appropriate for QRS/QRIS. In Figure 6 above and in the conclusion to this report below, there is a scenario where it can be used but Qualistar Colorado and each state must determine if this is an appropriate approach for their respective program. For example, key indicators will not work in a block model and with a point-system model may generate very limited time savings if the data distribution is normally distributed and there are very few programs at the highest star level. In licensing data base distributions there is always a large number of programs to select from in the highest compliance levels (usually a minimum of 25%).
CONCLUSION/FUTURE RESEARCH/DISCUSSION/RECOMMENDATIONS

This study is the first of its kind in generating key indicators for a QRS based upon the analyses performed with the Qualistar Rating data base. It potentially demonstrates that the use of the key indicator methodology with QRS/QRIS could be feasible and warranted in order to focus limited program monitoring resources in a most efficient and effective manner keeping the above stated limitations in mind as stated in the previous Limitations Section. In the future, Qualistar Colorado may want to pilot an approach utilizing a small group of programs and could focus resources on the Family Partnership/Engagement standards on an ongoing basis between comprehensive reviews as depicted in Figure 6 above for Star 4 programs. The time saved here could then be redistributed to spending more time with the Star 1 programs.

It will be timely to see other states and programs who are interested in generating key indicators if they have Family Partnership/Engagement standards as part of their respective QRS/QRIS to determine if these standards reach the same threshold for key indicator designation as has occurred in this study. It will also be interesting to see if any other state’s criteria/standards data distributions are similar to what has been found in the Qualistar Rating or not.

However, as highlighted in the Limitations Section, states and programs need to consider if the key indicator methodology and the resultant differential monitoring model is really warranted and appropriate for their respective QRS/QRIS’s. As has been the case with Colorado’s Qualistar Rating, only two of the five major criteria: Family Partnerships and Adult-Child Ratio/Group Size were determined to be good candidates for the key indicator Methodology in which the data were skewed enough to warrant dichotomization. The other three major criteria: Learning Environment, Training and Education, and Program Accreditation were determined not to be sufficiently skewed to warrant dichotomization. This sets up a decision making system in which only 40% of the criteria are being used and severely limits the overall predictability of the key indicators selected. Could the other criteria be used to generate key indicators? Of course, but dichotomization of data should not be done when data are not highly skewed (MacCallun, et al, 2002). Yes, we were successful in generating Key Indicators for the Qualistar Rating but within a limited scenario in how they should be used. The results are not equivalent to what has been found and utilized in the licensing literature where the licensing data are always highly skewed. If a state or program find that all the standards are skewed in a similar way to licensing data then dichotomization of data and the generation of key indicators is warranted.

A recommendation to Colorado’s Qualistar and other programs and states where they find the data from their standards more normally distributed that they not use a key indicator approach. The key indicator approach remains a reliable and valid methodology for licensing but only in very special and limited cases will it be an appropriate monitoring approach for more program quality focused systems, such as QRS/QRIS and accreditation. For those QRS/QRIS systems where the standards are more normally distributed, the recommendation would be to continue to use the full set of QRS/QRIS standards and not use an abbreviated set of standards.
NOTES:

1. For analytical purposes, the top 10% of programs received an average score of 8 points or higher on a 10 point scale and the bottom 10% of programs received an average score of 2 points or less on a 10 point scale.

2. The reason for pointing out the need to have a higher Phi Coefficient than what has been reported previously (Fiene & Nixon, 1983, 1985) is the fact that the dichotomization of data should only be used with skewed data and not normally distributed data because it will accentuate differences. However, since the purpose of the dichotomization of data is only for sorting into a high and low group, it would appear to be acceptable for this purpose (MacCallun, etal, 2002. On the practice of dichotomization of quantitative variables, Psychological Methods, 7, 1, 19-40.).

3. These results would show an increase in cells B and C in Figure 1 which is undesirable; it should always be the case where A + D > B + C for key indicators to maintain their predictive validity.

4. The following point values equate to the various Star levels in the Qualistar Rating System (for detailed information regarding the QRS system please see the following document: Qualistar Colorado – Qualistar Rating Criteria Chart, November 2012):
   - Provisional = 0 – 9 points or Learning Environment score of 0
   - Star 1 = 10 - 17 points
   - Star 2 = 18 - 25 points
   - Star 3 = 26 - 33 points
   - Star 4 = 34 - 42 points

Qualistar Rating Criteria Chart:
- Learning Environment = points are awarded based on average classroom scores on the ERS Scales. (Score of component: 1 – 10)
- Family Partnerships = points are awarded based on how well programs communicate with collaborate with, and involve families. Score of component: 1 – 10)
- Training and Education = points are awarded to teachers & center administrators based on their professional development level and amount of experience, with criteria separated by position. Score of component: 1 – 10
- Adult-to-Child Ratios & Group Size = points are awarded based on the average adult-to-child ratio and group size in each classroom. Score of component: 1 – 10
- Program Accreditation = points are awarded for receiving and maintaining national program accreditation through an approved organization. Score of component: 0 or 2 points

*The reader needs to keep in mind that Qualistar Colorado is not a state agency but rather a private non-profit agency.*

5. The three Family Partnership Standards were met at the Star 4 level always or most of the time (see Figure 2).

6. The respective skewness figures are the following: Family Partnership = -1.425; Adult-Child Ratio/Group Size = -1.506; Learning Environment = -0.946; Training and Education = 0.028; Program Accreditation = 7.548. See Figure 16 for basic descriptive statistics for these Criteria.

For additional information regarding this Report, please contact:
Richard Fiene, Ph.D., Director/President, Research Institute for Key Indicators (RIKI), 41 Grandview Drive, Middletown, PA. 17057; DrFiene@gmail.com; 717-944-5868 Phone and Fax; http://RIKInstitute.wikispaces.com
REFERENCES AND ADDITIONAL RELATED READINGS REGARDING DIFFERENTIAL MONITORING, RISK ASSESSMENT, AND KEY INDICATOR METHODOLOGIES:


Appendix – Figure 8

DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

\[ \text{CI x PQ} \rightarrow \text{RA} + \text{KI} \rightarrow \text{DM} + \text{PD} \rightarrow \text{CO} \]

Definitions of Key Elements:

- **PC** = Program Compliance/Licensing (Health and Safety) *(Caring for Our Children)*
- **PQ** = QRIS/Accreditation/Caregiver/Child Interactions/Classroom Environment Quality *(ERS/CLASS/PAS/BAS)*
- **RA** = Risk Assessment, (High Risk Rules) *(Stepping Stones)*
- **KI** = Key Indicators (Predictor Rules) *(13 Key Indicators of Quality Child Care)*
- **DM** = Differential Monitoring (How often to visit and what to review)
- **PD** = Professional Development/Technical Assistance/Training *(Not pictured but part of Model)*
- **CO** = Child Outcomes *(Not pictured but part of Model)*
Appendix – Figure 9 - Licensing Rules, Compliance Reviews, Differential Monitoring, Abbreviated Tools, Risk Assessment, and Key Indicators

All Licensing Rules – Full Compliance Reviews

Differential Monitoring

How Often to Visit?

What is Reviewed?

Frequency

More Often

Less Often

Abbreviated Tool

Risk Assessment Weights

Key Indicators Predictors
APPENDIX

Figures 10-14 depict the data distributions for overall Star points as well as for the major criteria/standards (Training & Education, Learning Environment, Adult-to-Child Ratios & Group Size, and Family Partnerships). Figures 13-14 clearly demonstrate how these respective criteria/standards are extremely skewed data distributions while Figures 10-12 show a more normally distributed data pattern. This is important for which standards can be dichotomized and phi coefficients generated. Dichotomization of data should only be used with skewed data which is the case in figures 13-14. It is not appropriate with the data distributions in figures 10-12. Also see Figure 16 for additional descriptive statistics for the specific criteria.
Figure 11

TRAINING EDUCATION STAR POINTS
Figure 12
Figure 13

![Bar chart showing the distribution of ratio star points.](chart)
**Figure 15**

**Selected Relationships amongst the Standards/Criteria and Star Level**

<table>
<thead>
<tr>
<th>Standards/Criteria</th>
<th>Correlation (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Partnerships x Star Level</td>
<td>.80****</td>
</tr>
<tr>
<td>Learning Environment x Star Level</td>
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<tr>
<td>Training/Education x Star Level</td>
<td>.54**</td>
</tr>
<tr>
<td>Adult-Child Ratio/Group Size x Star Level</td>
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<tr>
<td>Program Accreditation x Star Level</td>
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* p < .05  
** p < .01  
*** p < .001  
**** p < .0001

**Figure 15a**

<table>
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<th>Family Partnership Criteria</th>
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<td>Criterion 17</td>
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**Legend:**
Criteria 1 – 7 involve the program providing information to families.
Criteria 8 – 15 involve families in planning, communicating and decision making for the program.
Criteria 16 – 17 involve a written plan and evaluating the program’s family partnerships.
Family Partnerships and Adult-Child Ratio/Group Size standards/criteria phi coefficients were generated because of the skewed data distributions. Phi coefficients were not generated for Learning Environment, Training and Education or Program Accreditation because the data were not sufficiently skewed or showed no variability at all in their respective distributions.

Figure 16

Basic Descriptive Statistics for Criteria

<table>
<thead>
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NARA Illinois Key Indicator Report for Centers, Group Homes, and Family Homes

Richard Fiene, Ph.D.

May 30, 2014

ABSTRACT

This report will provide an analysis of Illinois Rules for child care centers, group homes, and family homes for generating key indicators. There is a brief introduction regarding differential monitoring and key indicators followed by the generated key indicators.

INTRODUCTION

The key indicator methodology is part of a program monitoring approach called Differential Program Monitoring which was developed to help streamline the program monitoring of early care and education programs (please see the appendix for two graphics which help to depict this relationship). It was first applied in child care licensing but has been used in many other service types, such as: Head Start Performance Standards, National Accreditation, and child and adult residential programs. The methodologies are based upon statistical protocols that have been developed in the tests and measurements literature in which an abbreviated set of items is used to statistically predict as if the full test was applied. This methodology has been used in regulatory analysis and is now being proposed for use in Quality Rating and Improvement Systems (QRIS).

TECHNICAL ASPECTS OF THE KEY INDICATOR METHODOLOGY

This section provides the technical and statistical aspects of the key indicator methodology. One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. In very large states this is done on a sampling basis which
will be described later in the blueprint. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each item within the specific assessment tool (see Figure 1).

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
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<tbody>
<tr>
<td><strong>highest level</strong> (top 20-25%)</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td><strong>lowest level</strong> (bottom 20-25%)</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
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</table>

Once the data are sorted in the above matrix, the following formula (Figure 2) is used to determine if the standard is a key indicator or not by calculating its respective Phi coefficient. Please refer back to Figure 1 for the actual placement within the cells. The legend (Figure 3) below the formula shows how the cells are defined.

**Figure 2 – Formula for Phi Coefficient**

\[
\phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}}
\]

**Figure 3 – Legend for the Cells within the Phi Coefficient**

- **A** = High Group + Programs In Compliance on Specific Compliance Measure.
- **B** = High Group + Programs Out Of Compliance on Specific Compliance Measure.
- **C** = Low Group + Programs In Compliance on Specific Compliance Measure.
- **D** = Low Group + Programs Out Of Compliance on Specific Compliance Measure.
- **W** = Total Number of Programs In Compliance on Specific Compliance Measure.
- **X** = Total Number of Programs Out Of Compliance on Specific Compliance Measure.
- **Y** = Total Number of Programs In High Group.
- **Z** = Total Number of Programs In Low Group.
Once the data are run through the formula in Figure 2, the following chart (Figure 4) can be used to make the final determination of including or not including the item as a key indicator. Based upon the chart in Figure 4, it is best to have a Phi Coefficient approaching +1.00 however that is rarely attained with licensing data but has occurred in more normally distributed data. Continuing with the chart in Figure 5, if the Phi Coefficient is between +.25 and -.25, this indicates that the indicator is unpredictable in being able to predict overall compliance with the quality rating assessment tool. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance. This can occur with Phi Coefficients above +.25 but it becomes unlikely as we approach +1.00 although there is always the possibility that other standards/rules/regulations could be found out of compliance (this was demonstrated in a study conducted by the author. Another solution is to increase the number of key indicators to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Phi Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

**Figure 4 – Thresholds for the Phi Coefficient**

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
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</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>
RESULTS

Key indicators for child care homes (Please see the Appendix - Figure 7 for Phi Coefficients):

Section 406.8 General Requirements for Day Care Homes
a) The physical facilities of the home, both indoors and outdoors, shall meet the following requirements for safety to children.
1) The home shall have a first aid kit consisting of adhesive bandages, scissors, thermometer, non-permeable gloves, Poison Control Center telephone number (1-800-222-1222 or 1-800-942-5969), sterile gauze pads, adhesive tape, tweezers and mild soap.

18) There shall be written plans for fire and tornado emergencies. Caregivers and assistants in the home shall be familiar with these plans.
   A) The fire evacuation plan shall identify the exits from each area used for child care and shall specify the evacuation route.
   B) The fire evacuation plan shall identify a safe assembly area outside of the home. It shall also identify a near-by indoor location for post-evacuation holding if needed.
   C) The fire evacuation plan shall require that the home be evacuated before calling the local emergency number 911.
   D) The written tornado plan shall specify what actions will be taken in the event of tornado or other severe weather warning, including designation of those areas of the home to be used as the safe spots.

23) The licensee shall inspect the home daily, prior to arrival of children, ensuring that escape routes are clear and that exit doors and exit windows are operable. A log of these daily inspections shall be maintained for at least one year, and shall be available for review. The log shall reflect, at minimum, the date and time of each inspection and the full name of the person who conducted it.

24) The licensee shall hold monthly fire inspections of the day care home.

Section 406.9 Characteristics and Qualifications of the Day Care Family
a) No individual may receive a license from the Department when the applicant, a member of the household age 13 and over, or any individual who has access to the children cared for in a day care home, or any employee of the day care home, has not authorized the background check required by 89 Ill. Adm. Code 385 (Background Checks) and been cleared in accordance with the requirements of Part 385.

t) The caregivers shall complete 15 clock hours of in-service training per licensing year in accordance with the requirements in Appendix D of the rules.
1) Such training may be derived from programs offered by any of the entities identified in Appendix D of the rules.
2) Courses or workshops to meet this requirement include, but are not limited to, those listed in Appendix D of the rules.
3) The records of the day care home shall document the training in which the caregiver has participated, and these records shall be available for review by the Department.
4) Caregivers obtaining clock hours in excess of the required 15 clock hours per year may apply up to 5 clock hours to the next year's training requirements.

Section 406.12 Admission and Discharge Procedures
b) Prior to acceptance of a child for care,
3) The caregiver shall require that the parent or guardian provide a certified copy of the child’s birth certificate. The caregiver:
A) Shall provide a written notice to the parent or guardian of a child to be enrolled for the first time that within 30 days after enrollment the parent or guardian shall provide a certified copy of the child’s birth certificate or other reliable proof of identity and age of the child.

i) The caregiver shall promptly make a copy of the certified copy and return the original certified copy to the parent or guardian.

ii) If a certified copy of the birth certificate is not available, the parent or guardian must submit a passport, visa or other governmental documentation as proof of the child’s identity and age and an affidavit or notarized letter explaining the inability to produce a certified copy of the birth certificate [325 ILCS 50/5]

iii) The notice to parent or guardian shall also indicate that the caregiver is required by law to notify the Illinois State Police or local law enforcement agency if the parent or guardian fails to submit proof of the child’s identity within the 30 day time frame;

h) All day care homes shall have a written policy that explains the actions the provider will take if a parent or guardian does not retrieve, or arrange to have someone retrieve, his or her child at the designated, agreed upon time. The policy shall consist of the provider’s expectations, clearly presented to the parent or guardian, in the form of a written agreement that shall be signed by the parent or guardian, and shall include at least the following elements:

- The consequences of not picking up the child on time, including:
  - Amount of late fee, if any, and when those fees begin to accrue;
  - The degree of diligence the provider will use to reach emergency contacts, e.g., number of attempted phone calls to parents and emergency contacts, requests for police assistance in finding emergency contacts; and
  - Length of time the facility will keep the child beyond the pick-up time before contacting outside authorities, such as the child abuse hotline or police.

- Emphasis on the importance of having up-to-date emergency contact numbers on file.
- Acknowledgement of the provider’s responsibility for the child’s protection and well-being until the parent or outside authorities arrive.
- A reminder to the day care provider that the child is not responsible for the situation. All discussions regarding these situations shall be with the parent or guardian, never the child.

Section 406.14 Health, Medical Care and Safety

c) A medical report, on forms prescribed by the Department, shall be on file for each child, on the first day of care, and shall be dated no earlier than 6 months prior to enrollment.

1) The medical report shall be valid for 2 years, except that subsequent examinations for school-age children shall be in accordance with the requirements of Section 27.8-1 of the School Code [105 ILCS 5/27-8.1], provided copies of the exam are on file at the facility.

2) If the child is in a high risk group, as determined by the examining physician, a tuberculin skin test by the Mantoux method and the results of that test shall be included in the initial examination for all children who have attained one year of age, or at the age of one year for children who are enrolled before their first birthday. The tuberculin skin test by the Mantoux method shall be repeated when the children in high-risk groups begin elementary and secondary school.

3) The initial examination shall show that children from 6 months through 6 years of age have been screened for lead poisoning for children residing in an area defined as high risk by the Illinois Department of Public Health in its Lead Poisoning Prevention Code (77 Ill. Adm. Code 845) or that a lead risk assessment has been completed for children residing in an area defined as low risk by the Illinois Department of Public Health.

4) The report shall indicate that the child has been immunized as required by the rules of the Illinois Department of Public Health for immunizations (77 Ill. Adm. Code 695). These required immunizations are poliomyelitis, measles, rubella, diphtheria, mumps, pertussis, tetanus, hepatitis B, haemophilus influenza B, and varicella (chickenpox) or provide proof of immunity according to requirements in Part 695.50 of the Department of Public Health.
Key indicators for Group Child Care Homes (Please see the Appendix - Figure 7 for Phi Coefficients):

Section 408.35 General Requirements for Group Day Care Home Family
f) The caregivers and all members of the household shall provide medical evidence that they are free of communicable disease that may be transmitted while providing child care; and, in the case of caregivers, that they are free of physical or mental conditions that could interfere with child care responsibilities. The medical report for the caregivers shall be valid for 3 years.

Section 408.45 Caregivers
f) The caregivers shall complete 15 clock hours of in-service training per licensing year in accordance with the requirements in Appendix G of the rules.
   1) Such training may be derived from programs offered by any of the entities identified in Appendix G of the rules.
   2) Courses or workshops to meet this requirement include, but are not limited to, those listed in Appendix G of the rules.

Section 408.60 Admission and Discharge Procedures
j) All group day care homes shall have a written policy that explains the actions the provider will take if a parent or guardian does not retrieve, or arrange to have someone retrieve, his or her child at the designated, agreed upon time. The policy shall consist of the provider's expectations, clearly presented to the parent or guardian in the form of a written agreement that shall be signed by the parent or guardian, and shall include at least the following elements:
   1) The consequences of not picking up the children on time, including:
      A) Amount of late fee, if any, and when those fees begin to accrue;
      B) The degree of diligence the provider will use to reach emergency contacts, e.g., number of attempted phone calls to parents and emergency contacts, requests for police assistance in finding emergency contacts; and
      C) Length of time the facility will keep the child beyond the pick-up time before contacting outside authorities, such as the child abuse hotline or police.
   2) Emphasis on the importance of having up-to-date emergency contact numbers on file.
   3) Acknowledgement of the provider's responsibility for the child's protection and well-being until the parent or outside authorities arrive.
   4) A reminder to staff that the child is not responsible for the situation. All discussions regarding these situations shall be with the parent or guardian, never with the child.

Section 408.70 Health, Medical Care and Safety
a) A medical report, on forms prescribed by the Department, shall be on file for each child, on the first day of care, and shall be dated no earlier than 6 months prior to enrollment.
   1) The medical report shall be valid for 2 years, except that subsequent examinations for school-age children shall be in accordance with the requirements of Section 27-8.1 of the School Code [105 ILCS 5/27-8.1], provided copies of the exam are on file at the facility.
   2) If the child is in a high risk group, as determined by the examining physician, a tuberculin skin test by the Mantoux method and the results of that test shall be included in the initial examination for all children who have attained one year of age, or at the age of one year for children who are enrolled before their first birthday. The tuberculin skin test by the Mantoux method shall be repeated when children in high risk groups begin elementary and secondary school.
   3) The initial examination shall show that children from 6 months through 6 years of age have been screened for lead poisoning for children residing in an area defined as high risk by the Illinois Department of Public Health in its Lead Poisoning Prevention Code (77 Ill. Adm. Code 845) or that a lead risk assessment has been completed for children residing in an area defined as low risk by the Illinois Department of Public Health.
   4) The report shall indicate that the child has been immunized as required by the rules of the Illinois Department of Public Health for immunizations (77 Ill. Adm. Code 695). These required immunizations are poliomyelitis, measles, rubella, diphtheria, mumps, pertussis, tetanus, hepatitis B, haemophilus influenza B, and varicella (chickenpox) or provide proof of immunity according to requirements in Part 695.50 of the Department of Public Health.
Section 408.120  Records and Reports
a) A facility shall maintain a record file on the children enrolled.
1) A written application for admission of each child shall be on file with the signature of the parent or guardian.
Key indicators for Child Care Centers (Please see the Appendix-Figure 7 for Phi Coefficients):

Section 407.100  General Requirements for Personnel
f) Staff shall have physical re-examinations every two years and whenever communicable disease or illness is suspected.

Section 407.120  Personnel Records
a) A confidential file shall be maintained on each staff person and contain at least the following information:
   1) A copy of a form prescribed by the Department which contains information on persons employed in the day care center;
   3) Three written character references, verified by the day care center;
   4) Proof of educational achievement as required for the individual's position. Foreign credentials require additional documentation providing a statement of the equivalency in the U.S. educational system;

Section 407.250  Enrollment and Discharge Procedures
d) The facility shall distribute a summary of the licensing standards, provided by the Department, to the parents or guardian of each child at the time that the child is accepted for care in the facility. In addition, consumer information materials provided by the Department including, but not limited to, information on reporting and prevention of child abuse and neglect and preventing and reporting communicable disease shall be distributed to the parents or guardian or each child cared for when designated for such distribution by the Department.

Section 407.260  Daily Arrival and Departure of Children
f) All day care centers shall have a written policy that explains to parents and staff the actions the center will take if a parent or guardian does not pick up, or arrange to have someone pick up, his or her child at the designated, agreed upon time. The policy shall consist of the provider's expectations clearly presented to the parent or guardian in the form of a written agreement that shall be signed by the parent or guardian and shall include at least the following elements:
   1) The consequences of not picking up children on time shall be precisely communicated to parents, for example:
      A) Amount of late fee, if any, and when those fees begin to accrue.
      B) The degree of diligence the provider will use to reach emergency contacts, e.g., number of attempted phone calls to parents and emergency contacts, requests for police assistance in finding emergency contacts, and so forth.
      C) Length of time the facility will keep the child beyond the pick-up time before contacting outside authorities, such as, the child abuse hotline, police, and so forth.
   2) Emphasis on the importance of having up-to-date emergency contact numbers on file.
   3) Acknowledgement of the provider's responsibility for the child's protection and well-being until the parent or outside authorities arrive.
   4) A policy that staff shall not hold the child responsible for the situation and that discussion of this issue will only be with the parent or guardian and never with the child.

Section 407.270  Guidance and Discipline
a) The day care center shall develop a guidance and discipline policy for staff use that is also provided to parents. Staff shall sign the guidance and discipline policy at the time of employment and parents shall sign the policy when their child is enrolled. The policy shall include:
   1) A statement of the center's philosophy regarding guidance and discipline;
   2) Information on how discipline will be implemented by staff;
   3) Information on how parents will be involved in the guidance and discipline process;
   4) Information on how children will be involved in the guidance and discipline process; and
   5) Written procedures for termination of a child's enrollment in the day care center because of disciplinary issues.

Section 407.310  Health Requirements for Children
a) A medical report on forms prescribed by the Department shall be on file for each child.
   1) The initial medical report shall be dated less than 6 months prior to enrollment of infants, toddlers and preschool children. For school-age children, a copy of the most recent regularly scheduled school physical may be submitted
(even if more than 6 months old) or the day care center may require a more recent medical report by its own enrollment policy. If a health problem is suspected, the day care center may require additional documentation of the child's health status.

**Section 407.380  Equipment and Materials**
b) Such equipment and materials for infants, toddlers and pre-school children shall be provided in the quantity and variety specified in Appendix A: Equipment for Infants and Toddlers, Appendix B: Equipment for Preschool Children and Appendix C: Equipment for School-Age Children of the Rules.
For additional information regarding this Report, please contact:
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Appendix – Figure 5

DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

Cl x PQ => RA + KI => DM + PD => CO

Definitions of Key Elements:

PC = Program Compliance/Licensing (Health and Safety) *(Caring for Our Children)*
PQ = QRIS/Accreditation/Caregiver/Child Interactions/Classroom Environment Quality *(ERS/CLASS/PAS/BAS)*
RA = Risk Assessment, (High Risk Rules) *(Stepping Stones)*
KI = Key Indicators (Predictor Rules) *(13 Key Indicators of Quality Child Care)*
DM = Differential Monitoring (How often to visit and what to review)
PD = Professional Development/Technical Assistance/Training (Not pictured but part of Model)
CO = Child Outcomes (Not pictured but part of Model)
Appendix – Figure 6 - Licensing Rules, Compliance Reviews, Differential Monitoring, Abbreviated Tools, Risk Assessment, and Key Indicators

All Licensing Rules – Full Compliance Reviews

Differential Monitoring
- How Often to Visit?
- What is Reviewed?

Frequency
- More Often
- Less Often

Abbreviated Tool
- Risk Assessment Weights
- Key Indicators Predictors
Appendix -- Figure 7 - Phi Coefficients for the Specific Key Indicators

### Family Child Care Homes:

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<th>Content</th>
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<td>First Aid Kit</td>
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<td>406.8a18</td>
<td>.38</td>
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<td>.36</td>
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<td>Written Application Admission for Each Child</td>
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### Child Care Centers:

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<td>.41</td>
<td>Three Written Character References</td>
</tr>
<tr>
<td>407.120a4</td>
<td>.34</td>
<td>Proof of Educational Achievement</td>
</tr>
<tr>
<td>407.250d</td>
<td>.34</td>
<td>Written Standards Given to Parents</td>
</tr>
<tr>
<td>407.260f</td>
<td>.32</td>
<td>Pick Up Policy</td>
</tr>
<tr>
<td>407.270a</td>
<td>.32</td>
<td>Discipline Policy</td>
</tr>
<tr>
<td>407.310a</td>
<td>.44</td>
<td>Medical Report for Each Child</td>
</tr>
<tr>
<td>407.380b</td>
<td>.34</td>
<td>Equipment Meets Standard Requirements</td>
</tr>
</tbody>
</table>
INTRODUCTION

The purpose of this report is to provide the Kansas Child Care Office with basic analyses for the development of their key indicator system for both centers and homes. Licensing data from 2012 taken from both centers (CCC) (n = 482) and homes (FCC) (n = 500) were used in this Licensing Key Indicator study. The centers were further broken down into 52 (11%) Head Start programs and 430 (89%) child care centers. The homes were further broken down into 115 (23%) group homes and 385 (77%) family homes.

Definitions:

Key Indicators (KI) = a differential monitoring approach that employs using only those rules that statistically predict overall compliance with all the rules. In other words, 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. In this study, 8 Key Indicator rules were identified for CCC and 6 Key Indicator rules for FCC. The Key Indicators can be found in the Findings Section of this report.

Rule Violations or Citations = this occurs when a program does not meet a specific rule and is cited as being out of compliance with that rule.

METHODOLOGY

A Differential Monitoring Logic Model and Algorithm (DMLMA©)(Fiene, 2012) was employed, in particular, the key indicator methodology to generate the Key Indicators for this project. The DMLMA© is the 4th generation of an Early Childhood Program Quality Indicator Model (ECPQIM)(Fiene & Nixon, 1985; Griffin & Fiene, 1995; Fiene & Kroh, 2000).

The DMLMA© (see Figure 1) provides the conceptual model for assessing the overall effectiveness of a differential monitoring system. The two main tools in a Differential Monitoring (DM) system are Risk Assessment (RA) and Key Indicator (KI) measurement tools. Both the Risk Assessment and Key Indicator tools are derived from a comprehensive licensing tool (CI) that measures compliance with all rules. For the purposes of this study the Licensing Data taken from Kansas Monitoring Reviews represents the comprehensive licensing tool (CI). Kansas presently does not use a Risk Assessment or a Program Quality tool (see Table 1).

Table 1

<table>
<thead>
<tr>
<th>DMLMA© Terminology</th>
<th>Kansas Examples and Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Tool (CI)</td>
<td>Licensing Data from Kansas Monitoring Visits</td>
</tr>
<tr>
<td>Program Quality Tool (PQ)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Risk Assessment Tool (RA)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Key Indicators (KI)</td>
<td>Generated from this Study</td>
</tr>
<tr>
<td>Differential Monitoring (DM)</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
FINDINGS

There are some overall demographic findings presented first that help to put the results in context. As mentioned in the introduction there were 482 centers and 500 homes that were part of these analyses. Eleven percent (11%) of the centers were 100% in compliance with all rules while 25% of the homes were 100% in compliance with all rules. These figures are fairly typical of state averages. The average number of violations for centers was 7.44 violations with all applicable rules and 3.52 violations for homes.

Location of the various facilities seemed to have an impact on average violations recorded. For example, with centers, urban facilities had a significantly higher level of violations (8.42 average violations; n = 279) than facilities located in rural communities (6.09 average violations; n = 203). This result was statistically significant ($F = 14.19; p < .0001$). However, the differences for homes was not statistically significant, with urban homes (n = 222) having 3.64 average violations versus 3.42 average violations for rural homes (n = 278).

There were statistically significant differences depending on the Region the facilities were located in. For centers, the highest levels of violations with child care rules were in Regions 1 (9.30 average violations; n = 109) and 2 (8.32 average violations; n = 191) while Regions 3 (5.31 average violations; n = 121) and 4 (5.57 average violations; n = 61) had lower averages (see Table 2). This result is statistically significant ($F = 9.82; p < .0001$).

<table>
<thead>
<tr>
<th>Region</th>
<th>Centers</th>
<th>Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Violations*</td>
<td>Number</td>
</tr>
<tr>
<td>1</td>
<td>9.30</td>
<td>109</td>
</tr>
<tr>
<td>2</td>
<td>8.32</td>
<td>191</td>
</tr>
<tr>
<td>3</td>
<td>5.31</td>
<td>121</td>
</tr>
<tr>
<td>4</td>
<td>5.57</td>
<td>61</td>
</tr>
</tbody>
</table>

* = Average Violations (Mean)

For homes, a slightly different distribution occurs in which Region 2 (4.63 average violations; n = 120) was significantly higher than the other three regions. This result is statistically significant ($F = 7.24; p < .0001$).

Also the type of licensing inspection saw some variation in the average number of violations although none of the following results were statistically significant (see Table 3).

<table>
<thead>
<tr>
<th>License Type</th>
<th>Centers</th>
<th>Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Violations*</td>
<td>Number</td>
</tr>
<tr>
<td>Initial</td>
<td>7.44</td>
<td>36</td>
</tr>
<tr>
<td>Renewal</td>
<td>7.07</td>
<td>368</td>
</tr>
<tr>
<td>Amendment</td>
<td>9.51</td>
<td>55</td>
</tr>
<tr>
<td>Correction</td>
<td>6.71</td>
<td>14</td>
</tr>
<tr>
<td>Temporary</td>
<td>11.22</td>
<td>9</td>
</tr>
</tbody>
</table>

* = Average Violations (Mean)

The last demographic analysis was to compare the average number of violations between group homes and family homes; and between child care centers and Head Start programs. There was not a significant difference between group homes (3.75 average violations; n = 115) and family homes (3.45 average violations; n = 385); but a statistically significant difference occurred ($F = 10.44; p < .001$) between child care centers (7.78 average violations; n = 430) and Head Start programs (4.60 average violations; n = 52) with the Head Start programs having significantly fewer rule violations.
Key Indicator Findings

The following findings will provide the Key Indicators for centers (child care centers and Head Start) and homes (family and group homes). It will provide a listing of the rules and the respective phi coefficients. These Key Indicators were obtained from rank ordering the total compliance scores into quartiles with the 25% highest violation scores for facilities as the low group and the lowest 25% violation scores for facilities as the high group. Each rule was compared to this result by their respective compliance level, either being in or out of compliance with the rule. Once these data were prepared the formula in Table 4 was used to determine if the rule met the predictive level. Separate analyses for generating Key Indicators were not run for Head Start or Group Homes because of the insufficient number of programs in each category.

Centers (Child Care Centers and Head Start)(See Table 5 for a Summary)

All results are reported with the specific rule, p < .0001, and phi coefficient from the formula in Table 4.

K.A.R.28-4-126b1. Each person regularly caring for children shall have a health assessment conducted by a licensed physician or by a nurse trained to perform health assessments. The health assessment shall be conducted no earlier than one year before the date of employment or initial application for a license or certificate of registration, or not later than 30 days after the date of employment or initial application. (phi = .59)

K.A.R.28-4-126c1. Each person living, working or regularly volunteering in the facility shall have a record of a negative tuberculin test or x-ray obtained not more than two years before the employment or initial application, for a license or certificate of registration or not later than 30 days after the date of employment or initial application. (phi = .62)

K.A.R.28-4-423a18. The premises shall be maintained in good condition and shall be clean at all times, free from accumulated dirt and trash, and any evidence of vermin or rodent infestation. Each outdoor trash and garbage container shall be covered, and the contents shall be removed at least weekly. (phi = .59)

K.A.R.28-4-423a23. Medicines, household poisons, and other dangerous substances and instruments shall be in locked storage. (phi = .60)

K.A.R.28-4-428aa3. Each licensee shall ensure that orientation is completed by each staff member who will be counted in the staff-child ratio and by each volunteer who will be counted in the staff-child ratio. Each staff member and volunteer shall complete the orientation within seven calendar days after the date of employment or volunteering and before the staff member or volunteer is given sole responsibility for the care and supervision of children. (phi = .51)

K.A.R.28-4-428ac1. Each staff member counted in the staff-child ratio, each volunteer counted in the staff-child ratio, and each program director shall obtain certification in pediatric first aid and in pediatric CPR as specified in this subsection either before the date of employment or volunteering or not later than 30 calendar days after the date of employment or volunteering. (phi = .53)

K.A.R.28-4-430c3. Each staff member shall be trained to observe symptoms of illness, neglect, and child abuse, and shall observe each child’s physical condition daily. (phi = .54)

K.A.R.28-4-437d. The outdoor play space shall be well drained and free of hazards. (phi = .59)

Footnote:
Child Care Centers (CCC) – The correlation between the Key Indicators and all the rules was .77.
Family Child Care (FCC) – The correlation between the Key Indicators and all the rules was .80.
Both these results exceed the DMLMA© Thresholds for KI x CI (.70).
Homes (Family and Group Homes)(See Table 5 for a Summary)

All results are reported with the specific rule, p < .0001, and phi coefficient from the formula in Table 4.

K.A.R.28-4-115g1. All household cleaning supplies and all bodily care products bearing warning labels to keep out of reach of children or containing alcohol shall be in locked storage or stored out of reach of children under six years of age. Soap used for hand washing may be kept unlocked and placed on the back of the counter by a bathroom or kitchen sink.  (phi = .47)

K.A.R.28-4-115aa1A. Supervision plan. Each applicant, each applicant with a temporary permit, and each licensee shall develop a supervision plan for children in care that includes all age ranges of children for whom care will be provided. A copy of the plan shall be available for review by the parents or legal guardians of children in care and by the department. The plan shall include the following: A description of the rooms, levels, or areas of the facility including indoor and outdoor areas in which the child will participate in activities, have snacks or meals, nap, or sleep.  (phi = .79)

K.A.R.28-4-115aa1B. Supervision plan. Each applicant, each applicant with a temporary permit, and each licensee shall develop a supervision plan for children in care that includes all age ranges of children for whom care will be provided. A copy of the plan shall be available for review by the parents or legal guardians of children in care and by the department. The plan shall include the following: the manner in which supervision will be provided.  (phi = .44)

K.A.R.28-4-117a1. A completed medical record on a form supplied by the department shall be on file for each child under 11 years of age enrolled for care and for each child under 16 living in the child care facility.  (phi = .44)

K.A.R.28-4-117c. Immunizations for each child, including each child of the provider under 16 years of age shall be current as medically appropriate and shall be maintained current for protection from the diseases specified in K.A.R. 28-1-20(d). A record of each child's immunizations shall be maintained on the child's medical record.  (phi = .68)

K.A.R.28-4-127b1A. Emergency medical treatment: Each facility shall have on file at the facility for each child: written permission of the parent, guardian, or legal custodian for emergency medical treatment on a form that meets the requirements of the hospital or clinic where emergency medical care will be given.  (phi = .53)

References


Table 4: Kansas Key Indicator (KSKI) Formula Matrix

<table>
<thead>
<tr>
<th></th>
<th>Providers In Compliance</th>
<th>Programs Out Of Compliance</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Group</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td>Low Group</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td>Column Total</td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

Key Indicator Statistical Methodology (Calculating the Phi Coefficient):

\[
\phi = \frac{(A)(D) - (B)(C)}{\sqrt{(W)(X)(Y)(Z)}
\]

A = High Group + Programs in Compliance on Specific Compliance Measure.
B = High Group + Programs out of Compliance on Specific Compliance Measure.
C = Low Group + Programs in Compliance on Specific Compliance Measure.
D = Low Group + Programs out of Compliance on Specific Compliance Measure.

W = Total Number of Programs in Compliance on Specific Compliance Measure.
X = Total Number of Programs out of Compliance on Specific Compliance Measure.
Y = Total Number of Programs in High Group.
Z = Total Number of Programs in Low Group.

Phi Coefficient Range | Characteristic of Indicator | Decision
----------------------|-----------------------------|----------
(+1.00) – (+.26)      | Good Predictor              | Include on KSKI |
(+.25) – (0)           | Too Easy                    | Do not Include |
(0) – (-.25)           | Too Difficult               | Do not Include |
(-.26) – (-1.00)       | Terrible Predictor          | Do not Include |
FIGURE 1- DIFFERENTIAL MONITORING LOGIC MODEL AND ALGORITHM (Fiene, 2012)

*DMLMA*© Applied to the Kansas Child Care Licensing System

\[ CI + PQ \rightarrow RA + KI \rightarrow DM \]

**Kansas Examples:**

- CI = Licensing Reviews (All Rules)
- PQ = Not Applicable (NA)
- RA = Not Applicable (NA)
- KI = Key Indicators (generated from this study)
- DM = Not Applicable (NA)

**DMLMA© Thresholds:**

- **High Correlations (.70+)** = CI x KI.
- **Moderate Correlations (.50+)** = CI x RA; RA x DM; RA x KI; KI x DM.
- **Lower Correlations (.30+)** = PQ x CI; PQ x RA; PQ x KI.

![Diagram](image-url)
Table 5 – Rule Numbers and Phi Coefficients for Centers and Homes

<table>
<thead>
<tr>
<th>Centers</th>
<th>Phi</th>
<th>Homes</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>K.A.R.28-4-126b1.</td>
<td>.59</td>
<td>K.A.R.28-4-115g1.</td>
<td>.47</td>
</tr>
<tr>
<td>K.A.R.28-4-126c1.</td>
<td>.62</td>
<td>K.A.R.28-4-115aa1A</td>
<td>.79</td>
</tr>
<tr>
<td>K.A.R.28-4-423a18.</td>
<td>.59</td>
<td>K.A.R.28-4-115aa1B</td>
<td>.44</td>
</tr>
<tr>
<td>K.A.R.28-4-423a23.</td>
<td>.60</td>
<td>K.A.R.28-4-117a1</td>
<td>.44</td>
</tr>
<tr>
<td>K.A.R.28-4-428aa3.</td>
<td>.51</td>
<td>K.A.R.28-4-117c</td>
<td>.68</td>
</tr>
<tr>
<td>K.A.R.28-4-428ae1.</td>
<td>.53</td>
<td>K.A.R.28-4-127b1A</td>
<td>.53</td>
</tr>
<tr>
<td>K.A.R.28-4-430c3.</td>
<td>.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K.A.R.28-4-437d.</td>
<td>.59</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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These are the results from the key indicator analyses performed on the randomly selected 400 group child care home providers who comply with the 416 Rules for announced Renewal Inspections and 400 group child care home providers who had unannounced Monitoring inspections completed. Specific reference and documentation for the key indicator analyses and methodology can be found in Appendix 1.

As with all early care and education (ECE) licensing quality assurance data sets the data from the above two groups is highly skewed which means that the majority of programs are in full compliance (100%) with all the group child care home rules/regulations. In the sample drawn for the Renewal Inspections, 64% of the programs were in full compliance while for the Monitoring Inspections, 87% of the programs were in full compliance. See Appendix 2.

Table 1 contains the specific key indicators from the Renewal Inspections while Table 2 contains the specific key indicators from the Monitoring Inspections.

**Table 1 - Renewal Inspections**

<table>
<thead>
<tr>
<th>Rule Number</th>
<th>Content</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>416.5.L.3</td>
<td>Vaccine for pets</td>
<td>.29</td>
</tr>
<tr>
<td>416.5.A</td>
<td>Hazard free</td>
<td>.26</td>
</tr>
<tr>
<td>416.7.L</td>
<td>Sleeping and napping arrangements</td>
<td>.42</td>
</tr>
<tr>
<td>416.11.A.3</td>
<td>Child Immunizations</td>
<td>.27</td>
</tr>
<tr>
<td>416.11.H.1.L</td>
<td>Emergency Health Care</td>
<td>.25</td>
</tr>
<tr>
<td>416.12.O</td>
<td>Infant formula</td>
<td>.27</td>
</tr>
<tr>
<td>416.12.Q</td>
<td>Bottles labeled</td>
<td>.25</td>
</tr>
<tr>
<td>416.15.C.3</td>
<td>Emergency contact information</td>
<td>.35</td>
</tr>
<tr>
<td>416.15.C.4</td>
<td>Adults who have permission to pick up child</td>
<td>.38</td>
</tr>
<tr>
<td>416.15.C.6</td>
<td>Daily record of illnesses, injury, indicators of abuse</td>
<td>.33</td>
</tr>
</tbody>
</table>

These above 10 rules statistically predict overall compliance with all the rules. They represent about 4% of the total number of rules.
Monitoring Inspections

These are the results from the key indicator analyses performed on the randomly selected 400 group child care home providers who comply with the 416 Rules for unannounced Monitoring Inspections.

Table 2 - Monitoring Inspections

<table>
<thead>
<tr>
<th>Rule Number</th>
<th>Content</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>416.4.H.4</td>
<td>Paths of egress free of obstacles</td>
<td>.28</td>
</tr>
<tr>
<td>416.5.J</td>
<td>Toxic items are inaccessible</td>
<td>.31</td>
</tr>
<tr>
<td>416.8.A</td>
<td>Supervision at all times</td>
<td>.44</td>
</tr>
<tr>
<td>416.8.E</td>
<td>Approved primary caregiver present</td>
<td>.35</td>
</tr>
<tr>
<td>416.8.J.1</td>
<td>Adult child ratio for preschoolers &amp; school age</td>
<td>.28</td>
</tr>
<tr>
<td>416.8.J.2</td>
<td>Two caregivers present when 6+ children</td>
<td>.34</td>
</tr>
<tr>
<td>416.8.J.3</td>
<td>Adult child ratio for infant &amp; toddlers</td>
<td>.33</td>
</tr>
<tr>
<td>416.14.M</td>
<td>First aid and CPR</td>
<td>.52</td>
</tr>
<tr>
<td>416.15.B.12</td>
<td>Any changes to the home reported</td>
<td>.29</td>
</tr>
<tr>
<td>416.15.B.20</td>
<td>Supervision by approved primary caregiver</td>
<td>.38</td>
</tr>
</tbody>
</table>

These above 10 rules statistically predict overall compliance with all the monitoring rules. These 10 rules represent 77% of the total monitoring rules reviewed on any inspection. These results support the use of unannounced monitoring inspections as a very effective and efficient means of assuring an overall quality assurance in the licensing system.

However, it is not recommended that only these monitoring predictive rules be used, the State of New York should consider using the Monitoring Inspection Protocol along with the newly generated key indicators from the Renewal Inspection analyses as delineated in Table 1. The data from Table 1 were generated from full licensing inspections where all the rules were reviewed. By using both sets of key indicators, the state will balance the predictive and risk assessment aspects in their quality assurance licensing system.

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Appendix 1: TECHNICAL ASPECTS OF THE KEY INDICATOR METHODOLOGY

This section provides the technical and statistical aspects of the key indicator methodology. One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each child care rule (see Figure 1).

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers In Compliance on Rule</th>
<th>Programs Out Of Compliance on Rule</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Highest level</strong> (top 20-25%)</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Lowest level</strong> (bottom 20-25%)</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>W</td>
<td>X</td>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 2) is used to determine if the rule is a key indicator or not by calculating its respective Phi coefficient. Please refer back to Figure 1 for the actual placement within the cells. The legend (Figure 3) below the formula shows how the cells are defined.

**Figure 2 – Formula for Phi Coefficient**

\[
\phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}}
\]

**Figure 3 – Legend for the Cells within the Phi Coefficient**

\[A = \text{High Group + Programs in Compliance on Specific Rule.}\]
\[B = \text{High Group + Programs out of Compliance on Specific Rule.}\]
\[C = \text{Low Group + Programs in Compliance on Specific Rule.}\]
\[D = \text{Low Group + Programs out of Compliance on Specific Rule.}\]
\[W = \text{Total Number of Programs in Compliance on Specific Rule.}\]
\[X = \text{Total Number of Programs out of Compliance on Specific Rule.}\]
\[Y = \text{Total Number of Programs in High Group.}\]
\[Z = \text{Total Number of Programs in Low Group.}\]
Once the data are run through the formula in Figure 2, the following chart (Figure 4) can be used to make the final determination of including or not including the rule as a key indicator. Based upon the chart in Figure 4, it is best to have a Phi Coefficient approaching +1.00 however that is rarely attained with licensing data but has occurred in more normally distributed data.

Continuing with the chart in Figure 4, if the Phi Coefficient is between +.25 and -.25, this indicates that the indicator rule is unpredictable in being able to predict overall compliance with the full set of rules. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance. This can occur with Phi Coefficients above +.25 but it becomes unlikely as we approach +1.00 although there is always the possibility that other rules could be found out of compliance. Another solution is to increase the number of key indicator rules to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Phi Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator rule would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

**Figure 4 – Thresholds for the Phi Coefficient**

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>
APPENDIX 2

Figure 5 – Bar Chart of Renewal Inspections Compliance Levels (Number of Violations)
Figure 6 – Bar Chart of Monitoring Inspections Compliance Levels (Number of Violations)
Figure 7 – Line Chart of Renewal Inspections Compliance Levels (Number of Violations)
Figure 8 – Line Chart of Monitoring Inspections Compliance Levels (Number of Violations)
New York Quality Indicators Project: Group Child Care Home Key Indicators (Renewal Inspections)

June 2015

Richard Fiene, Ph.D.

These are the results from the key indicator analyses performed on the full data base of group child care homes (N = 1399) with the 416 Rules for announced Renewal Inspections. Usually these types of analyses are performed using a sample of data, such as 200 – 400 programs. The specific statistics used are most sensitive with a sample size within this range. Therefore, utilizing the full data set with well over 1000 programs is a new use of the Key Indicator methodology. The methodology and the results are still a very efficient way to reduce the full set of rules to a statistically predictive set of rules but there are some cautions which are pointed out throughout this brief report.

Some cautions noted are the following: 1) With the increased number of programs, the number of rules attaining the phi coefficient increases because the p-values decreased very significantly making many more rules statistically significant well below the .25 threshold. This is an expected result; however, the original decision table of maintaining the .25 threshold was used. 2) Whenever substantial compliance is introduced into the high group which was the case in two of the four analytical frameworks, it potentially increases the possibility that a specific key indicator rule could be out of compliance when the key indicators are used.

These analyses were unique in that the full data set was used which provided enhancements to the Key Indicator Methodology. In Table 1 below, the various results are provided demonstrating the differences amongst the various analytical frameworks. Four frameworks were used in constructing the analytical matrix for generating the Key Indicators: 1) (100/99) The high compliance group was defined as 100% in compliance (no violations) while the low compliance group was defined as 1 or more violations, 2) (99/95) The high compliance group was defined as 1 violation while the low compliance group was defined as 5 or more violations, 3) (100/95) The high compliance group was defined as 100% in compliance (no violations) while the low compliance group was defined as 5 or more violations, and 4) (100-99/95) The high compliance group was defined as 0-1 violations while the low compliance group was defined as 5 or more violations.
### Table 1 – Four Frameworks for Generating Key Indicators for Group Child Care Homes (416 Rules)

<table>
<thead>
<tr>
<th>Rule</th>
<th>100/99</th>
<th>99/95</th>
<th>100/95</th>
<th>100-99/95</th>
<th>TOTAL</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>3H</td>
<td>------</td>
<td>------</td>
<td>.33</td>
<td>.27</td>
<td>2</td>
<td>no peeling paint</td>
</tr>
<tr>
<td>4B1</td>
<td>------</td>
<td>------</td>
<td>.31</td>
<td>.25</td>
<td>2</td>
<td>evacuation drills</td>
</tr>
<tr>
<td>5A</td>
<td>------</td>
<td>------</td>
<td>.42</td>
<td>.33</td>
<td>2</td>
<td>hazard free</td>
</tr>
<tr>
<td>5J</td>
<td>------</td>
<td>------</td>
<td>.27</td>
<td></td>
<td>1</td>
<td>danger items inaccess</td>
</tr>
<tr>
<td>5L2</td>
<td>------</td>
<td>------</td>
<td>.30</td>
<td>.26</td>
<td>2</td>
<td>pets licensed</td>
</tr>
<tr>
<td>L3</td>
<td>------</td>
<td>.27</td>
<td>.32</td>
<td>.32</td>
<td>3</td>
<td>pet vaccines</td>
</tr>
<tr>
<td>5N5</td>
<td>------</td>
<td>------</td>
<td>.25</td>
<td></td>
<td>1</td>
<td>outdoor surface</td>
</tr>
<tr>
<td>5R</td>
<td>------</td>
<td>------</td>
<td>.25</td>
<td>.25</td>
<td>2</td>
<td>flashlight</td>
</tr>
<tr>
<td>5V</td>
<td>------</td>
<td>------</td>
<td>.30</td>
<td>.29</td>
<td>2</td>
<td>carbon monoxide alarm</td>
</tr>
<tr>
<td>6L</td>
<td>------</td>
<td>------</td>
<td>.26</td>
<td></td>
<td>1</td>
<td>transportation schedule</td>
</tr>
<tr>
<td>7L</td>
<td>.31</td>
<td>.50</td>
<td>.61</td>
<td>.57</td>
<td>4</td>
<td>sleeping arrangements</td>
</tr>
<tr>
<td>8A</td>
<td>------</td>
<td>.32</td>
<td>.38</td>
<td>.37</td>
<td>3</td>
<td>supervision</td>
</tr>
<tr>
<td>8E</td>
<td>------</td>
<td>------</td>
<td>.27</td>
<td>.25</td>
<td>2</td>
<td>primary caregiver</td>
</tr>
<tr>
<td>8F</td>
<td>------</td>
<td>.26</td>
<td>.30</td>
<td>.30</td>
<td>3</td>
<td>assistant present</td>
</tr>
<tr>
<td>8J2</td>
<td>------</td>
<td>------</td>
<td>.26</td>
<td></td>
<td>1</td>
<td>2 caregivers present</td>
</tr>
<tr>
<td>8J3</td>
<td>------</td>
<td>.31</td>
<td>.35</td>
<td>.36</td>
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<td>one caregiver</td>
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<td>11B1ii</td>
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<td>------</td>
<td>.27</td>
<td></td>
<td>1</td>
<td>med statement</td>
</tr>
<tr>
<td>11c1</td>
<td>------</td>
<td>------</td>
<td>.26</td>
<td></td>
<td>1</td>
<td>health care plan</td>
</tr>
<tr>
<td>11c2i</td>
<td>------</td>
<td>------</td>
<td>.31</td>
<td>.28</td>
<td>2</td>
<td>health checks</td>
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<tr>
<td>11H1i</td>
<td>------</td>
<td>.30</td>
<td>.43</td>
<td>.38</td>
<td>3</td>
<td>emergency medical</td>
</tr>
<tr>
<td>12N</td>
<td>------</td>
<td>.30</td>
<td>.42</td>
<td>.37</td>
<td>3</td>
<td>parent agree feeding</td>
</tr>
<tr>
<td>12O</td>
<td>------</td>
<td>------</td>
<td>.28</td>
<td>.28</td>
<td>2</td>
<td>parent agree formula</td>
</tr>
<tr>
<td>13C</td>
<td>------</td>
<td>------</td>
<td>.34</td>
<td>.26</td>
<td>2</td>
<td>caregivers &amp; SEL</td>
</tr>
<tr>
<td>14F</td>
<td>------</td>
<td>------</td>
<td>.33</td>
<td></td>
<td>1</td>
<td>30 hrs training</td>
</tr>
<tr>
<td>14M</td>
<td>.32</td>
<td>------</td>
<td>.49</td>
<td>.32</td>
<td>3</td>
<td>cert in FA/CPR</td>
</tr>
<tr>
<td>15A9</td>
<td>------</td>
<td>------</td>
<td>.25</td>
<td></td>
<td>1</td>
<td>licensed capacity</td>
</tr>
<tr>
<td>15B12</td>
<td>------</td>
<td>------</td>
<td>.26</td>
<td></td>
<td>1</td>
<td>notified of any change</td>
</tr>
<tr>
<td>15B22</td>
<td>------</td>
<td>------</td>
<td>.28</td>
<td>.26</td>
<td>2</td>
<td>written policies</td>
</tr>
<tr>
<td>15C3</td>
<td>------</td>
<td>.44</td>
<td>.54</td>
<td>.51</td>
<td>3</td>
<td>emergency contact</td>
</tr>
<tr>
<td>15C4</td>
<td>.27</td>
<td>.47</td>
<td>.59</td>
<td>.55</td>
<td>4</td>
<td>pickup child</td>
</tr>
<tr>
<td>15C5</td>
<td>------</td>
<td>.34</td>
<td>.43</td>
<td>.40</td>
<td>3</td>
<td>daily attendance</td>
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<td>15C6</td>
<td>.41</td>
<td>.38</td>
<td>.67</td>
<td>.52</td>
<td>4</td>
<td>health record</td>
</tr>
<tr>
<td>15C13</td>
<td>.25</td>
<td>.29</td>
<td>.49</td>
<td>.40</td>
<td>4</td>
<td>arrival departure</td>
</tr>
</tbody>
</table>

**TOTAL** 5 12 33 24
These four frameworks provide guidance in determining the best combination of Key Indicators given the various compliance determinations, such as 100% compliance versus substantial but not full compliance with all the group child care home rules. In reviewing the frameworks, clearly the 100/99 option #1 where the high group is 100% in compliance with no violations is too stringent a criteria since so few rules make the cut for the Key Indicator threshold. The second option (99/95) where the high group has only 1 violation is a better option because it introduces additional Key Indicators. This option was completed by both the author and staff at NY/OCFS. The third option (100/95) where the high group is 100% in compliance with no violations but where the low group has 5 or more violations provides a much larger number of Key Indicators. This option really is less efficient (usually key indicator tools represent 10% or less of the full set of rules) by providing over 30 Key Indicators but it could be a good resource to add other Key Indicators randomly. The last option (100-99/95) where the high group has either no violations or 1 violation provides a nice balance with the number of Key Indicators generated. This option gets closer to the 10% ratio of Key Indicators to the full set of rules.

Based upon the results from Table 1, a recommendation could be made to use those Key Indicators that appear the most often in the four options. That would appear to be the best balanced approach. However, one must look at the licensing law to make certain that even this approach is a valid policy to pursue. For example, if the licensing law requires 100% full compliance with all rules, then this approach may not be the best policy decision. Selecting one of the 100% full compliance frameworks may be the better choice. However, if the state has discretion in issuing licenses on the basis of substantial but not full compliance than any of the frameworks will be ok or a combination of any of the four would also be a good policy decision.

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New York Quality Indicators

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Introduction

This document will provide the basic standards to be used by New York Licensing staff when they conduct monitoring visits focusing on the quality elements of a child care home based provider. New York is interested in being able to balance program compliance with program quality. The standards suggested in this document are drawn from their licensing rules, quality rating and improvement system, and general research literature for child care home based providers. These standards are based upon previous research conducted by this author in determining the key indicators of quality over a 40 year time period. There were several parameters in the selection of these standards, such as: there were to be a smaller rather than a larger number given the time constraints in conducting these reviews; they needed to be straightforward and easy to measure; and they needed to be drawn from empirical evidence in that they have been useful in determining overall quality.

The important concept to keep in mind is the building block format of the standards in which these more program quality focused standards have their origin in the licensing rules. There should always be a clear link between licensing compliance and program quality; it is a continuum of overall quality starting with health and safety and moving towards quality learning environments for young children.
The Standards

Licensing Rules

The main areas taken from the licensing rules are the following: behavior management (416.9), programming (416.7), supervision (416.8), and training (416.18). These rules are more program quality oriented than they are health and safety oriented.

Behavior management (416.9): children are not isolated; corporal punishment is prohibited; frightening, demeaning or humiliating techniques are not used; physical restraint is prohibited; written behavior management plan is provided to caregivers, staff and parents.

Programming (416.7): a daily schedule has been established which includes daily physical activity; awake infants less than 6 months are placed on stomach/back/side for short supervised periods; children can not be confined to a high chair for more than 15 minutes except while eating; children must be allowed freedom of movement; children must be provided opportunity to choose between quiet and active play; children must have daily outdoor play; sufficient quantity and variety of materials and play equipment are provided.

Supervision (416.8): supervision ratios are maintained during off site activities and transportation; two caregivers are present when more than 6 children, none of whom are school age, are in care.

Training (416.14): provider and assistant have completed 15 hours of training in first 6 months; provider and assistant must complete 30 hours in all topics every 2 years.
Quality Rating and Improvement System Standards

The basic standard that builds upon the licensing rules relates to family engagement. These standards are based upon studies completed by the author in validating QRIS standards.

Provider communicates with parents of infants in writing on a daily basis about caregiving routines, such as feeding, sleeping, and diapering/toileting.

Program communicates with families in a comprehensive, written format about the program’s history, philosophy, admissions policies, other procedures, applicable regulations, and parent involvement opportunities.

Provider periodically communicates in writing with families about program and child activities and other pertinent information.

Provider meets one-on-one with parents about their individual children’s developments at least twice a year.

Provider shares information with parents about the provider’s and any assistant’s, educational qualifications and professional experience.

Provider provides written information about family resources and supports, such as information on child development, oral health, child health insurance, tax credits, and child care financial assistance.
**Rationale**

These above standards constitute a balanced protocol between program compliance/licensing and program quality. The standards build upon each other in somewhat of a stepwise fashion. They are supported by 40+ years of research in identifying key compliance/quality indicators. For example, having the proper programming in place builds upon the need and importance of having a structured curriculum for young children. Past research has demonstrated that this is an important indicator of quality and one that really makes a difference for children.

The training of staff fits with the overall qualifications of staff which is a key indicator of compliance and quality programming for young children. One cannot have a high quality program without highly qualified teachers and a high quality director. In fact, if I had to select one key indicator above all others in determining the overall quality of a program, it would be having a highly qualified ECE Director. Based upon my 40+ years of research into identifying key elements/indicators of ECE program quality, this would be my number selection.

**Conclusion/Next Steps**

If the state is in agreement with these above stated standards then the next step would be to actually design the specific tool/checklist to be used to measure compliance with these standards and complete a pilot study to establish reliability and validity of the tool as well as to determine the amount of time needed to do the checklist.
Additional information regarding this report:

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Hawaii QRIS Key Indicator Blueprint Report

Richard Fiene, Ph.D.

August 30, 2013

ABSTRACT

This report will provide a blueprint for Hawaii’s QRIS in developing a key indicator approach to help streamline their present assessment process. The report will be organized into the following major headings: an introduction to the key indicator methodology; how key indicators fit into the larger program monitoring of early care and education programs; how key indicators will be applied to QRIS and to Hawaii’s QRIS in particular; the technical aspects of the key indicator methodology, the sample to be drawn from the population, although the full population of early care and education programs may be able to be used; potential results from the analyses; a timeline for this developmental effort; and potential cost savings from the approach. This blueprint report will answer all the questions about developing key indicators for QRIS, the what, how, why, when, etc…

INTRODUCTION

The Key Indicator Methodology was developed to help streamline the program monitoring of early care and education programs. It was first applied in child care licensing (Fiene & Nixon, 1985) but has been used in many other service types, such as: Head Start Performance Standards (Fiene, 2013a), National Accreditation (Fiene, 1996), and child and adult residential programs (Kroh & Melusky, 2010). The methodology is based upon statistical protocols that have been developed in the tests and measurements literature in which an abbreviated set of items is used to statistically predict as if the full test was applied. This methodology has been used in regulatory analysis and more recently has been proposed for use in Quality Rating and Improvement Systems (QRIS) (Fiene, 2013b).
DIFFERENTIAL PROGRAM MONITORING

Key indicators are an important component of differential program monitoring which employs an abbreviated review rather than a comprehensive or full review of a program. It is one of several key elements that have been identified in the research literature to help improve the cost effectiveness and efficiency of the program monitoring of early care and education programs (Fiene, 2013b, c)(See the Appendix). A recent addition to differential monitoring are QRIS – Quality Rating and Improvement Systems. Key indicators have a long history of development within the licensing literature (Fiene & Kroh, 2000) but have only recently been proposed to be used with QRIS. This proposed blueprint is a first for a state to determine the feasibility of using the key indicator approach with its QRIS system.

The other key elements of the differential program monitoring approach are the following: program compliance/licensing which is generally a state’s health and safety rules/regulations that govern child care. At the national level this would be Caring for Our Children: National Performance Standards for Health and Safety in Child Care (2012). The program quality key element is generally represented by the state’s QRIS. At the national level it is represented by accreditation, such as NAEYC, NECPA, or NAFCC. The key indicator element is represented by the state’s statistical predictor rules/regulations drawn from their comprehensive set of health and safety rules/regulations that govern child care. At the national level, an example is the 13 Indicator of Quality Child Care (2002). This element can also represent a state’s statistical predictor QRIS standards drawn from the comprehensive set of QRIS standards. The purpose of this Blueprint Report is to develop these statistically predictor QRIS standards. The last key element to be addressed in this report is the risk assessment key element in which these are the high risk rules/regulations that place children at greatest risk of mortality or morbidity. At the national level, an example is Stepping Stones to Caring for Our Children (2013). These are generally determined via a weighting system in licensing or a point system with QRIS.

KEY INDICATORS APPLIED TO HAWAII'S QRIS

Hawaii’s QRIS is somewhat unique in that its assessment system is drawn very heavily from off-the-shelf assessment tools, such as the ERS’s, CLASS, PAS/BAS in addition to QRIS program standards. This will pose significant challenges because of the psychometric properties of these standardized tools. However, with that said, the key indicator methodology is drawn directly from the tests and measurements research literature in which it is an approach in taking a comprehensive test and reducing it down to a group of statistical predictor items. The key indicator methodology will not alter the scale structure of any of the assessment tools. The purpose of the key indicator methodology is to establish a protocol.
so that a determination of a full score and the appropriate level can be statistically predicted from a smaller set of items from that respective tool, in Hawaii’s QRIS standards, ERS’s, CLASS, PAS/BAS, NAEYC, NAFCC.

The key indicators can eventually be tied to the professional development/training/technical assistance system to link resources to specific needs of the programs. It also has the capability of tying them to an early learning benchmarking and child outcomes at some point in the future. This would be accomplished in the full implementation of the Differential Monitoring Logic Model and Algorithm (DMLMA©) as depicted in the Appendix.

TECHNICAL ASPECTS OF THE KEY INDICATOR METHODOLOGY

This section provides the technical and statistical aspects of the key indicator methodology. It will provide the roadmap in taking the Hawaii QRIS data base through the necessary steps to generating the respective key indicators.

One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. In very large states this is done on a sampling basis but in Hawaii’s case we should be able to use all the programs who participate in the QRIS and not take a sample. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each item within the specific assessment tool (see Figure 1). An example would be the following: Item 16 from the ECERS – Encouraging Children to Communicate. Sort all the providers by the number in the highest group and the lowest. Then determine how each program scored on item 16, did they get a 5 or higher or a 3 and lower? Fill in the cells within Figure 1 accordingly (see Figure 2).

Figure 1

<table>
<thead>
<tr>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Highest level (top 20-25%)</strong></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td><strong>Lowest level (bottom 20-25%)</strong></td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>W</td>
<td>X</td>
</tr>
</tbody>
</table>
Figure 2 depicts that all programs that were in the top 25% (5+ on ECERS, Item 16) were also in the highest rating while the bottom 25% (3 or lower on the ECERS, Item 16) were also in the lowest rating. The data depicted in Figure 2 are taken from studies completed in Pennsylvania in 2002 (Fiene, et al) and 2006 (Barnard, Smith, Fiene & Swanson) in which their quality rating and improvement system (QRIS), Keystone STARS, was validated.

<table>
<thead>
<tr>
<th>Figure 2 – Pa. Study (Fiene, etal, 2002).</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Star level in Pa.</td>
<td>117</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td>Lowest Star level in Pa.</td>
<td>0</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Column Total</td>
<td>117</td>
<td>35</td>
<td>152</td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 3) is used to determine if Item 16 is a key indicator or not by calculating its respective Phi coefficient. Please refer back to Figure 1 for the actual placement within the cells and Figure 2 for the data within the cells. The legend (Figure 4) below the formula shows how the cells are defined.

**Figure 3 – Formula for Phi Coefficient**

$$\phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}}$$

**Figure 4 – Legend for the Cells within the Phi Coefficient**

- **A** = High Group + Programs in Compliance on Specific Compliance Measure.
- **B** = High Group + Programs out of Compliance on Specific Compliance Measure.
- **C** = Low Group + Programs in Compliance on Specific Compliance Measure.
- **D** = Low Group + Programs out of Compliance on Specific Compliance Measure.
- **W** = Total Number of Programs in Compliance on Specific Compliance Measure.
- **X** = Total Number of Programs out of Compliance on Specific Compliance Measure.
- **Y** = Total Number of Programs in High Group.
- **Z** = Total Number of Programs in Low Group.
Once the data are run through the formula in Figure 3, the following chart (Figure 5) can be used to make the final determination of including or not including the item as a key indicator. Based upon the chart in Figure 5, it is best to have a Phi Coefficient approaching +1.00 since we are dealing with normally distributed data\(^1\). This requirement is relaxed with licensing rules & QRIS selected standards only (+.26 and higher) because the data are more skewed but this should not be the case as much with Hawaii’s Quality Rating and Improvement System (QRIS) data because the measures selected in the QRIS are mostly standardized tools with more normally distributed data.

Continuing with the chart in Figure 5, if the Phi Coefficient is between +.25 and -.25, this indicates that the indicator is unpredictable in being able to predict overall compliance with the quality rating assessment tool. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance\(^2\). This can occur with Phi Coefficients above +.25 but it becomes unlikely as we approach +1.00 although there is always the possibility that other standards/rules/regulations could be found out of compliance (this was demonstrated in a study conducted by the author (Fiene, 2013c) with Head Start programs). Another solution is to increase the number of key indicators to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Phi Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

**Figure 5 – Thresholds for the Phi Coefficient (Fiene & Nixon, 1983, 1985)**

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

The key indicators should then only be used with those programs who have attained the highest rating. It is not intended for those programs that have attained lower ratings. However, even with those programs that have attained the highest rating, every 3-5 years a full, comprehensive
review using the full assessment tools and QRIS standards should occur (see Figure 6 for a graphical depiction). It is intended that a re-validation of the key indicators occur on a periodic basis to make certain that the key indicators have not changed because of differences in compliance history. This is an important and necessary step for the state to engage in to ascertain the overall validity and reliability of the assessment system. Also there should not have been any major changes in the program while the key indicators are being administered, such as the director leaving or a large percentage of teachers leaving or enrollment increasing significantly, or a change in the licensing status of the program.

**Figure 6 - Proposed DMLMA System with Key Indicators (KI)**

*Use of Hawaii Key Indicators (HIKI) for QRIS with a Full Review every 4th Year*

![Diagram](image)

**SAMPLE**

Generally a sample is drawn from the population of early care and education facilities in the respective state. With this being said, the chances are the full population will be able to be used in Hawaii’s case because of the manageable number of facilities. This should be able to be done with centers as well as with homes²a.

**POTENTIAL RESULTS**

The potential results are drawn from previous studies conducted by the author (Fiene, 2013b) in which key indicators were generated for the ECERS-R and FCCERS-R. All the specific items in the ECERS-R and FCCERS-R were run through the Phi Coefficient formula in Figure 3 above after having sorted the data into a high group (5 or higher) and a low group (3 or less) for the overall ECERS-R and FCCERS-R scores. This same procedure will be followed with the Hawaii QRIS but in this case the individual ERS item score will be compared with the respective Star Levels which will be sorted into a high group (top Level) and a low group (bottom Level) in order to determine which individual ERS items become key indicators. This process will be repeated for all ERS items and then extended to CLASS and PAS/BAS items as well as QRIS standards and where appropriate to NAEYC and NAFCC items.
It is estimated from previous studies (Fiene, 2013a; 2013c; 2013d) that approximately 10% of the ERS, CLASS, PAS/BAS, NAEYC, NAFCC items & QRIS standards will become key indicators. If this holds true it will substantially reduce the total number of items to review for QRIS assessments. It is also expected that the Phi Coefficients will be very high at a .90 level or higher because of the dichotomization of the data which should be normally distributed rather than significantly skewed. Also there will be significant redundancy in the data because the rating levels are so much tied to the standardized assessments in that the ERS, CLASS, PAS/BAS, NAEYC, and NAFCC are directly cross-walked to increasing rating levels.

As mentioned earlier, the measurement issues with the various standardized tools will provide challenges because of their data distributions. In the past when key indicators have been generated with licensing data which are highly skewed, dichotomization of the data is regularly done. However, when one looks at Figure 7 it is clear that the standardized assessments are more normally distributed than skewed\(^3\). Generally dichotomization of data should not be done with normally distributed data\(^4\); however, in this case with Hawaii’s QRIS and how the standardized assessments are used to make decisions regarding rating levels, it is appropriate to do so since the data lend themselves to being sorted into discrete categories, such as rating levels. The dichotomization will compare the lowest rating level with the highest rating level in order to generate the key indicators.

**Figure 7 – Data Distribution Comparisons of ERS, QRIS, and Licensing Data**

![ERS, QRIS, Licensing Distributions](image)
TIMELINE

As soon as all early care and education programs have gone through their assessment phase, it will be possible to do the calculations to determine the Phi Coefficients and generate the key indicators. I am guessing that this should not take any longer than 1 year but could be completed in a much shorter period of time if the assessments on individual programs could be moved up (see Figure 8). The analytical phase should take no longer than a month with an additional month to write up the report. A face to face presentation of the analyses could be done after these two months.

The timeline presented in Figure 8 can be adjusted to the specific needs of Hawaii’s QRIS system. The timeline is based upon previous projects and the average time to generate key indicators. Another consideration or task is the development of the policies and procedures to be developed and implemented regarding the use of key indicators. This was not specifically listed on the timeline because it is something that is generally developed throughout the project with feedback from all the stakeholders who will be impacted by the use of this new approach to assessment and monitoring.

**Figure 8 - HAWAII QRIS KEY INDICATOR (KI) PROJECT TIMELINE**

<table>
<thead>
<tr>
<th>TASK</th>
<th>MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Collect Data</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Sort Data</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Run Analyses</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Generate KI</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Training on KI</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>KI Reliability</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>Implementation</td>
<td>XXXXXX</td>
</tr>
</tbody>
</table>

**Legend:**
Collect Data – dependent upon the total number of programs participating it would be determined to collect data on all participants or to complete a sample.
Sort Data – the individual programs are sorted into high and low groups representing the top 25% and the bottom 25% of programs as they have scored on the respective assessment tools and standards.
Run Analyses – each individual item within each of the assessment tools for every program will be compared to the sorting process of the high and low groups.

Generate KI – a 2 x 2 matrix is constructed and the key indicators (KI) are generated from this matrix through the use of a phi coefficient. A final report will be delivered to Hawaii executive staff.

Training on KI – all staff who will be using the KI will be trained on its use.

KI Reliability – reliability will be established by having two staff go out together and administer the key indicators separately and comparing their results.

Implementation – once reliability has been established, full implementation will begin.

COST SAVINGS

Again based upon previous studies most recently completed in California in 2010 (http://www.myccl.ca.gov/res/docs/12022010HandoutStakeholderMeeting.pdf), time savings of 50% have been attained by using a key indicator or abbreviated tool in completing assessments. It only makes sense that if an assessment can be completed in one hour rather than 2 – 4 hours that a state will see time savings. It is being assumed that equivalent savings should also be the case with Hawaii’s QRIS although this cannot be made certain until the new key indicator or abbreviated tool is actually used for a period of time. Once the new key indicators are used for several months, comparisons could be made to when the full assessments were done.

CONCLUSION AND NEXT STEPS

This blueprint report has given the basic parameters to develop a key indicator approach to Hawaii’s QRIS assessment tools. By following this blueprint Hawaii staff should be able to fully implement the approach. Hawaii staff would also need to determine if they have the internal capability for the development of the key indicators or if there will be the need to outsource certain aspects of the development. This will be an important consideration as Hawaii moves forward with this project. I have provided two options for your consideration in moving forward.

Option 1 – Development of System Internally:

This would require either information systems or research & evaluation staff to analyze the data, generate key indicators for each assessment tool, and training of staff. I could provide the necessary consulting services to help the staff work through the methodology. This would probably require at least one face to face meeting with regular monthly conference calls between myself and staff. Discussions of the formatting of data and the types of analyses would be discussed and demonstrated.

Option 2 – Development of System Externally:

In this option I could do all the methodological work demonstrating how I would need the data sent to me, the analytical work in generating key indicators for each assessment tool, a report
detailing the methodology and results. The only thing that Hawaii staff would need to do is get the data to me, all other aspects of what is delineated in the timeline in Figure 8 would be completed by me. This would probably require several face to face trips to explain the process, the results, and do training of staff. Once everything was in place, Hawaii staff would have a fully implemented system.

If the above options are of interest I can provide detailed budgets for either one or both.

Notes:

1. 4. The reason for pointing out the need to have a higher Phi Coefficient than what has been reported previously (Fiene & Nixon, 1983, 1985) is the fact that the dichotomization of data should only be used with skewed data and not normally distributed data because it will accentuate differences. However, since the purpose of the dichotomization of data is only for sorting into a high and low group, it would appear to be acceptable for this purpose (MacCallun, etal, 2002. On the practice of dichotomization of quantitative variables, Psychological Methods, 7, 1, 19-40.).

2. These results would show an increase in cells B and C in Figure 1 which is undesirable; it should always be the case where \( A + D > B + C \) for key indicators to maintain their predictive validity.

2a. If a sample must be drawn, I can help to provide the guidance in pulling such a sample.

3. The distinction between making decisions with skewed (Licensing) as versus normally distributed (ERS) data is an important one because there is a greater likelihood with skewed data of introducing less than optimal programs into the high group when sorting programmatic data into high and low groups. This then makes it more difficult to identify the best programs. However, because of the distribution with skewed data the same cannot be said with the low group in which case it is relatively easy to identify the problem programs. This is not as much of a concern when the data are more normally distributed in which it is relatively easy to identify both the optimal and problem programs. This is an excellent example of the need of weighting of standards in order to increase the normal distribution of the data.
REFERENCES AND ADDITIONAL RELATED READINGS REGARDING DMLMA:


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Appendix

DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

\[ C_I \times P_Q \Rightarrow R_A + K_I \Rightarrow D_M + P_D \Rightarrow C_O \]

Definitions of Key Elements:

**PC** = Program Compliance/Licensing (Health and Safety) *(Caring for Our Children)*  
**PQ** = QRIS/Accreditation/Caregiver/Child Interactions/Classroom Environment Quality *(ERS/CLASS/PAS/BAS)*  
**RA** = Risk Assessment, (High Risk Rules) *(Stepping Stones)*  
**KI** = Key Indicators (Predictor Rules) *(13 Key Indicators of Quality Child Care)*  
**DM** = Differential Monitoring (How often to visit and what to review)  
**PD** = Professional Development/Technical Assistance/Training (Not pictured but part of Model)  
**CO** = Child Outcomes (Not pictured but part of Model)
ABSTRACT

This report will provide a blueprint for Oregon’s Early Care and Education/Child Care program monitoring system in developing a Differential Program Monitoring, Risk Assessment, and Key Indicator approach to help streamline their present licensing process. The report will be organized into the following major headings: an introduction to the differential monitoring methodology; how key indicators and risk assessment fit into the larger program monitoring of early care and education programs; how key indicators and risk assessment will be applied to Oregon’s system in particular; the technical aspects of differential monitoring, risk assessment and key indicator methodology, the sample to be drawn from the population, potential results from the analyses; a timeline for this developmental effort; and potential cost savings from the approach.

INTRODUCTION

The Risk Assessment, Key Indicator, and Differential Program Monitoring Methodologies were developed to help streamline the program monitoring of early care and education programs. It was first applied in child care licensing (Fiene & Nixon, 1985) but has been used in many other service types, such as: Head Start Performance Standards (Fiene, 2013a), National Accreditation (Fiene, 1996), and child and adult residential programs (Kroh & Melusky, 2010). The methodologies are based upon statistical protocols that have been developed in the tests and measurements literature in which an abbreviated set of items is used to statistically predict as if the full test was applied. This methodology has been used in regulatory analysis and more recently has been proposed for use in Quality Rating and Improvement Systems (QRIS) (Fiene, 2013b).
DIFFERENTIAL PROGRAM MONITORING

Risk Assessment and Key Indicators are important components of differential program monitoring which employs an abbreviated review rather than a comprehensive or full review of a program. It is one of several key elements that have been identified in the research literature to help improve the cost effectiveness and efficiency of the program monitoring of early care and education programs (Fiene, 2013b, c)(See the Appendix). A recent addition to differential monitoring are QRIS – Quality Rating and Improvement Systems. Key indicators have a long history of development within the licensing literature (Fiene & Kroh, 2000) but have only recently been proposed to be used with QRIS. This proposed blueprint is to assist Oregon to develop a fully functional differential program monitoring, risk assessment, and key indicator approach to their child care licensing system and then determine the feasibility of using the these approaches with its QRIS system.

The other key elements of the differential program monitoring approach are the following: program compliance/licensing which is generally a state’s health and safety rules/regulations that govern child care. At the national level this would be Caring for Our Children: National Performance Standards for Health and Safety in Child Care (2012). The program quality key element is generally represented by the state’s QRIS. At the national level it is represented by accreditation, such as NAEYC, NECPA, or NAFCC. The key indicator element is represented by the state’s statistical predictor rules/regulations drawn from their comprehensive set of health and safety rules/regulations that govern child care. At the national level, an example is the 13 Indicator of Quality Child Care (2002). This element can also represent a state’s statistical predictor QRIS standards drawn from the comprehensive set of QRIS standards. The purpose of this Blueprint Report is to develop these statistically predictor standards first for Oregon’s child care licensing system and explore the possibility of expanding this to their QRIS system. The last key element to be addressed in this report is the risk assessment key element in which these are the high risk rules/regulations that place children at greatest risk of mortality or morbidity. At the national level, an example is Stepping Stones to Caring for Our Children (2013). These are generally determined via a weighting system in licensing or a point system with QRIS.

KEY INDICATORS APPLIED TO OREGON’S CHILD CARE LICENSING SYSTEM

Oregon’s licensing and QRIS systems are very similar to many other states’ licensing and QRIS systems so that the methodologies employed in the past for developing risk assessment and key indicators will be employed in this blueprint. There are some significant challenges because of the psychometric properties of licensing data because of the severe skewness and kurtosis
present in state data systems. These challenges will be addressed later in this blueprint in how to deal skewness and kurtosis.

The risk assessment and key indicators can eventually be tied to the professional development/training/technical assistance system to link resources to specific needs of the programs. It also has the capability of tying them to an early learning benchmarking and child outcomes at some point in the future. This would be accomplished in the full implementation of the Differential Monitoring Logic Model and Algorithm (DMLMA©) as depicted in the Appendix.

TECHNICAL ASPECTS OF THE KEY INDICATOR METHODOLOGY

This section provides the technical and statistical aspects of the key indicator methodology. It will provide the roadmap in taking the Oregon licensing and QRIS data bases through the necessary steps to generating the respective key indicators.

One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. In very large states this is done on a sampling basis which will be described later in the blueprint. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each item within the specific assessment tool (see Figure 1). An example would be the following: Item 16 from the ECERS – Encouraging Children to Communicate. Sort all the providers by the number in the highest group and the lowest. Then determine how each program scored on item 16, did they get a 5 or higher or a 3 and lower? Fill in the cells within Figure 1 accordingly (see Figure 2).

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level (top 20-25%)</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td>Lowest level (bottom 20-25%)</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td>Column Total</td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>
Figure 2 depicts that all programs that were in the top 25% (5+ on ECERS, Item 16) were also in the highest rating while the bottom 25% (3 or lower on the ECERS, Item 16) were also in the lowest rating. The data depicted in Figure 2 are taken from studies completed in Pennsylvania in 2002 (Fiene, et al) and 2006 (Barnard, Smith, Fiene & Swanson) in which their quality rating and improvement system (QRIS), Keystone STARS, was validated. The reason for selecting this particular item from the ECERS is that it demonstrates a perfect phi coefficient in discriminating between the highest level and the lowest level. Most, if not all, of the licensing items that will attain the threshold levels to become key indicators will not approach this phi coefficient.

<table>
<thead>
<tr>
<th>Figure 2 – Pa. Study (Fiene, etal, 2002).</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Highest Star level in Pa.</strong></td>
<td>117</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td><strong>Lowest Star level in Pa.</strong></td>
<td>0</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>117</td>
<td>35</td>
<td>152</td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 3) is used to determine if Item 16 is a key indicator or not by calculating its respective Phi coefficient. Please refer back to Figure 1 for the actual placement within the cells and Figure 2 for the data within the cells. The legend (Figure 4) below the formula shows how the cells are defined.

**Figure 3 – Formula for Phi Coefficient**

\[ \phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}} \]

**Figure 4 – Legend for the Cells within the Phi Coefficient**

- \(A\) = High Group + Programs in Compliance on Specific Compliance Measure.
- \(B\) = High Group + Programs out of Compliance on Specific Compliance Measure.
- \(C\) = Low Group + Programs in Compliance on Specific Compliance Measure.
- \(D\) = Low Group + Programs out of Compliance on Specific Compliance Measure.
- \(W\) = Total Number of Programs in Compliance on Specific Compliance Measure.
- \(X\) = Total Number of Programs out of Compliance on Specific Compliance Measure.
- \(Y\) = Total Number of Programs in High Group.
- \(Z\) = Total Number of Programs in Low Group.
Once the data are run through the formula in Figure 3, the following chart (Figure 5) can be used to make the final determination of including or not including the item as a key indicator. Based upon the chart in Figure 5, it is best to have a Phi Coefficient approaching +1.00 since we are dealing with normally distributed data\(^1\). This requirement is relaxed with licensing rules & QRIS selected standards only (+.26 and higher) because the data are more skewed but this should not be the case as much with Oregon’s Quality Rating and Improvement System (QRIS).

Continuing with the chart in Figure 5, if the Phi Coefficient is between +.25 and -.25, this indicates that the indicator is unpredictable in being able to predict overall compliance with the quality rating assessment tool. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance\(^2\). This can occur with Phi Coefficients above +.25 but it becomes unlikely as we approach +1.00 although there is always the possibility that other standards/rules/regulations could be found out of compliance (this was demonstrated in a study conducted by the author (Fiene, 2013c) with Head Start programs). Another solution is to increase the number of key indicators to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Phi Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

**Figure 5 – Thresholds for the Phi Coefficient (Fiene & Nixon, 1983, 1985)**

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

The key indicators should then only be used with those programs who have attained the highest rating. It is not intended for those programs that have attained lower ratings. However, even with those programs that have attained the highest rating, every 3-5 years a full, comprehensive review using the full set of rules/standards for licensing and QRIS should occur (see Figure 6 for a graphical depiction). It is intended that a re-validation of the key indicators occur on a periodic basis to make certain that the key indicators have not changed because of differences in compliance history. This is an important and necessary step for the state to engage in to
ascertain the overall validity and reliability of the assessment system. Also there should not have been any major changes in the program while the key indicators are being administered, such as the director leaving or a large percentage of teachers leaving or enrollment increasing significantly, or a change in the licensing status of the program.

Figure 6 - Proposed DMLMA System with Key Indicators (KI)

Use of Oregon Key Indicators (ORKI) for Licensing and/or QRIS with a Full Review every 4th Year

Figure 6A – Example of a Likert Scale for Measuring Risk to Children

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Medium Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Once the data are collected from all the experts, it is averaged for each rule to determine its relative rank in comparison to all the other rules. A significantly high threshold or cut off point is determined so that no more than 5-10% of the rules become core rules. These core rules can then be used in a differential monitoring approach (to be described more fully in the next section).
and/or with the key indicators to complete abbreviated reviews of child care programs. It is recommended that such a practice of using both core rules and key indicators be used together because than the state has the benefits of both methodologies in measuring risk and being able to statistically predict overall compliance with a very short list of rules.

**TECHNICAL ASPECTS DIFFERENTIAL MONITORING METHODOLOGY**

There are a couple of other key technical aspects that need to be in place for a differential monitoring system to work. The Differential Monitoring Logic Model and Algorithm (DMLMA©)(see the Appendix) is a 4th generational Early Childhood Program Quality Indicator Model4 (ECPQIM4©) in which the major monitoring systems in early care and education are integrated conceptually so that the overall early care and education system can be assessed and validated. With this new model, it is now possible to compare results obtained from licensing systems, quality rating and improvement systems (QRIS), risk assessment systems, key indicator systems, technical assistance, and child development/early learning outcome systems. The various approaches to validation are interposed within this model and the specific expected correlational thresholds that should be observed amongst the key elements of the model are suggested (see Figure 6B).

**Figure 6B – Inter-Correlational Threshold Matrix**

<table>
<thead>
<tr>
<th></th>
<th>PQ</th>
<th>RA</th>
<th>KI</th>
<th>DM</th>
<th>PD</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI</td>
<td>0.3</td>
<td>0.5</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>PQ</td>
<td></td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA</td>
<td>0.5</td>
<td></td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>KI</td>
<td></td>
<td>0.5</td>
<td></td>
<td>0.5</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>DM</td>
<td></td>
<td></td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.3</td>
<td></td>
</tr>
</tbody>
</table>
Key Elements (see the Appendix): CI = state or federal standards, usually rules or regulations that measure health and safety - Caring for Our Children or Head Start Performance Standards will be applicable here. PQ = Quality Rating and Improvement Systems (QRIS) standards at the state level; ERS (ECERS, ITERS, FDCRS), CLASS, or CDPES (Fiene, 2007). RA = risk assessment tools/systems in which only the most critical rules/standards are measured. Stepping Stones is an example of this approach. KI = key indicators in which only predictor rules/standards are measured. The Thirteen Indicators of Quality Child Care is an example of this approach. DM = differential monitoring decision making in which it is determined if a program is in compliance or not and the number of visits/the number of rules/standards are ascertained from a scoring protocol. PD = technical assistance/training and/or professional development system which provides targeted assistance to the program based upon the DM results. CO = child outcomes which assesses how well the children are developing which is the ultimate goal of the system.

Once the above key elements are in place, it is then possible to look at the relationships amongst them to determine if the system is operating as it was intended. This is done through a validation of the overall system and assessing the inter-correlations (Table 6B) to determine that the DM system is improving the health, safety, program quality and ultimately the overall development of the children it serves.

Oregon should use the following plan to implement the above approach:

STATE AGENCY PLAN (These Steps can be viewed as an overall plan as outlined in Zellman & Fiene (2012):

The first step in utilizing the DMLMA for a state is to take a close look at its Comprehensive Licensing Tool (CI) that it uses to collect violation data on all rules with all facilities in its respective state. If the state does not utilize a tool or checklist or does not review all violation data than it needs to consider these changes because the DMLMA is based upon an Instrument Based Program Monitoring System (IPM) which utilizes tools/checklists to collect data on all rules.

The second step for the state is to compare their state’s rules with the National Health and Safety Performance Standards (Caring for Our Children) to determine the overlap and coverage between the two. This is the first approach to validation which involves Standards review (Zellman & Fiene, 2012).

The third step for the state if it utilizes a Risk Assessment (RA) tool is to assess the relationship between this tool and Stepping Stones to determine the overlap and coverage between the two. This is a continuation of the first approach to validation which involves Standards review (Zellman & Fiene, 2012).
The fourth step for the state is to compare the results from the CI with the RA tools. This step is the second approach to validation which involves Measures (Zellman & Fiene, 2012). The correlation between CI and RA should be at the .50 level or higher (.50+) (see Figure 6B).

In the fifth step, if a state is fortunate enough to have a QRIS – Quality Rating and Improvement System in place and has sufficient program quality (PQ) data available then they will have the ability to compare results from their CI tool with their PQ tool and validate outputs by determining the relationship between compliance with health and safety rules (CI) and program quality (PQ) measures, such as the ERS’s, CLASS, CDPES, etc… This is a very important step because very few empirical demonstrations appear in the research literature regarding this relationship. This step is the third approach to validation which involves Outputs (Zellman & Fiene, 2012). It would be expected that lower correlations (.30+) would be found between CI and PQ because these tools are measuring different aspects of quality such as health & safety versus caregiver-child interactions or overall classroom quality.

The sixth step is for the state to generate a Key Indicator (KI) tool from the CI data base. Please see Fiene & Nixon (1985) and Fiene & Kroh (2000) for a detailed explanation of the methodology for generating a KI tool. This step is also part of the second approach to validation which involves Measures. The correlation between the CI and KI should be very high (.70+) because the KI is a subset of predictor rules taken from the CI data base. If a state did not want to use the KI methodology, a direct comparison could be drawn from The Thirteen Indicators of Quality Child Care (Fiene, 2002).

The seventh step for the state is to use the RA and KI tools together to determine overall compliance of facilities and how often and which rules will be monitored for future visits. This is the basic component of a Differential Monitoring (DM) approach and continues the second approach to validation (Measures). Also, this step should drive decisions within the technical assistance/training/professional development (PD) system in what resources are allocated to a particular facility. It would be expected that moderate correlations (.50+) would be found amongst RA, KI, DM, and PD.

The eighth and final step for the state is to compare the results from the various monitoring tools (CI, PQ, RA, KI) with any child development outcome (CO) data they collect. This is a relatively new area and few, if any, states at this point have this capability on a large scale. However, as Early Learning Networks and Standards are developed, this will become more common place. This step is the forth approach to validation which involves Outcomes (Zellman & Fiene, 2012). The correlations between CI, PQ, RA, KI and CO will be on the lower end (.30+) because there are so many other variables that impact children’s development other than child care facilities.

The last step is to present a logic model which depicts how a differential monitoring system could potentially be actually used in Oregon (see Figure 6C).
Figure 6C – Logic Model for Compliance Decisions

Compliance Decisions:

Core Indicators = Core Rules + Key Indicators – this becomes a screening tool to determine if a program receives an AV or FV visit.

Core Indicators (100%) = the next visit is an Abbreviated Visit. Every 3-4 years a Full Licensing Visit is conducted.

Core Indicators (not 100%) = The next visit is a Full Licensing Visit where all rules are reviewed.

Compliance = 96%+ with all rules which indicates substantial to full compliance with all rules and 100% with Core Indicators. The next visit is an Abbreviated Visit.

Non-compliance = less than 96% with all rules which indicates lower compliance with all rules. The next visit is a Full Visit Study.

SAMPLE

Generally a sample is drawn from the population of early care and education facilities in respective states. Oregon will not be any different because of the size of the overall child care program. A random sample will be selected that represents the state population of child care programs. This will be determined by the number of programs, how the programs are distributed throughout the state, the size of the programs, the type of programs, etc… This will need to be determined once the actual implementation of this blueprint report is started. The author of this report can assist Oregon staff in how best to select the sample of programs.

POTENTIAL CHALLENGES

As mentioned earlier, the measurement issues with licensing data will provide challenges because of their data distributions. In the past when key indicators have been generated with
licensing data which are highly skewed, dichotomization of the data is regularly done\(^3\). Generally dichotomization of data should not be done with normally distributed data\(^4\); however, in this case with QRIS systems, it is appropriate to do so since the data lend themselves to being sorted into discrete categories, such as rating levels. The dichotomization will compare the lowest rating level with the highest rating level in order to generate the key indicators.

**Figure 7 – Data Distribution Comparisons of ERS, QRIS, and Licensing Data**

**TIMELINE**

As soon as all early care and education programs have gone through their assessment phase, it will be possible to do the calculations to determine the Phi Coefficients and generate the key indicators. I am guessing that this should not take any longer than 1 year but could be completed in a much shorter period of time if the assessments on individual programs could be moved up (see Figure 8). The analytical phase should take no longer than a month with an additional month to write up the report. A face to face presentation of the analyses could be done after these two months.

The timeline presented in Figure 8 can be adjusted to the specific needs for the Oregon system. The timeline is based upon previous projects and the average time to generate risk assessment
core rules and key indicators. Another consideration or task is the development of the policies and procedures to be developed and implemented regarding the use of key indicators. This was not specifically listed on the timeline because it is something that is generally developed throughout the project with feedback from all the stakeholders who will be impacted by the use of this new approach to assessment and monitoring.

Figure 8 - OREGON DMLMA PROJECT TIMELINE

<table>
<thead>
<tr>
<th>TASK</th>
<th>MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect Data</td>
<td>M1-M3</td>
</tr>
<tr>
<td>Sort Data</td>
<td>M2-3</td>
</tr>
<tr>
<td>Run Analyses</td>
<td>M3-5</td>
</tr>
<tr>
<td>Generate KI/RA</td>
<td>M6</td>
</tr>
<tr>
<td>Train on KI/RA</td>
<td>M6-7</td>
</tr>
<tr>
<td>KI/RA Reliable</td>
<td>M7-9</td>
</tr>
<tr>
<td>Implementation</td>
<td>M10-12</td>
</tr>
</tbody>
</table>

Legend:
- KI – Key Indicators
- RA – Risk Assessment
- Collect Data – identify participant programs via sampling for KI and the stakeholders for RA.
- Sort Data – KI - the individual programs are sorted into high and low groups representing the top 25% and the bottom 25% of programs as they have scored on the respective rules/standards.
- Run Analyses – KI - each individual item within each of the assessment tools for every program will be compared to the sorting process of the high and low groups. RA – aggregate data into means for each rule, rank order the rules.
- Generate KI/RA – a 2 x 2 matrix is constructed and the key indicators (KI) are generated from this matrix through the use of a phi coefficient. A final report will be delivered to Oregon executive staff for both KI and RA core indicator rules.
- Training on KI/RA – all staff who will be using the KI/RA will be trained on its use.
- KI/RA Reliability – reliability will be established by having two staff go out together and administer the key indicators separately and comparing their results.
- Implementation – once reliability has been established, full implementation will begin.

COST SAVINGS

Again based upon previous studies most recently completed in California in 2010 (http://www.mycll.ca.gov/res/docs/12022010HandoutStakeholderMeeting.pdf), time savings of 50% have been attained by using a key indicator or abbreviated tool in completing assessments. It only makes sense that if an assessment can be completed in one hour rather than 2 – 4 hours that a state will see time savings. It is being assumed that equivalent savings should also be the case with Oregon’s licensing/QRIS although this cannot be made certain until the new key indicator or abbreviated tool is actually used for a period of time. Once the new key indicators are used for several months, comparisons could be made to when the full assessments were done.
CONCLUSION AND NEXT STEPS

This blueprint report has given the basic parameters to develop a differential monitoring, risk assessment, and key indicator approach to Oregon’s Licensing/QRIS systems. By following this blueprint Oregon staff should be able to fully implement the approach. Oregon staff would also need to determine if they have the internal capability for the development of the key indicators or if there will be the need to outsource certain aspects of the development. This will be an important consideration as Oregon moves forward with this project. I have provided two options for your consideration in moving forward.

Option 1 – Development of System Internally:

This would require either information systems or research & evaluation staff to analyze the data, generate core key indicator rules, and training of staff. I could provide the necessary consulting services to help the staff work through the methodology. This would probably require at least one face to face meeting with regular monthly conference calls between myself and staff. Discussions of the formatting of data and the types of analyses would be discussed and demonstrated.

Option 2 – Development of System Externally:

In this option I could do all the methodological work demonstrating how I would need the data sent to me, the analytical work in generating core key indicator rules, a report detailing the methodology and results. The only thing that Oregon staff would need to do is get the data to me, all other aspects of what is delineated in the timeline in Figure 8 would be completed by me. This would probably require several face to face trips to explain the process, the results, and do training of staff. Once everything was in place, Oregon staff would have a fully implemented system.

If the above options are of interest I can provide detailed budgets for either one or both.
Notes:

1, 4. The reason for pointing out the need to have a higher Phi Coefficient than what has been reported previously (Fiene & Nixon, 1983, 1985) is the fact that the dichotomization of data should only be used with skewed data and not normally distributed data because it will accentuate differences. However, since the purpose of the dichotomization of data is only for sorting into a high and low group, it would appear to be acceptable for this purpose (MacCallun, et al, 2002. On the practice of dichotomization of quantitative variables, *Psychological Methods, 7, 1*, 19-40.).

2. These results would show an increase in cells B and C in Figure 1 which is undesirable; it should always be the case where A + D > B + C for key indicators to maintain their predictive validity.

3. The distinction between making decisions with skewed (Licensing) as versus normally distributed (ERS) data is an important one because there is a greater likelihood with skewed data of introducing less than optimal programs into the high group when sorting programmatic data into high and low groups. This then makes it more difficult to identify the best programs. However, because of the distribution with skewed data the same cannot be said with the low group in which case it is relatively easy to identify the problem programs. This is not as much of a concern when the data are more normally distributed in which it is relatively easy to identify both the optimal and problem programs. This is an excellent example of the need of weighting of standards in order to increase the normal distribution of the data.
REFERENCES AND ADDITIONAL RELATED READINGS REGARDING DMLMA:


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Appendix

DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA®) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

$CI \times PQ \Rightarrow RA + KI \Rightarrow DM + PD \Rightarrow CO$

Definitions of Key Elements:

PC = Program Compliance/Licensing (Health and Safety) *(Caring for Our Children)*

PQ = QRIS/Accreditation/Caregiver/Child Interactions/Classroom Environment Quality *(ERS/CLASS/PAS/BAS)*

RA = Risk Assessment, (High Risk Rules) *(Stepping Stones)*

KI = Key Indicators (Predictor Rules) *(13 Key Indicators of Quality Child Care)*

DM = Differential Monitoring (How often to visit and what to review)

PD = Professional Development/Technical Assistance/Training *(Not pictured but part of Model)*

CO = Child Outcomes *(Not pictured but part of Model)*
OREGON’S STEPPING STONES\(^2\) RISK FACTORS ANALYSIS

The purpose of this analysis is to provide Oregon OCC with a basic risk factor analysis comparing its child care center rules to Stepping Stones (SS) standards. This analysis will delineate, based upon Stepping Stones’ major content areas (chapters from Caring for our Children (CFOC)), where there may be gaps in their child care center rules.

This analysis is a summary look at the comparison between Stepping Stones and Oregon’s Rules; it is now intended to be an in-depth crosswalk between the two sets of standards and rules. In order to do that type of analysis, Fiene’s Stepping Stones to Validate State Rules Template (2013) is the suggested source to use.

Table 1 provides the comparisons between Stepping Stones and the Oregon Child Care Center Rules in which a search of the rules was done to determine if the specific SS standard was present or not. Every time the search contained a match, it was recorded as a “1”. When there was no match, it was recorded as a “0”.

Table 1 – Comparison of Stepping Stones (SS) Standards and Oregon Child Care Center Rules

<table>
<thead>
<tr>
<th>SS</th>
<th>RULES</th>
<th>PERCENT</th>
<th>CONTENT AREA/RISK FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>11</td>
<td>79</td>
<td>STAFFING</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>56</td>
<td>PROGRAM ACTIVITIES FOR HEALTHY DEVELOPMENT</td>
</tr>
<tr>
<td>25</td>
<td>16</td>
<td>64</td>
<td>HEALTH PROMOTION/PROTECTION</td>
</tr>
<tr>
<td>13</td>
<td>10</td>
<td>77</td>
<td>NUTRITION AND FOOD SERVICE</td>
</tr>
<tr>
<td>20</td>
<td>12</td>
<td>60</td>
<td>FACILITIES, SUPPLIES, EQUIPMENT, ENVIRON HEALTH</td>
</tr>
<tr>
<td>21</td>
<td>7</td>
<td>33</td>
<td>PLAY AREAS/PLAYGROUNDS AND TRANSPORTATION</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>10</td>
<td>INFECTIOUS DISEASES</td>
</tr>
<tr>
<td>10</td>
<td>7</td>
<td>70</td>
<td>POLICIES</td>
</tr>
<tr>
<td>122</td>
<td>69</td>
<td>56.125</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Legend for Table 1:
Nominal scaling to determine if the Oregon CCC Rules have any reference to the specific SS3 Standard.
It is scored 1/0 where 1 = Present and 0 = Absent. Percent is the total number of “1”. Higher the percent the better.
SS = STEPPING STONES STANDARDS
RULES = OREGON CHILD CARE CENTER RULES
PERCENT = RULES/SS
CONTENT = RISK FACTOR/SS/CFOC CHAPTER
This comparison was completed on the major chapter headings in *Stepping Stones* and *Caring for our Children* as delineated in the Content/Risk Factor Column in Table 1. The following table (Table 2) provides the detail of the contents of each content area/risk factor.

**Table 2 – Major Content/Risk Factor Areas (1-8) and Specific Content for Each Area**

<table>
<thead>
<tr>
<th>1. STAFFING</th>
<th>A. CHILD:STAFF RATIO AND GROUP SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. RECRUITMENT AND BACKGROUND</td>
</tr>
<tr>
<td></td>
<td>SCREENING</td>
</tr>
<tr>
<td></td>
<td>C. DIRECTOR’S QUALIFICATIONS</td>
</tr>
<tr>
<td></td>
<td>D. TEACHER’S QUALIFICATIONS</td>
</tr>
<tr>
<td></td>
<td>E. PRE-SERVICE TRAINING</td>
</tr>
<tr>
<td></td>
<td>F. ORIENTATION TRAINING</td>
</tr>
<tr>
<td></td>
<td>G. FIRST AID AND CPR TRAINING</td>
</tr>
<tr>
<td></td>
<td>H. STAFF HEALTH</td>
</tr>
<tr>
<td>2. PROGRAM ACTIVITIES FOR HEALTH DEVELOPMENT</td>
<td>A. PROGRAM ACTIVITIES FOR INFANTS, TODDLERS, PRESCHOOLERS, AND SCHOOL AGE CHILDREN</td>
</tr>
<tr>
<td></td>
<td>B. SUPERVISION AND DISCIPLINE</td>
</tr>
<tr>
<td></td>
<td>C. HEALTH INFORMATION SHARING</td>
</tr>
<tr>
<td></td>
<td>D. HEALTH EDUCATION FOR CHILDREN</td>
</tr>
<tr>
<td></td>
<td>E. HEALTH EDUCATION FOR STAFF</td>
</tr>
<tr>
<td></td>
<td>F. HEALTH EDUCATION FOR PARENTS</td>
</tr>
<tr>
<td>3. HEALTH PROMOTION AND PROTECTION</td>
<td>A. DAILY HEALTH CHECK</td>
</tr>
<tr>
<td></td>
<td>B. ROUTINE HEALTH SUPERVISION</td>
</tr>
<tr>
<td></td>
<td>C. PHYSICAL ACTIVITY AND LIMITING</td>
</tr>
<tr>
<td></td>
<td>SCREEN TIME</td>
</tr>
<tr>
<td></td>
<td>D. SAFE SLEEP</td>
</tr>
<tr>
<td></td>
<td>E. ORAL HEALTH</td>
</tr>
<tr>
<td></td>
<td>F. DIAPERING AND CHANGING SOILED</td>
</tr>
<tr>
<td></td>
<td>CLOTHING</td>
</tr>
<tr>
<td></td>
<td>G. HAND HYGIENE</td>
</tr>
<tr>
<td></td>
<td>H. EXPOSURE TO BODY FLUIDS</td>
</tr>
<tr>
<td></td>
<td>I. EMERGENCY PROCEDURES</td>
</tr>
<tr>
<td></td>
<td>J. CHILD ABUSE AND NEGLECT</td>
</tr>
<tr>
<td></td>
<td>K. INCLUSION/EXCLUSION DUE TO ILLNESS</td>
</tr>
<tr>
<td></td>
<td>L. CARING FOR CHILDREN WHO ARE ILL</td>
</tr>
<tr>
<td></td>
<td>M. MEDICATIONS</td>
</tr>
<tr>
<td>4. NUTRITION AND FOOD SERVICE</td>
<td>A. MEAL SERVICE, SEATING, SUPERVISION</td>
</tr>
<tr>
<td></td>
<td>B. FOOD BROUGHT FROM HOME</td>
</tr>
<tr>
<td></td>
<td>C. KITCHEN AND EQUIPMENT</td>
</tr>
<tr>
<td></td>
<td>D. FOOD SAFETY</td>
</tr>
</tbody>
</table>
### Oregon’s Stepping Stones Risk Factors Analysis

<table>
<thead>
<tr>
<th>5. FACILITIES, SUPPLIES, EQUIPMENT, AND ENVIRONMENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. GENERAL LOCATION, LAYOUT, AND CONSTRUCTION OF THE FACILITY</td>
</tr>
<tr>
<td>B. SPACE PER CHILD</td>
</tr>
<tr>
<td>C. EXITS</td>
</tr>
<tr>
<td>D. STEPS AND STAIRS</td>
</tr>
<tr>
<td>E. EXTERIOR AREAS</td>
</tr>
<tr>
<td>F. VENTILATION, HEATING, COOLING, AND HOT WATER</td>
</tr>
<tr>
<td>G. LIGHTING</td>
</tr>
<tr>
<td>H. NOISE</td>
</tr>
<tr>
<td>I. ELECTRICAL FIXTURES AND OUTLETS</td>
</tr>
<tr>
<td>J. FIRE WARNING SYSTEMS</td>
</tr>
<tr>
<td>K. WATER SUPPLY AND PLUMBING</td>
</tr>
<tr>
<td>L. SEWAGE AND GARBAGE</td>
</tr>
<tr>
<td>M. INTEGRATED PEST MANAGEMENT</td>
</tr>
<tr>
<td>N. PREVENTION AND MANAGEMENT OF TOXIC SUBSTANCES</td>
</tr>
<tr>
<td>O. TOILET AND HANDWASHING AREAS</td>
</tr>
<tr>
<td>P. DIAPER CHANGING AREAS</td>
</tr>
<tr>
<td>Q. SLEEP AND REST AREAS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. PLAY AREAS/PLAYGROUNDS AND TRANSPORTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. PLAYGROUND SIZE AND LOCATION</td>
</tr>
<tr>
<td>B. USE ZONES AND CLEARANCE REQUIREMENTS</td>
</tr>
<tr>
<td>C. PLAY AREA AND PLAYGROUND SURFACING</td>
</tr>
<tr>
<td>D. INSPECTION OF PLAY AREAS AND EQUIPMENT</td>
</tr>
<tr>
<td>E. ACCESS TO AND SAFETY AROUND BODIES OF WATER</td>
</tr>
<tr>
<td>F. POOL EQUIPMENT AND MAINTENANCE</td>
</tr>
<tr>
<td>G. WATER QUALITY OF POOLS</td>
</tr>
<tr>
<td>H. TRANSPORTATION SAFETY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. INFECTIOUS DISEASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. HOW INFECTIONS SPREAD</td>
</tr>
<tr>
<td>B. IMMUNIZATIONS</td>
</tr>
<tr>
<td>C. RESPIRATORY TRACT INFECTIONS</td>
</tr>
<tr>
<td>D. ENTERIC (DIARRHEAL) INFECTIONS AND HEPATITIS A VIRUS (HAV)</td>
</tr>
<tr>
<td>E. SKIN AND MUCOUS MEMBRANE INFECTIONS</td>
</tr>
</tbody>
</table>
Table 2 provides you with the specific content as it relates to the risk factors. Figures 1 and 2 as well as Table 3 will provide the comparison between SS standards and Oregon’s child care center rules by these content areas/risk factors.

Figure 1 does this comparison by listing for each content area/risk factor the frequency count where there is a match between rules and standards.

**Figure 1 – Comparing Stepping Stones (SS) Standards and Oregon’s Child Care Center Rules**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SS</strong></td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>RULES</strong></td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>

**Legend for Figure 1:**

1 = STAFFING  
2 = PROGRAM ACTIVITIES FOR HEALTHY DEVELOPMENT  
3 = HEALTH PROMOTION/PROTECTION  
4 = NUTRITION AND FOOD SERVICE
Figure 2 takes the data from Table 1 and Figure 1 and expresses the content areas/risk factors in the form of percents in which the percents represent the number of times the Oregon child care center rules and the Stepping Stones standards match.

Figure 2 – Percent of Stepping Stones Standards in Oregon’s Child Care Center Rules

Legend for Figure 1:
1 = STAFFING
2 = PROGRAM ACTIVITIES FOR HEALTHY DEVELOPMENT
3 = HEALTH PROMOTION/PROTECTION
4 = NUTRITION AND FOOD SERVICE
5 = FACILITIES, SUPPLIES, EQUIPMENT, ENVIRON HEALTH
6 = PLAY AREAS/PLAYGROUNDS AND TRANSPORTATION
7 = INFECTIOUS DISEASES
8 = POLICIES

It is evident from Table 1 and Figures 1 and 2 that the two areas where the greatest gap between the Stepping Stones standards and Oregon’s child care center rules is in the Infectious Diseases and Play Areas/Playgrounds and Transportation content areas/risk factors with a match rate of 10% and 33% respectively. The highest match rates are with the Staffing (79%) and Nutrition & Food Service (77%).
Based upon the above results there are some recommendations to be made where Oregon Office of Child Care staff may want to focus their attention for future rule formulation in the infectious diseases and the play area/playgrounds & transportation content areas.

Notes:
1 The reason for using Stepping Stones rather than Caring for our Children is that Stepping Stones are the selected standards from CFOC that place children at greatest risk of mortality and morbidity if the standards are not complied with.

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Email: RIKI.Institute@gmail.com
Wisconsin Department of Children and Youth Services Program Monitoring Options Blueprint Report

Richard Fiene, Ph.D.

May 15, 2014

ABSTRACT

This report will provide a blueprint for consideration by Wisconsin’s Office of Children and Youth Services regarding options for their program monitoring system. The report will be organized into the following major headings: an introduction to program monitoring; how key indicators and risk assessment fit into the larger program monitoring of human services; how key indicators and risk assessment could be applied to Wisconsin’s system in particular; the technical aspects of differential monitoring, risk assessment and key indicator methodology, the sample to be drawn from the population, a timeline for this developmental effort; and potential cost savings from the approach. Many of the examples drawn are from the child care/early care and education field rather than the child welfare/child residential field because most of the best examples are occurring in child care and not child welfare at this point in time. Hopefully, with this blueprint implemented in children and youth services, we can begin to change this fact.

INTRODUCTION

An effective and efficient program monitoring system is a goal of every state human service agency in the USA. This has been an issue in the human services for over the past half century as states grapple with increasing caseload sizes with shrinking resources. This report will provide an overview to the topic and several options that the State of Wisconsin can begin to explore related the program monitoring of children and youth services. The Risk Assessment, Key Indicator, and Differential Program Monitoring Methodologies were developed to help streamline the program monitoring of early care and education programs. It was first applied in child care licensing (Fiene & Nixon, 1985) but has been used in many other service types, such as: Head Start Performance Standards (Fiene, 2013a), National Accreditation (Fiene, 1996), and child and adult residential programs (Kroh & Melusky, 2010). The methodologies are based
upon statistical protocols that have been developed in the tests and measurements literature in which an abbreviated set of items is used to statistically predict as if the full test was applied. This methodology has been used in regulatory analysis and more recently has been proposed for use in Quality Rating and Improvement Systems (QRIS) (Fiene, 2013b). In reviewing the various states and the research literature, one state did not come to the surface with all the components in place for child welfare/child residential services, therefore a preponderance of examples drawn from the child care/early care and education field are used throughout the report. However, there are many similarities obviously from child care to child welfare with the most obvious being the protection of children and “to do no harm” as the ultimate outcome of services.

DIFFERENTIAL PROGRAM MONITORING

Risk Assessment and Key Indicators are important components of differential program monitoring which employs an abbreviated review rather than a comprehensive or full review of a program. It is one of several key elements that have been identified in the research literature to help improve the cost effectiveness and efficiency of the program monitoring of early care and education programs (Fiene, 2013b, c)(See the Appendix for two graphics that depict the key elements). A recent addition to differential monitoring are QRIS – Quality Rating and Improvement Systems. Key indicators have a long history of development within the licensing literature (Fiene & Kroh, 2000) but have not had a long history in child and adult residential services. This proposed blueprint is to assist Wisconsin to develop a fully functional differential program monitoring, risk assessment, and key indicator approach to their licensing system and then determine the cost and resources needed in implementing this approach.

The graphics in the Appendix depict the critical key elements of a differential program monitoring approach. In the first graphic program compliance/licensing is generally a state’s health and safety rules/regulations. The program quality key element for children and youth services would generally be represented by the national standards, such as the Child Welfare League of America’s Standards. The key indicator element is represented by the state’s statistical predictor rules/regulations drawn from their comprehensive set of rules/regulations. The last key element to be addressed in this report is the risk assessment key element in which these are the high risk rules/regulations that place children at greatest risk of mortality or morbidity. All these key elements will be addressed in this report in greater detail outlining the technical aspects of each. The second graphic in the Appendix – Graphic 2 depicts the relationship between licensing rules, compliance reviews, differential monitoring, abbreviated tools, risk assessment and key indicators. As one can see from this graphic it demonstrates the inter-relationships amongst all the program monitoring components.
KEY INDICATORS APPLIED TO WISCONSIN’S CHILDREN AND YOUTH LICENSING SYSTEM

Before beginning the description of each of the key elements it is important to note that there are some significant challenges because of the psychometric properties of licensing data such as the severe skewness and kurtosis present in state licensing data systems. These challenges will be addressed later in this blueprint in how to deal with skewness and kurtosis.

As a footnote, the risk assessment and key indicators can eventually be tied to the professional development/training/technical assistance system to link resources to specific needs of the programs. It also has the capability of tying them to specific child outcomes at some point in the future. This would be accomplished in the full implementation of the Differential Monitoring Logic Model and Algorithm (DMLMA©) as depicted in the Appendix – Graphic 1.

TECHNICAL ASPECTS OF THE KEY INDICATOR METHODOLOGY

This section provides the technical and statistical aspects of the key indicator methodology. It will provide the roadmap in taking the Wisconsin licensing data base through the necessary steps to generating the respective key indicators.

One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. In very large states this is done on a sampling basis which will be described later in the blueprint. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each item within the specific assessment tool (see Figure 1). An example is provided in Figure 2 from a previous study conducted by the author (see Figure 2).

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level (top 20-25%)</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td>Lowest level (bottom 20-25%)</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td>Column Total</td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>
Figure 2 depicts that all programs that were in the top 25% were also in the highest rating while the bottom 25% were also in the lowest rating. The data depicted in Figure 2 are taken from studies completed in Pennsylvania in 2002 (Fiene, et al) and 2006 (Barnard, Smith, Fiene & Swanson) in which their quality rating and improvement system, Keystone STARS, was validated. The reason for selecting this particular item from the ECERS – Early Childhood Environment Rating Scale is that it demonstrates a perfect phi coefficient in discriminating between the highest level and the lowest level. Most, if not all, of the licensing items that will attain the threshold levels to become key indicators will not approach this phi coefficient.

<table>
<thead>
<tr>
<th>Figure 2 – Pa. Study (Fiene, et al, 2002).</th>
<th>Providers In Compliance or Top 25%</th>
<th>Programs Out Of Compliance or Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Star level in Pa.</td>
<td>117</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td>Lowest Star level in Pa.</td>
<td>0</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Column Total</td>
<td>117</td>
<td>35</td>
<td>152</td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 3) is used to determine if Item 16 is a key indicator or not by calculating its respective Phi coefficient. Please refer back to Figure 1 for the actual placement within the cells and Figure 2 for the data within the cells. The legend (Figure 4) below the formula shows how the cells are defined.

**Figure 3 – Formula for Phi Coefficient**

\[
\phi = \frac{(A)(D) - (B)(C)}{\sqrt{(W)(X)(Y)(Z)}}
\]

**Figure 4 – Legend for the Cells within the Phi Coefficient**

- A = High Group + Programs in Compliance on Specific Compliance Measure.
- B = High Group + Programs out of Compliance on Specific Compliance Measure.
- C = Low Group + Programs in Compliance on Specific Compliance Measure.
- D = Low Group + Programs out of Compliance on Specific Compliance Measure.
- W = Total Number of Programs in Compliance on Specific Compliance Measure.
- X = Total Number of Programs out of Compliance on Specific Compliance Measure.
- Y = Total Number of Programs in High Group.
- Z = Total Number of Programs in Low Group.
Once the data are run through the formula in Figure 3, the following chart (Figure 5) can be used to make the final determination of including or not including the item as a key indicator. Based upon the chart in Figure 5, it is best to have a Phi Coefficient approaching +1.00 if we are dealing with normally distributed data.

Continuing with the chart in Figure 5, if the Phi Coefficient is between +.25 and -.25, this indicates that the indicator is unpredictable in being able to predict overall compliance with the quality rating assessment tool. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance. This can occur with Phi Coefficients above +.25 but it becomes unlikely as we approach +1.00 although there is always the possibility that other standards/rules/regulations could be found out of compliance (this was demonstrated in a study conducted by the author (Fiene, 2013c). Another solution is to increase the number of key indicators to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Phi Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

**Figure 5 – Thresholds for the Phi Coefficient (Fiene & Nixon, 1983, 1985)**

<table>
<thead>
<tr>
<th>Phi Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

The key indicators should then only be used with those programs who have attained the highest rating. It is not intended for those programs that have attained lower ratings. However, even with those programs that have attained the highest rating, every 3-5 years a full, comprehensive review using the full set of rules/standards for licensing should occur (see Figure 6 for a graphical depiction). It is intended that a re-validation of the key indicators occur on a periodic basis to make certain that the key indicators have not changed because of differences in compliance history. This is an important and necessary step for the state to engage in to
ascertain the overall validity and reliability of the assessment system. Also there should not have been any major changes in the program while the key indicators are being administered, such as the director/administrator leaving or a large percentage of staff leaving or caseloads increasing significantly, or a change in the licensing status of the program.

**Figure 6 - Proposed DMLMA System with Key Indicators (KI)**

*Use of Wisconsin Key Indicators (WKI) for Licensing with a Full Review every 4th Year*

![DMLMA System Diagram]

**TECHNICAL ASPECTS OF THE RISK ASSESSMENT METHODOLOGY**

The risk assessment methodology is very different from the key indicator methodology in that compliance history data are not utilized but rather a best practice ranking according to risk is used to determine which rules become core rules which have the greatest likelihood to place children at significant risk of morbidity or mortality. This is done by having a group of experts rank order all the rules on a Likert Scale from low risk to high risk of mortality or morbidity that non-compliance with the rule places children at. This is generally done on a 1-10 scale with 1 = low risk; 5 = medium risk; and 10 = high risk (see Figure 6A). The experts selected include but are not limited to licensing staff, policy makers, researchers, providers, advocacy groups, parents, and other significant stakeholders who will be impacted by the weighting of the rules.

**Figure 6A – Example of a Likert Scale for Measuring Risk to Children**

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Medium Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Once the data are collected from all the experts, it is averaged for each rule to determine its relative rank in comparison to all the other rules. A significantly high threshold or cut off point is determined so that no more than 5-10% of the rules become core rules. These core rules can then be used in a differential monitoring approach (to be described more fully in the next section) and/or with the key indicators to complete abbreviated reviews of child welfare programs. It is recommended that such a practice of using both core rules and key indicators be used together.
because than the state has the benefits of both methodologies in measuring risk and being able to statistically predict overall compliance with a very short list of rules.

TECHNICAL ASPECTS DIFFERENTIAL MONITORING METHODOLOGY

There are a couple of other key technical aspects that need to be in place for a differential monitoring system to work. The Differential Monitoring Logic Model and Algorithm (DMLMA©)(see the Appendix) is a 4th generational Early Childhood Program Quality Indicator Model4 (ECPQIM4©) in which the major monitoring systems in early care and education are integrated conceptually so that the overall early care and education system can be assessed and validated. With this new model, it is now possible to compare results obtained from licensing systems, quality assurance systems, risk assessment systems, key indicator systems, technical assistance, and child protection outcome systems. The various approaches to validation are interposed within this model and the specific expected correlational thresholds that should be observed amongst the key elements of the model are suggested (see Figure 6B).

Figure 6B – Inter-Correlational Threshold Matrix

<table>
<thead>
<tr>
<th></th>
<th>PQ</th>
<th>RA</th>
<th>KI</th>
<th>DM</th>
<th>PD</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI</td>
<td>0.3</td>
<td>0.5</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>PQ</td>
<td></td>
<td></td>
<td></td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>RA</td>
<td></td>
<td></td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>KI</td>
<td></td>
<td></td>
<td></td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>DM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.3</td>
</tr>
</tbody>
</table>

Key Elements (see the Appendix): CI = state or federal standards, usually rules or regulations. PQ = CWLA Standards or a Quality Assurance System. RA = risk assessment tools/systems in
which only the most critical rules/standards are measured. KI = key indicators in which only predictor rules/standards are measured. DM = differential monitoring decision making in which it is determined if a program is in compliance or not and the number of visits/the number of rules/standards are ascertained from a scoring protocol. PD = technical assistance/training and/or professional development system which provides targeted assistance to the program based upon the DM results. CO = child outcomes which assesses how well the children are protected which is the ultimate goal of the system.

Once the above key elements are in place, it is then possible to look at the relationships amongst them to determine if the system is operating as it was intended. This is done through a validation of the overall system and assessing the inter-correlations (Table 6B) to determine that the DM system is improving the overall protection of the children it serves.

Wisconsin could use the following plan to implement the above approach:

STATE AGENCY PLAN (These Steps can be viewed as an overall plan as outlined in Zellman & Fiene (2012):

The first step in utilizing the DMLMA for a state is to take a close look at its Comprehensive Licensing Tool (CI) that it uses to collect violation data on all rules with all facilities in its respective state. If the state does not utilize a tool or checklist or does not review all violation data than it needs to consider these changes because the DMLMA is based upon an Instrument Based Program Monitoring System (IPM) which utilizes tools/checklists to collect data on all rules.

The second step for the state is to compare their state’s rules with the National Standards (such as the CWLA National Standards for Best Practices) to determine the overlap and coverage between the two. This is the first approach to validation which involves Standards review (Zellman & Fiene, 2012).

The third step for the state is to compare the results from the CI with the RA tools. This step is the second approach to validation which involves Measures (Zellman & Fiene, 2012). The correlation between CI and RA should be at the .50 level or higher (.50+)(see Figure 6B).

The fourth step is for the state to generate a Key Indicator (KI) tool from the CI data base. Please see Fiene & Nixon (1985) and Fiene & Kroh (2000) for a detailed explanation of the methodology for generating a KI tool. This step is also part of the second approach to validation which involves Measures. The correlation between the CI and KI should be very high (.70+) because the KI is a subset of predictor rules taken from the CI data base.

The fifth step for the state is to use the RA and KI tools together to determine overall compliance of facilities and how often and which rules will be monitored for future visits. This is the basic
component of a Differential Monitoring (DM) approach and continues the second approach to validation (Measures). Also, this step should drive decisions within the technical assistance/training/professional development (PD) system in what resources are allocated to a particular facility. It would be expected that moderate correlations (.50+) would be found amongst RA, KI, DM, and PD.

The sixth and final step for the state is to compare the results from the various monitoring tools (CI, PQ, RA, KI) with any child development outcome (CO) data they collect. This is a relatively new area and few, if any, states at this point have this capability on a large scale. This step is the fourth approach to validation which involves Outcomes (Zellman & Fiene, 2012). The correlations between CI, PQ, RA, KI and CO will be on the lower end (.30+) because there are so many other variables that impact the child other than child welfare services.

The last step is to present a logic model which depicts how a differential monitoring system could potentially be actually used in Wisconsin (see Figure 6C).

**Figure 6C – Logic Model for Compliance Decisions**

![Diagram of Compliance Decisions]

**Compliance Decisions:**

- **Core Indicators Screener = CR + KI**
- **Abbreviated Visit (AV)**
- **Abbreviated Visit (AV)**
- **Abbreviated Visit (AV)**
- **Full Visit (FV)**
- **Full Visit (FV)**
- **Full Visit (FV)**

- **Core Indicators = Core Rules + Key Indicators** – this becomes a screening tool to determine if a program receives an AV or FV visit.
- **Core Indicators (100%)** = the next visit is an Abbreviated Visit. Every 3–4 years a Full Licensing Visit is conducted.
- **Core Indicators (not 100%)** = The next visit is a Full Licensing Visit where all rules are reviewed.
- **Compliance = 96%+ with all rules** which indicates substantial to full compliance with all rules and 100% with Core Indicators. The next visit is an Abbreviated Visit.
- **Non-compliance = less than 96% with all rules** which indicates lower compliance with all rules. The next visit is a Full Visit Study.
SAMPLE

Generally a sample is drawn from the population of early care and education facilities in respective states. Wisconsin will not be any different because of the size of the overall child welfare program. A random sample will be selected that represents the state population of child welfare programs. This will be determined by the number of programs, how the programs are distributed throughout the state, the size of the programs, the type of programs, etc... This will need to be determined once the actual implementation of this blueprint report is started. The author of this report can assist Wisconsin staff in how best to select the sample of programs.

TIMELINE

As soon as all the Wisconsin child welfare/child residential programs have gone through their assessment phase, it will be possible to do the calculations to determine the Phi Coefficients and generate the key indicators. I am guessing that this should not take any longer than 1 year but could be completed in a much shorter period of time if the assessments on individual programs could be moved up (see Figure 7). The analytical phase should take no longer than a month with an additional month to write up the report. A face to face presentation of the analyses could be done after these two months.

The timeline presented in Figure 7 can be adjusted to the specific needs for the Wisconsin system. The timeline is based upon previous projects and the average time to generate risk assessment core rules and key indicators. Another consideration or task is the development of the policies and procedures to be developed and implemented regarding the use of key indicators. This was not specifically listed on the timeline because it is something that is generally developed throughout the project with feedback from all the stakeholders who will be impacted by the use of this new approach to assessment and monitoring.

Figure 7 - WISCONSIN DMLMA PROJECT TIMELINE

<table>
<thead>
<tr>
<th>TASK</th>
<th>MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect Data</td>
<td>M1-M3</td>
</tr>
<tr>
<td>Sort Data</td>
<td>M2-3</td>
</tr>
<tr>
<td>Run Analyses</td>
<td>M3-5</td>
</tr>
<tr>
<td>Generate KI/RA</td>
<td>M6</td>
</tr>
<tr>
<td>Train on KI/RA</td>
<td>M6-7</td>
</tr>
<tr>
<td>KI/RA Reliable</td>
<td>M7-9</td>
</tr>
<tr>
<td>Implementation</td>
<td>M10-12</td>
</tr>
</tbody>
</table>
Legend:

**KI** – Key Indicators
**RA** – Risk Assessment

**Collect Data** – identify participant programs via sampling for KI and the stakeholders for RA.

**Sort Data** – KI - the individual programs are sorted into high and low groups representing the top 25% and the bottom 25% of programs as they have scored on the respective rules/standards.

**Run Analyses** – KI - each individual item within each of the assessment tools for every program will be compared to the sorting process of the high and low groups. RA – aggregate data into means for each rule, rank order the rules.

**Generate KI/RA** – a 2 x 2 matrix is constructed and the key indicators (KI) are generated from this matrix through the use of a phi coefficient. A final report will be delivered to Wisconsin executive staff for both KI and RA core indicator rules.

**Training on KI/RA** – all staff who will be using the KI/RA will be trained on its use.

**KI/RA Reliability** – reliability will be established by having two staff go out together and administer the key indicators separately and comparing their results.

**Implementation** – once reliability has been established, full implementation will begin.

**COST SAVINGS**

Again based upon previous studies most recently completed in California in 2010 (http://www.myccl.ca.gov/res/docs/12022010HandoutStakeholderMeeting.pdf), time savings of 50% have been attained by using a key indicator or abbreviated tool in completing assessments. It only makes sense that if an assessment can be completed in one hour rather than 2 – 4 hours that a state will see time savings. It is being assumed that equivalent savings should also be the case with Wisconsin’s licensing system although this cannot be made certain until the new key indicator or abbreviated tool is actually used for a period of time. Once the new key indicators are used for several months, comparisons could be made to when the full assessments were done.

**CONCLUSION, OPTIONS, AND RECOMMENDATIONS**

This blueprint report has given the basic empirical parameters to develop a differential monitoring, risk assessment, and key indicator approach to Wisconsin’s Children and Youth Licensing system. By following this blueprint Wisconsin staff should be able to fully implement the approach. Wisconsin staff would also need to determine if they have the internal capability for the development of the key indicators or if there will be the need to outsource certain aspects of the development. This will be an important consideration as Wisconsin moves forward with this project. I have provided two options for your consideration in moving forward.

**Option 1 – Development of System Internally:**

This would require either information systems or research & evaluation staff to analyze the data, generate core key indicator rules, and training of staff. I could provide the necessary consulting services to help the staff work through the methodology. This would probably require at least one face to face meeting with regular monthly conference calls between myself and staff. Discussions of the formatting of data and the types of analyses would be discussed and
demonstrated. The overall cost to develop the system internally with NARA support would be approximately $100,000.

**Option 2 – Development of System Externally:**

In this option I could do all the methodological work demonstrating how I would need the data sent to me, the analytical work in generating core key indicator rules, a report detailing the methodology and results. The only thing that Wisconsin staff would need to do is get the data to me, all other aspects of what is delineated in the timeline in Figure 7 would be completed by me. This would probably require several face to face trips to explain the process, the results, and do training of staff. Once everything was in place, Wisconsin staff would have a fully implemented system. The overall cost to develop the system externally with NARA support would be approximately $300,000.

Whatever option is selected the following **recommendations** are provided if Wisconsin staff want to develop a program monitoring system based upon empirical data:

1) Wisconsin should move forward with enhancing their differential monitoring approach in order to institute potential cost savings and reallocation of resources based upon those cost savings.

2) Develop and implement a key indicator approach based upon the methodology described in this blueprint.

3) Develop and implement a risk assessment approach based upon the methodology described in this blueprint.

4) A staff caseload analysis should be completed based upon *NARA’s Licensing Workload Assessment* in order to determine the exact number of additional staff needed to fully implement a Differential Monitoring Approach.
Notes:

1. The reason for pointing out the need to have a higher Phi Coefficient than what has been reported previously (Fiene & Nixon, 1983, 1985) is the fact that the dichotomization of data should only be used with skewed data and not normally distributed data because it will accentuate differences. However, since the purpose of the dichotomization of data is only for sorting into a high and low group, it would appear to be acceptable for this purpose (MacCallun, etal, 2002. On the practice of dichotomization of quantitative variables, Psychological Methods, 7, 1, 19-40.).

2. These results would show an increase in cells B and C in Figure 1 which is undesirable; it should always be the case where A + D > B + C for key indicators to maintain their predictive validity. The distinction between making decisions with skewed (Licensing) as versus normally distributed (ERS) data is an important one because there is a greater likelihood with skewed data of introducing less than optimal programs into the high group when sorting programmatic data into high and low groups. This then makes it more difficult to identify the best programs. However, because of the distribution with skewed data the same cannot be said with the low group in which case it is relatively easy to identify the problem programs. This is not as much of a concern when the data are more normally distributed in which it is relatively easy to identify both the optimal and problem programs. This is an excellent example of the need of weighting of standards in order to increase the normal distribution of the data.

3. It is important to note that many of the examples are drawn from the child care research literature and not from the child welfare research literature. The reason for this is most of the empirical basis for the development of these methodologies was completed in child care over the past 40 years. It is important for the reader of this report to keep this in mind and to make the necessary translations to the child welfare literature research base. For example, when I describe the national health and safety standards in child care, the reader should be thinking of the CWLA national standards for the various child welfare service types. QRIS systems can translate to child welfare systems that locally have been built upon generic licensing systems. The DMLMA model is a generic model for all human services and not only for child care, so the reader should be able to make the translation from child care to child welfare.

4. There are two publications that are more pertinent to children & youth services and child welfare that I wrote back in the 1980’s the Wisconsin staff may be interested in (Fiene & McDonald, (1987), Instrument Based Program Monitoring and Indicator Checklist for Child Welfare, and Fiene (1981), Conceptual Framework for Program Monitoring).

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REFERENCES AND ADDITIONAL RELATED READINGS REGARDING DIFFERENTIAL MONITORING, RISK ASSESSMENT, AND KEY INDICATOR METHODOLOGIES:


Appendix – Graphic 1

DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

\[ CI \times PQ \Rightarrow RA + KI \Rightarrow DM + PD \Rightarrow CO \]

Definitions of Key Elements:

PC = Program Compliance/Licensing (Health and Safety, Protections for Children)
PQ = QRIS/Accreditation/Caregiver/Child Interactions
RA = Risk Assessment, (High Risk Rules)
KI = Key Indicators (Predictor Rules)
DM = Differential Monitoring (How often to visit and what to review)
PD = Professional Development/Technical Assistance/Training (Not pictured but part of Model)
CO = Child Outcomes (Not pictured but part of Model)
Appendix – Graphic 2 - Licensing Rules, Compliance Reviews, Differential Monitoring, Abbreviated Tools, Risk Assessment, and Key Indicators

- All Licensing Rules – Full Compliance Reviews
  - Differential Monitoring
    - How Often to Visit?
    - Frequency
      - More Often
      - Less Often
    - What is Reviewed?
      - Abbreviated Tool
        - Risk Assessment Weights
        - Key Indicators Predictors
The Relationship of Licensing, Head Start, Pre-K, QRIS, Accreditation, and Professional Development and their Potential Impact on Child Outcomes

Richard Fiene, Ph.D.

October 11, 2013

ABSTRACT

This short paper will provide some thoughts about the various public policy initiatives/systems to improve early care and education, such as licensing, Head Start, Pre-K, QRIS, accreditation, and professional development and their potential impact on child outcomes. Early care and education is at a major crossroads as a profession in attempting to determine which quality initiatives have the greatest impact on children. Results are starting to come in from early studies which may provide some guidance as policy makers begin making decisions about where to focus their limited funding resources.

Improving early care and education programs has a long public policy history as we attempt to find the most cost effective and efficient means for attaining this lofty goal. There have been many ups and downs over the years where funding was adequate and when it was not, but our desire to accomplish this goal has always been front and center. Now, as a profession, we are at somewhat of a crossroads in determining which of the many quality initiatives appear to have the greatest impact on children’s development. When I refer to children’s development, I am looking at the whole child from the perspective of a child’s developmental status as well as the child’s health and safety.

Presently we have many quality initiatives to look at which is a very good thing since at times in the past we did not always have so many choices. Probably the one constant throughout the history of early care and education in the past century has been licensing or regulations/rule formulation. Some many argue that licensing is not a quality initiative but I would suggest that licensing has many of the structural aspects of quality that have been identified in the research literature. The other quality initiatives I will discuss have really started and been implemented in the very later part of the 20th century so we are talking about a relatively new science when we think about having its intended impact on children. Also, I am talking about large public policy initiatives rather than highly structured, single focused research studies involving small samples of children.
Let’s start with licensing since this system has been present for the longest period of time. The purpose of licensing is to act as the gatekeeper to the early care and education field in which only those providers who meet specific standards, generally called rules or regulations are permitted to operate and care for children. The rules are dominated by health and safety concerns with less emphasis on curriculum planning and staff-child interactions. The rules measure more structural aspects of quality than the process aspects of quality; dealing with what attorney’s call the “hard data” rather than the “soft data”.

Since licensing rules allow entry into the early care and education field to provide services usually the rules are not overly stringent with the majority of providers being in high compliance if not full compliance with all the rules. This would be expected since these are basic health and safety standards. And in fact when one looks at compliance data, it is extremely skewed with the majority of providers having very high compliance scores with relatively few violations of the rules. However, this does introduce a certain difficulty in using these data for decision making purposes at an aggregate level because so many providers score at a high level it becomes increasingly difficult to distinguish between the really excellent providers and the somewhat mediocre providers. Another way of looking at this skewing of the data is to term it as a plateau effect in which there is very little variance at the upper ends of the compliance spectrum. This is a major issue with skewed data and basic standards which is an important consideration with licensing but will also be an important consideration when one looks at the other quality initiatives to be addressed shortly.

Because of this plateau effect with licensing data, it may explain much of the lack of relationships found between compliance with rules and any types of outcomes related to children’s outcomes and provider’s overall quality. However, with licensing data and making comparisons to children’s outcomes we should be looking at general health data such as immunization status and safety data such as the number of injuries at programs with varying levels of compliance with health and safety rules.

A significant development over the past two decades has been the development of national health and safety standards with the publication of Caring for Our Children (CFOC3) and Stepping Stones (SS3). Although these standards are not required but are only recommended practice that provides guidance to states as they revise their rules, these two documents have been embraced by the licensing/regulatory administration field. Although unlikely, if not impossible, to comply with all the CFOC3 standards, it would be interesting to compare states on this set of standards which may add a good deal of variance to the basic health and safety data that has been missing with licensing rules.

The next system to look at is the national Head Start program. Out of the major programs that are national in scope, Head Start has a long history of providing services to low income children and their families. Head Start Performance Standards are definitely more stringent than licensing rules but not as stringent as accreditation standards. Based upon Head Start’s more stringent
standards and the additional supports that are part of its program, Head Start generally scores higher on program quality tools (e.g., CLASS or ERS) than licensed child care in states.

With Head Start programs, we at times find skewing or plateauning of data when we compare compliance with the Head Start Performance Standards (HSPS) and program quality tools such as the CLASS. However, this is dependent upon the various subscales within the CLASS in which the plateauning of data does not occur all of the time. I think that has a lot to do with the HSPS being fairly stringent standards as compared to state licensing rules in general.

A program that has gotten a good deal of support at the state level are Pre-K programs. These programs come with stricter standards than licensed child care with an emphasis on the professional development of staff. There is more concern about the process aspects of quality which focus more on teacher-child interactions. This emphasis on teacher-child interaction has paid off in which these programs generally are high performers when you compare Pre-K funded classrooms to licensed child care classrooms. In fact, Pre-K funding appears to have a positive impact on licensed child care in raising overall quality scores on the ECERS-R for all classrooms in programs that receive Pre-K funding even if some of the classrooms are not the direct beneficiaries of the funding. This is a very significant finding because we knew that Pre-K funding increased the quality of care in classrooms receiving those funds, but now, it appears that there is a spillover effect to all classrooms co-located with Pre-K funded classrooms. I must admit that I was initially skeptical when Pre-K funding was first proposed because I thought it would take funding and the focus away from improving licensed child care at the state level; but it appears that the advocates for Pre-K were right in their assertion that Pre-K would increase the quality of all early care and education which includes licensed child care.

A more recent entry into the state funding scene are QRIS (Quality Rating and Improvement Systems) which build upon licensing systems, are voluntary, and have substantial financial incentives for participating in this quality improvement system. It is too early to really determine if QRIS is having the intended impact because the program is so new (50% of states have a QRIS), and the penetration rate is usually below 50% in any given state (remember the system is voluntary). However, in the few studies done, the results are mixed. It does appear that programs which move up the various star levels do increase the quality of care they provide; but in a most recent study looking at child outcomes, no relationship was found between increasing levels of compliance with QRIS standards and how well children did in those programs with the exception of CLASS scores in which teacher-child interactions were measured and emphasized – here there were significant relationships between higher scores on the CLASS and child outcomes.

Accreditation systems come in many varieties but there are only three that I know of in which empirical studies have been done to validate their systems: NAEYC, NECPA for centers and NAFDC for homes. Also reliability testing has been done in each of these systems. Accreditation is a rigorous self-study that really improves programs through the self-study
process. This should come as no surprise because we have known for some time that program monitoring all by itself leads to program improvements. Now when you couple that with technical assistance you see even more improvement. Accreditation is usually the other pillar of a QRIS system with licensing being the first pillar. The QRIS standards fill the gap from licensing to accreditation. Accreditation is a voluntary system just as in most cases with QRIS. However, in accreditation we are reaching less than 10% of the programs with the majority of these attaining NAEYC accreditation. NECPA and NAFDC have much smaller market shares.

The last system to be addressed is the professional development systems that have been established in all states. This is one quality improvement initiative that has 100% penetration in all states. It is usually tied to QRIS through technical assistance and mentoring (coaching). When it focuses on mentoring rather than workshops, it has demonstrated its effectiveness in changing teachers behaviors in how they interact with children in their care in a very positive fashion. This is very important because the research literature is clear about the importance of the teacher-child interaction when it comes to child outcomes. Professional development runs the gamut from pre-service (University based programs) to in-service (training, technical assistance, mentoring, coaching) programming for teachers and directors.

So where does this leave us when policy makers begin to try to determine which quality improvement initiatives should be invested in to start with, which to increase in funding, and maybe even which ones should be defunded. I think there are some trends we need to begin to look at, such as the following:

1) Having stringent and rigorous standards is very important. The more that we do not, the more opportunities for mediocre programs to score artificially higher on whatever scale that is used. This is evident with licensing data where the data are significantly skewed with a major plateau effect at the upper end of compliance rules/regulations.

2) Emphasis on teacher-child interaction needs to be paramount in our quality improvement initiatives. Working with teachers through mentoring/coaching appears to be most effective in changing teachers’ behaviors in interacting more positively with children.

3) Making sure we are measuring the right outcomes. Match health and safety standards with health and safety outcomes for children. Match developmental outcomes for children with standards that emphasize positive teacher-child interactions.

4) Building upon #1 above, find what the key indicators are with all the data that we collect. We are spending too much time in looking at too many things which in many cases are simply just not the right things to look at. As states’ data systems become more sophisticated, and they are, this will be easier to do. Let’s begin to utilize the data we have already collected.
Fiene’s Key Indicator Statistical Methodology

September 13, 2013

This short paper provides the technical and statistical aspects of the Fiene key indicator methodology. It will provide the roadmap in taking businesses through the necessary steps to generating the respective key indicators which will then predict overall successful outcomes for their respective businesses.

One of the first steps is to sort the data into high and low groups, generally the highest and lowest ratings can be used for this sorting. Frequency data will be obtained on those data elements in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each data element (see Figure 1). An example would be the following: let’s say a business has varying levels of success in selling a specific product. Sort all the salespersons by the number in the highest group and the lowest group by successful sales. Then determine how the groups scored on specific data elements, such as number of phone calls back to each client. Sort the number of phone calls into the top 25% number of calls and the bottom 25% of calls. Fill in the cells within Figure 1 accordingly (see Figure 2).

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Data Element in the Top 25%</th>
<th>Data Element in the Bottom 25%</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level (top 20-25%)</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td>Lowest level (bottom 20-25%)</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td>Column Total</td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>
Figure 2 depicts that all programs that were in the top 25% (5+ calls) were also in the highest rating while the bottom 25% (3 or fewer calls) were also in the lowest rating.

<table>
<thead>
<tr>
<th>Figure 2</th>
<th>5+ Calls</th>
<th>3 or Fewer Calls</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Level</td>
<td>117</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td>Lowest Level</td>
<td>0</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Column Total</td>
<td>117</td>
<td>35</td>
<td>152</td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 3) is used to determine if Item 16 is a key indicator or not by calculating its respective Fiene coefficient. Please refer back to Figure 1 for the actual placement within the cells and Figure 2 for the data within the cells. The legend (Figure 4) below the formula shows how the cells are defined.

**Figure 3 – Formula for Fiene Coefficient**

\[ \phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}} \]

**Figure 4 – Legend for the Cells within the Fiene Coefficient**

- \( A = \) High Group + Data Element in High Group.
- \( B = \) High Group + Data Element in Low Group.
- \( C = \) Low Group + Data Element in High Group.
- \( D = \) Low Group + Data Element in Low Group.
- \( W = \) Total Number of Times Data Element in High Group.
- \( X = \) Total Number of Times Data Element in Low Group.
- \( Y = \) Total Number of Times in High Group.
- \( Z = \) Total Number of Times in Low Group.

Once the data are run through the formula in Figure 3, the following chart (Figure 5) can be used to make the final determination of including or not including the item as a key indicator. Based upon the chart in Figure 5, it is best to have a Fiene Coefficient approaching +1.00 if we are dealing with normally distributed data. This requirement is relaxed with skewed data (+.26 and higher).
Continuing with the chart in Figure 5, if the Fiene Coefficient is between +.25 and -.25, this indicates that the indicator is unpredictable in being able to predict overall compliance with the quality rating assessment tool. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance.

The last possible outcome with the Fiene Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

**Figure 5 – Thresholds for the Fiene Coefficient**

<table>
<thead>
<tr>
<th>Fiene Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

Notes:

1. The reason for pointing out the need to have a higher Phi Coefficient than what has been reported previously is the fact that the dichotomization of data should only be used with skewed data and not normally distributed data because it will accentuate differences. However, since the purpose of the dichotomization of data is only for sorting into a high and low group, it would appear to be acceptable for this purpose (MacCallun, etal, 2002. On the practice of dichotomization of quantitative variables, *Psychological Methods, 7, 1, 19-40.*).

2. These results would show an increase in cells B and C in Figure 1 which is undesirable; it should always be the case where A + D > B + C for key indicators to maintain their predictive validity.

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This short paper will present the Key Indicators as they appear in Stepping Stones (3rd edition). It provides the statistically predictive standards (Key Indicators) that could determine overall compliance with Stepping Stones (AAP, APHA, NRC, 2013) and Caring for Our Children (AAP, APHA, NRC, 2011) based upon the statistical methodology (Fiene & Nixon, 1985). But before delineating the Key Indicators a few definitions need to be provided to put these key indicators in perspective.

Definitions:

**Risk Assessment (RA)** - a differential monitoring approach that employs using only those rules, standards, or regulations that place children at greatest risk of mortality or morbidity if violations/citations occur with the specific rule, standard, or regulation. Stepping Stones (3rd edition) is an example of a risk assessment approach.

**Key Indicators (KI)** - a differential monitoring approach that employs using only those rules, standards, or regulations that statistically predict overall compliance with all the rules, standards, or regulations. In other words, if a program is 100% in compliance with the Key Indicators the program will also be in substantial to full compliance with all rules, standards, or regulations. 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, standards, or regulations. The key indicators put forth in this paper are an example of the approach.

**Differential Monitoring (DM)** - this is a relatively new approach to determining the number of visits made to programs and what rules, standards, or regulations are reviewed during these visits. There are two measurement tools that drive differential monitoring, one is Weighted Risk Assessment tools and the other is Key Indicator checklists. Weighted Risk Assessments determine how often a program will be visited while Key Indicator checklists determine what rules, standards, or regulations will be reviewed in the program. Differential monitoring is a very powerful approach when Risk Assessment is combined with Key Indicators because a program is reviewed by the most critical rules, standards, or regulations and the most predictive rules, standards, or regulations. See Fiene’s Logic Model & Algorithm for Differential Monitoring (DMLMA©)(Fiene, 2013).

**Early Childhood Program Quality Indicator Model (ECPQIM)**(Fiene, 2013; Fiene & Kroh, 2000; Griffin & Fiene, 1995; Fiene & Nixon, 1985) – this definition is provided to place the results of this paper into the larger program monitoring systems perspective. ECPQIM are models that employ a key indicator or dashboard approach to program monitoring. Major program monitoring systems in early care and education are integrated conceptually so that the overall early care and education system can be assessed and validated. With these models, it is possible to compare results obtained from licensing systems, quality rating and improvement systems (QRIS), risk assessment systems, key indicator systems, technical assistance, and child development/early learning outcome systems. The various approaches to validation (Zellman & Fiene, 2012) are interposed within this model and the specific
expected correlational thresholds that should be observed amongst the key elements of the model are suggested. **Key Elements** of the model are the following: **CI** = Comprehensive Instrument - state or federal standards, usually rules or regulations that measure health and safety - Caring for Our Children or Head Start Performance Standards will be applicable here. Quality Rating and Improvement Systems (QRIS) standards at the state level; ERS (ECERS, ITERS, FDCRS), CLASS, or CDPES (Fiene & Nixon, 1985). **RA** = Risk assessment tools/systems in which only the most critical rules/standards are measured. *Stepping Stones* is an example of this approach. **KI** = Key indicators in which only predictor rules/standards are measured. The Thirteen Indicators of Quality Child Care (Fiene, 2003) is an example of this approach. **DM** = Differential monitoring decision making in which it is determined if a program is in compliance or not and the number of visits/the number of rules/standards are ascertained from a scoring protocol. Technical assistance/training and/or professional development system which provides targeted assistance to the program based upon the Differential Monitoring results. And finally, child outcomes which assesses how well the children are developing which is the ultimate goal of the system.

The Key Indicators from *Stepping Stones (3rd Edition)*

1.1.1.2 - Ratios for Large Family Child Care Homes and Centers

1.3.1.1 - General Qualifications of Directors

1.3.2.2 - Qualifications of Lead Teachers and Teachers

1.4.3.1 - First Aid and CPR Training for Staff

1.4.5.2 - Child Abuse and Neglect Education

2.2.0.1 - Methods of Supervision of Children

3.2.1.4 - Diaper Changing Procedure

3.2.2.2 - Handwashing Procedure

3.4.3.1 - Emergency Procedures

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

3.6.3.1 - Medication Administration

5.2.7.6 - Storage and Disposal of Infectious and Toxic Wastes

6.2.3.1 - Prohibited Surfaces for Placing Climbing Equipment

7.2.0.2 - Unimmunized Children

9.2.4.5 - Emergency and Evacuation Drills/Exercises Policy
Just as there has been three editions of *Caring for Our Children* and *Stepping Stones*, this paper and the resulting Key Indicators represents the third edition of Key Indicators for early care and education. The first two editions are represented in the publications by Fiene & Nixon (1985) and Fiene (2003) respectively (see the reference list below).

**References**


Notes:

1. Please see Stepping Stones (3rd edition) and Caring for Our Children (3rd edition) for the details of each Key Indicator.

2. For the reader who is interested in learning more about the DMLMA/ECPQIM model, please refer to these publications which are available through the following website:

   http://RIKInstitute.wikispaces.com

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Technical Detail Updates to the Fiene Key Indicator Methodology

January 2015

The Key Indicator Methodology has recently been highlighted in a very significant Federal Office of Child Care publication series on Contemporary Licensing Highlights. In that Brief the Key Indicator Methodology is described as part of a differential monitoring approach along with the risk assessment methodology. Because of the potential increased interest in the Key Indicator Methodology, a brief update regarding the technical details of the methodology is warranted. For those readers who are interested in the historical development of Key Indicators I would suggest they download the resources available at the end of the paper.

This brief paper provides the technical and statistical updates for the key indicator methodology based upon the latest research in the field related to licensing and quality rating & improvement systems (QRIS). The examples will be drawn from the licensing research but all the reader needs to do is substitute “rule” for “standard” and the methodology holds for QRIS.

Before proceeding with the technical updates, let me review the purpose and conceptual underpinning of the Key Indicator Methodology. Key Indicators generated from the methodology are not the rules that have the highest levels of non-compliance nor are they the rules that place children most at risk of mortality or morbidity. Key Indicators are generally somewhere in the middle of the pack when it comes to non-compliance and risk assessment. The other important conceptual difference between Key Indicators and risk assessment is that only Key Indicators statistically predict or are predictor rules of overall compliance with all the rules for a particular service type. Risk assessment rules do not predict anything other than a group of experts has rated these rules as high risk for children’s mortality/morbidity if not complied with.

Something that both Key Indicators and risk assessment have in common is through their use one will save time in their monitoring reviews because you will be looking at substantially fewer rules. But it is only with Key Indicators that you can statistically predict additional compliance or non-compliance; this is not the case with risk assessment in which one is only looking at those rules which are a state’s high risk rules. And this is where differential monitoring comes into play by determining which programs are entitled to either Key Indicators and/or risk assessment for more abbreviated monitoring reviews rather than full licensing reviews (the interested reader
should see the *Contemporary Licensing Series on Differential Monitoring, Risk Assessment and Key Indicators* published by the Office of Child Care.

**Technical and Statistical Framework**

One of the first steps in the Key Indicator Methodology is to sort the licensing data into high and low groups, generally the highest and lowest licensing compliance with all the rules can be used for this sorting. Frequency data will be obtained on those programs in the top level (usually top 20-25%) and the bottom level (usually the bottom 20-25%). The middle levels are not used for the purposes of these analyses. These two groups (top level & the bottom level) are then compared to how each program scored on each child care rule (see Figure 1). In some cases, especially where there is very high compliance with the rules and the data are extremely skewed, it may be necessary to use all those programs that are in full (100%) compliance with all the rules as the high group. The next step is to look at each rule and determine if it is in compliance or out of compliance with the rule. This result is cross-referenced with the High Group and the Low Group as depicted in Figure 1.

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers In Compliance on Rule</th>
<th>Programs Out Of Compliance on Rule</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level</td>
<td>A</td>
<td>B</td>
<td>Y</td>
</tr>
<tr>
<td>(top 20-25%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest level</td>
<td>C</td>
<td>D</td>
<td>Z</td>
</tr>
<tr>
<td>(bottom 20-25%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>W</td>
<td>X</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

Once the data are sorted in the above matrix, the following formula (Figure 2) is used to determine if the rule is a key indicator or not by calculating its respective Key Indicator coefficient. Please refer back to Figure 1 for the actual placement within the cells. The legend (Figure 3) below the formula shows how the cells are defined.
Figure 2 – Formula for Fiene Key Indicator Coefficient

\[ \phi = (A)(D) - (B)(C) \div \sqrt{(W)(X)(Y)(Z)} \]

Figure 3 – Legend for the Cells within the Fiene Key Indicator Coefficient

- \( A = \) High Group + Programs in Compliance on Specific Rule.
- \( B = \) High Group + Programs out of Compliance on Specific Rule.
- \( C = \) Low Group + Programs in Compliance on Specific Rule.
- \( D = \) Low Group + Programs out of Compliance on Specific Rule.
- \( W = \) Total Number of Programs in Compliance on Specific Rule.
- \( X = \) Total Number of Programs out of Compliance on Specific Rule.
- \( Y = \) Total Number of Programs in High Group.
- \( Z = \) Total Number of Programs in Low Group.

Once the data are run through the formula in Figure 2, the following chart (Figure 4) can be used to make the final determination of including or not including the rule as a key indicator. Based upon the chart in Figure 4, it is best to have a Key Indicator Coefficient approaching +1.00 however that is rarely attained with licensing data but has occurred in more normally distributed data.

Continuing with the chart in Figure 4, if the Key Indicator Coefficient is between +.25 and -.25, this indicates that the indicator rule is unpredictable in being able to predict overall compliance with the full set of rules. Either a false positive in which the indicator appears too often in the low group as being in compliance, or a false negative in which the indicator appears too often in the high group as being out of compliance. This can occur with Key Indicator Coefficients above +.25 but it becomes unlikely as we approach +1.00 although there is always the possibility that other rules could be found out of compliance. Another solution is to increase the number of key indicator rules to be reviewed but this will cut down on the efficiency which is desirable and the purpose of the key indicators.

The last possible outcome with the Key Indicator Coefficient is if it is between -.26 and -1.00, this indicates that the indicator is a terrible predictor because it is doing just the opposite of the decision we want to make. The indicator rule would predominantly be in compliance with the low group rather than the high group so it would be statistically predicting overall non-compliance. This is obviously something we do not want to occur.

Figure 5 gives the results and decisions for a QRIS system. The thresholds in a QRIS system are increased dramatically because QRIS standard data are less skewed than licensing data and a
more stringent criterion needs to be applied in order to include particular standards as Key Indicators.

**Figure 4 – Thresholds for the Fiene Key Indicators for Licensing Rules**

<table>
<thead>
<tr>
<th>Key Indicator Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

**Figure 5 – Thresholds for the Fiene Key Indicators for QRIS Standards**

<table>
<thead>
<tr>
<th>Key Indicator Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.76)</td>
<td>Good Predictor</td>
<td>Include</td>
</tr>
<tr>
<td>(+.75) – (-.25)</td>
<td>Unpredictable</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

**RESOURCES AND NOTES**

For those readers who are interested in finding out more about the Key Indicator Methodology and the more recent technical updates as applied in this paper in actual state examples, please see the following publication:

In this book of readings/presentations are examples and information about differential monitoring, risk assessment, key indicators, validation, measurement, statistical dichotomization of data, and regulatory paradigms. This publication delineates the research projects, studies, presentations, & reports completed during 2013-14 in which these updates are drawn from.
For those readers interested in a historical perspective to the development of the Key Indicator methodology and licensing measurement, please see the following publications (most of these publications are available at the following website (http://rikinstitute.wikispaces.com/home):


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http://DrFiene.wordpress.com/home
These notes will provide guidance on validating existing Key Indicator Licensing Systems. These notes are based upon the last three years of research and data analysis in determining the best means for conducting these validation studies.

These notes are based upon existing Key Indicator Systems in which data can be drawn from an already present data base which contains the comprehensive instrument (total compliance data) and the key indicator instrument (key indicator rule data). When this is in place and it can be determined how licensing decisions are made: full compliance with all rules or substantial compliance with all rules to receive a license, then the following matrix can be used to begin the analyses (see Figure 1):

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Providers who fail the Key Indicator review</th>
<th>Providers who pass the Key Indicator review</th>
<th>Row Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers who fail the Comprehensive review</td>
<td>W</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Providers who pass the Comprehensive Review</td>
<td>Y</td>
<td>Z</td>
<td></td>
</tr>
<tr>
<td>Column Totals</td>
<td></td>
<td></td>
<td>Grand Total</td>
</tr>
</tbody>
</table>
A couple of annotations regarding Figure 1.

\( W + Z \) = the number of agreements in which the provider passed the Key Indicator review and also passed the Comprehensive review.

\( X \) = the number of providers who passed the Key Indicator review but failed the Comprehensive review. This is something that should not happen, but there is always the possibility this could occur because the Key Indicator Methodology is based on statistical methods and probabilities. We will call these False Negatives (FN).

\( Y \) = the number of providers who failed the Key Indicator review but passed the Comprehensive review. Again, this can happen but is not as much of a concern as with “\( X \)”. We will call these False Positives (FP).

Figure 2 provides an example with actual data from a national organization that utilizes a Key Indicator System. It is taken from 50 of its program providers.

<table>
<thead>
<tr>
<th>Figure 2</th>
<th>Providers who fail the Key Indicator review</th>
<th>Providers who pass the Key Indicator review</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers who fail the Comprehensive review</td>
<td>25</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Providers who pass the Comprehensive Review</td>
<td>7</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>Column Total</td>
<td>32</td>
<td>18</td>
<td>50</td>
</tr>
</tbody>
</table>

To determine the agreement ratio, we use the following formula:

\[
\frac{A}{A + D}
\]

Where \( A = \text{Agreements} \) and \( D = \text{Disagreements} \).
Based upon Figure 2, A + D = 42 which is the number of agreements; while the number of disagreements is represented by B = 1 and C = 7 for a total of 8 disagreements. Putting the numbers into the above formula:

\[
\frac{42}{42 + 8}
\]

Or

\[
.84 = \text{Agreement Ratio}
\]

The False Positives (FP) ratio is .14 and the False Negatives (FN) ratio is .02. Once we have all the ratios we can use the ranges in Figure 3 to determine if we can validate the Key Indicator System. The FP ratio is not used in Figure 3 but is part of the Agreement Ratio.

**Figure 3 – Thresholds for Validating the Fiene Key Indicators for Licensing Rules**

<table>
<thead>
<tr>
<th>Agreement Ratio Range</th>
<th>False Negative Range</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1.00) – (.90)</td>
<td>.05+</td>
<td>Validated</td>
</tr>
<tr>
<td>(.89) – (.85)</td>
<td>.10 - .06</td>
<td>Borderline</td>
</tr>
<tr>
<td>(.84) – (.00)</td>
<td>.11 or more</td>
<td>Not Validated</td>
</tr>
</tbody>
</table>
RESOURCES AND NOTES

For those readers who are interested in finding out more about the Key Indicator Methodology and the more recent technical updates as applied in this paper in actual state examples, please see the following publication:


In this book of readings/presentations are examples and information about differential monitoring, risk assessment, key indicators, validation, measurement, statistical dichotomization of data, and regulatory paradigms. This publication delineates the research projects, studies, presentations, & reports completed during 2013-14 in which these updates are drawn from.

For those readers interested in a historical perspective to the development of the Key Indicator methodology and licensing measurement, please see the following publications (most of these publications are available at the following website [http://rikinstitute.wikispaces.com/home](http://rikinstitute.wikispaces.com/home)):

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Differential Monitoring, Risk Assessment, and Key Indicators: What they are and why they are important to Human Services Licensing – A Blueprint Paper

Richard Fiene, Ph.D.

National Association for Regulatory Administration/Research Institute for Key Indicators
Introduction

Differential monitoring, risk assessment and key indicators were created 40 years ago in response to the increased pressures placed upon licensing offices to do more with less. They are monitoring efficiencies pure and simple. They are not intended to lessen regulatory administration or rule formulation. Many misconceptions have developed over the past 40 years where their impact, their use, and definitions are not perfectly clear. As the author and original developer of these methodologies, I felt it was incumbent upon me to clear up some confusion while at the same time addressing some of my concerns that I have learned over the past 40 years regarding these methodologies. This paper will describe the various methodologies, pluses and minuses, how best to utilize these methodologies and what future research should be done.

Differential monitoring is a targeted mode of program monitoring where decisions are made about how often to visit, what to look at, and in what depth is based upon previous compliance history with human service rules/regulations. For the remainder of this paper, rules will be used which refer to regulations in certain jurisdictions. The other form of monitoring is to visit all programs in exactly the same manner regardless of prior compliance history. Differential monitoring saves time through the use of abbreviated visits using either risk assessment or key indicator methods. With this savings in time resources can be reallocated to spend more time with programs that are having difficulty complying with a jurisdiction’s rules. Because of this reallocation of resources differential monitoring is generally a cost neutral approach, it doesn’t save money and it doesn’t cost more money.

According to the National Center on Child Care Quality Improvement, 70% of the states use differential monitoring with the majority using a risk assessment approach rather than a key indicator approach. A misconception about differential monitoring is that a state will not have to visit as often or they can reduce staff. These misconceptions are just incorrect. A state could visit programs more often but targeting their visits to those programs that need more assistance
while visiting the really optimal programs as often but with a streamlined/abbreviated monitoring tool based upon risk assessment or key indicators.

What have we learned over the past 40 years is that key indicators have been pretty consistent over this timeframe. They are consistent from state to state where we have been able to identify 13 key indicators. This was done back in 2002 and most recently in 2015 this original list changed very little although now we have 10 key indicators rather than 13 but that is still pretty consistent for over 40 years of research on this topic. Keep in mind that these rule indicators are not the most out of compliance rules nor do they necessarily place children at greatest risk. What they do is discriminate between those programs that are in high compliance with all rules and those who are not. Sometimes they are high risk rules but generally not and they have a moderate level on non-compliance rather than a really high level of non-compliance.

Probably the most consistent rule indicator that is a good predictor is having children properly immunized. So why is this particular rule a good discriminator of high versus low compliance with all rules or a good predictor of compliance. Why do programs that have a history of high compliance usually have this immunization rule in compliance while programs that have a history of low compliance usually have this rule out of compliance?

Some other key indicator rules are the following: proper hand washing, training of staff, adequate supervision, proper staff to child ratios and group sizes, proper background checks, hazard free environments, and proper medication administration are other examples.

I get asked a lot to distill the key indicators down to major factors for both compliance and quality now that we have quality rating and improvement systems (QRIS) and in doing these types of analyses there are three major areas that appear to have the most significant in determining quality and they are the following: having a highly qualified director and staff who have degrees in early childhood implementing a structured curriculum and having families engaged in the program appear to be the key standards that make the biggest difference between a high quality and a marginal ECE program.
Best Practices

There are several states and jurisdictions that we can point to as good examples of best practices when it comes to differential monitoring, risk assessment and key indicators. Some of these are the following states and jurisdictions.

The Province of Ontario is an excellent example of a systemic change in which they provide examples of how a jurisdiction can change their program monitoring system, risk assessment and key indicators. I recommend people look at Ontario if they are interested in seeing how a full change in implementation can be done.

Along with a full re-alignment of a system is Head Start in which they have made changes in their whole system in moving from a one size fits all every five years to a more targeted monitoring system.

The Administration for Children and Families Caring for Our Children Basics document is probably the best example combining a risk assessment and key indicator approach together into a manageable set of standards.

Georgia has a solid core rule risk assessment approach that has been recently validated that I would highly recommend for states and jurisdictions to look at for both the risk assessment and validation components.

Kansas and Washington states are excellent examples of key indicator approaches that are simple and straightforward.

Also I would recommend that states and jurisdictions read through the licensing brief and white paper published by the Office of Child Care and the Assistant Secretary’s Office of Program Evaluation that provide excellent summaries of program monitoring, differential monitoring, risk assessment and key indicators.
What It Is Not

Differential monitoring, risk assessment and key indicators does not and should not lead to a reduction in rule formulation. Always keep in mind that these methodologies are program monitoring efficiencies and not regulatory administration efficiencies. They are not intended to reduce the number of licensing staff, the number of rules, nor the number of visits. In fact with the number of visits which was mentioned earlier, licensing staff would be conducting more visits to programs that have a history of high non-compliance with rules.

Cautions

Over the years I have been able to identify several cautions in utilizing these methodologies especially in the case of key indicators that states and jurisdictions need to be aware of as they implement this particular methodology.

We need to be vigilant in maintaining a balance between program efficiency and effectiveness. There are tradeoffs in that as we become more efficient we do lose some effectiveness where additional errors can be made in deciding that a program is in full compliance based upon the key indicators. These errors are either false positives or false negatives. False positives are not as bothersome since a decision of a full review is made when it should not. This is inconvenient but not critical. What is critical is when false negatives are made. This occurs when a decision of an abbreviated only review is completed when a full review should have occurred. This can occur when too few key rule indicators are used.

Future Research

One area of future research which is solely needed is to conduct validation studies to make sure the methodologies are working as intended. There is a great deal of anecdotal evidence but little empirical evidence that the methodologies are working as intended.

Another area of future research is to continue to validate the key indicators to see if they change overtime. This is something that all states and jurisdictions need to do if they are using the key
indicator methodology. This should be done every 3-4 years where comprehensive reviews are completed of programs and new key indicators are generated. The new key indicators are then compared to the existing key indicators to look at consistency between the two lists.

Conclusion

Differential monitoring, risk assessment, and key indicators are promising methodologies that have a long history of use in the human services arena, especially in early care and education. However, as pointed out in this paper, there are some specific additional research that needs to be done and certain cautionary aspects of the methodologies that need to be addressed.

The CDPES scale was originally developed in 1984 and has been used over the past 30 years by ECE providers and state human service agencies in evaluating and validating local ECE programs. It is presented in its current version with few changes because of its applicability for QRIS systems. The CDPES is a unique scale in that it has observational items and a specific sub-scale (COFAS), along with a health and safety sub-scale based upon thirteen key indicators, and then a rather comprehensive program quality sub-scale which measures administrative and classroom overall quality.
CDEES
CHILD DEVELOPMENT PROGRAM EVALUATION SCALE

Richard Pieme, Ph.D.

Research and Information Systems
Office of Children Youth and Families
Harrisburg, Pennsylvania

August 1984
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Nutrition
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COPAS
Introduction

The Child Development Program Evaluation Scale (Cdpes) is the result of 10 years of research in the Child Day Care Field. It is a generic Scale that incorporates results from Pennsylvania’s Child Development Evaluation Instruments, West Virginia’s and New York City’s Child Development Compliance Instruments, California Child Development Quality Assessment Instrument, NAEYC and CWLA National Standards and the results of the National Day Care Study. The Child Development Program Evaluation Scale was constructed through the use of a Statistical Methodology originally designed in Pennsylvania—Pine & Nixon’s IPM Systems and later refined by the Children’s Services Monitoring Consortium—Pine & Nixon’s Indicator Checklist Methodology.

The Child Development Program Evaluation Scale (Cdpes) is actually two scales in one. The Licensing Scale lists a series of predictor items at the minimal compliance level. These licensing predictor items are statistically significant items that have been found to predict the overall compliance of child day care centers with state regulations in four states’ regulations. These items appear to have high face validity when they are compared with national child care standards. The Quality Scale lists a series of predictor items at a quality level. These items are statistically significant items that have been found to predict the overall quality of child day care centers. These items also appear to have high face validity when they are compared with national child care standards.

The purpose in constructing the Cdpe Scale was the perceived need in the child development program area to have a comprehensive scale that could be used by states or local agencies to determine compliance of child development programs with basic minimal requirements that ensure a child is in a safe and healthy environment. But at the same time the Scale needed to measure the quality of this same child development program. The Scale should be comprehensive but efficient where it could be administered in one day or less by a program monitor/evaluator.

The Cdpe Scale is a comprehensive scale that measures the following areas of a child development program: administration, environmental safety, curriculum, health, nutrition, social services, parental involvement. The 57 ITEM SCALE was selected from nearly 900 Items. These 900 items were from different states’ Compliance Instruments. The 57 Items were selected because of their ability to statistically predict overall compliance. These compliance instruments have been extensively field tested and implemented in each of the respective states over a number of years before the Cdpe Scale was constructed. The Indicator Checklist Methodology is recommended only after a full year of data has been collected using a comprehensive compliance instrument. See Pine & Nixon’s Indicator Checklist Statistical Model for a full discussion in how these statistical predictors were determined.

The licensing items are to be measured in an all or none fashion, either the program is in compliance or out of compliance on the item. These items are minimally essential items. The second group—Program Quality items are measured at different levels, with each level building on the one previous to it. See the instructions in the Program Quality Section that describes the measurement of this section more clearly. For the Caregiver Observations see the Caregiver Observation Form and Scale (COPAS) at the end of the Cdpe Scale for measuring compliance with this section.
Notes on Instructions

Read each item carefully in order to determine complete compliance. Once you have made your decision if the item is in or out of compliance on the licensing scale, circle either (0) for out of compliance or (5) for in compliance. For the program quality scale, make your determination of which level (1-5) the program passes for each particular item. Circle on the score sheet one of the levels (1, 2, 3, 4, 5) or if there are only four levels then circle either (1, 2, 3, 4). The program quality scale builds one level upon the other. For a program to pass at a level 3, they must be doing everything at levels 1 and 2. For items 21-26—SOCIAL EMOTIONAL DEVELOPMENT to DRAMATIC PLAY, your observations should be done in the classroom. If there is more than one classroom, select one classroom randomly and do all your observations for Items 21-26 in that classroom.

After you have completed all thirty seven items, compile the results by each subscale: Administration (A), Environmental Safety (ES), Child Development Curriculum (CD), Health Services (H), Nutritional Services(H), Social Services (SS), and Transportation (T). On each subscale line, write in the total scores obtained. Save this score sheet so that when you do a re-administration of the scale, you will have a reference point to compare your results.
CENTER LICENSING SCALE

HEALTH APPRAISAL

All staff, including temporary and substitute employees and volunteers who serve on a regular basis, who come into contact with the children, or who work with food preparation, have a health appraisal within 3 months prior to providing initial day care service and annually thereafter? (Health appraisals shall be certified by a licensed physician.)

OBSERVATIONS

Do activities promote:

(a) development of skills?
(b) self esteem?
(c) positive self-identity?
(d) choice of activities?

(Use COFAS at end of CDPE Scales to determine compliance with this item).

EMERGENCY CONTACT

Is there emergency contact information on each child including the following:

(a) name, address and telephone number of child’s physician or source of health care?
(b) home and work addresses and home and work telephone numbers of both parents
(c) name, address and telephone number of emergency contact person?

HAZARD FREE

Are play areas free of hazards and unsafe areas such as open drainage ditches, wells, holes, and heavy street traffic surrounded by fences or natural barriers to limit access of children to hazards?

CLEANING MATERIALS/DETERGENT ACCESSIBILITY

Are all cleaning materials, detergents, aerosol cans and other poisonous and toxic materials kept in a place inaccessible to children and separate from child care areas, food and food preparation areas?

SUPERVISION OF CHILDREN

Do staff supervise the children at all times, both indoors and out?
STAFF QUALIFICATIONS

DO THE GROUP SUPERVISORS HAVE THE FOLLOWING QUALIFICATIONS?

completion of an undergraduate program at an accredited college or university with a bachelor's degree in early childhood education, child development, special education, elementary education or the human services field;
completion of an undergraduate program at an accredited college or university with a bachelor's degree; and teaching certification in early childhood education, child development, special education or human services field; or
completion of an undergraduate program in an accredited college of university with an associate's degree or its equivalent in early childhood education, child development, special education, elementary education or the human services field; and two years work experience related to the care and development of children.

DOES THE DIRECTOR HAVE THE FOLLOWING QUALIFICATIONS:

completion of a graduate program at an accredited college or university with a master's degree in administration, early childhood education, child development, special education, elementary education or the human services field;
completion of an undergraduate program at an accredited college or university with a bachelor's degree in administration, early childhood education, child development, special education, elementary education, or the human services field; and two year work experience related to the care and development of children; or
completion of an undergraduate program at an accredited college or university with an associate's degree or its equivalent in administration, early childhood education, child development, special education, elementary education or the human services field; and four years work experience related to the care and development of children?

Note: Human services field includes psychology, nursing, social work, health related services, home economics, secondary education. It does not include general sociology, art, music, history, mathematics, anthropology, etc.
<table>
<thead>
<tr>
<th>Developmental Level</th>
<th>Staff</th>
<th>Children</th>
<th>Group Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>1</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Toddlers</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Preschoolers</td>
<td>1</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>School Age Children</td>
<td>1</td>
<td>15</td>
<td>30</td>
</tr>
</tbody>
</table>

**Mixed Developmental Level**

<table>
<thead>
<tr>
<th>Developmental Level</th>
<th>Staff</th>
<th>Children</th>
<th>Group Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants/Toddlers</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Infants/Toddlers/Preschoolers</td>
<td>1</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Infants/Preschoolers</td>
<td>1</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Toddlers/Preschoolers</td>
<td>1</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Infants/Toddlers/Preschoolers/School age</td>
<td>1</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Infants/Preschoolers/School age children</td>
<td>1</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Toddlers/Preschoolers/School age children</td>
<td>1</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Infants/Toddlers/School age children</td>
<td>1</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Infants/School age children</td>
<td>1</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Toddlers/School age children</td>
<td>1</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Preschoolers/School age children</td>
<td>1</td>
<td>12</td>
<td>24</td>
</tr>
</tbody>
</table>
SUFFICIENT SPACE

Is sufficient (40 square feet per child) space available for each group of children in the center?

NUTRITION

Is food handled, stored, prepared and served in a healthful, safe and sanitary manner, observing principles of food preparation and food services for young children.

ADMINISTRATION OF MEDICATION

Does the facility have any children receiving medication or health aids (i.e., cough drops, aspirin, vitamins, ear drops, asperm, cough syrup, peroxide, alcohol, ciments, creams, mercurochrome, iodine, methiolate)? If yes, do the records/medicaton log include:

(a) physician's current written instructions for all prescription medication?
(b) parent's current written instruction for all non-prescription medication?
(c) written consent from child's parents for prescription and non-prescription medication?
(d) record of dose and time medication is administered?

SAFETY CARRIER

Is each vehicle equipped with operable age-appropriate safety carriers or restraints for each child?

EQUIPMENT

Is the equipment easily accessible to the children, readily washable, clean, in good repair and free from hazards such as sharp or pointed parts, or toxic or poisonous finishes or materials?
PROGRAM QUALITY SCALE

CHILD DEVELOPMENT PROGRAM
1. The board has approved the overall child development program goals, which include: administration, program activities, staffing, support services, and family/community involvement.
Verify that the program goals were submitted to the board and approved.

2. The agency has a clearly stated plan to achieve the program goals.
Verify that there is a plan for achieving program goals and that the plan identifies person(s) responsible for achieving goals.

3. The agency can demonstrate implementation of the plan to achieve overall child development program goals.
Determine through documentation and observation that the plan is being implemented.

4. The board and staff are involved in the annual review of the program goals.
Determine through documentation that the board and staff review program goals annually.

5. Parents are involved in the annual review of program goals.
Verify through documentation and parent interviews that parents are involved in the review of program goals.

EMPLOYEE PERFORMANCE EVALUATION
1. The agency has a policy for performance appraisal of all staff members.
Interview director to determine agency’s policy on performance appraisals of staff.

2. The agency has a written employee evaluation plan designed to improve performance. The plan should include:
   1. Who will do the evaluation
   2. The form to be used in the evaluation
   3. The process for employee evaluation
   4. The process for employee review and response to the evaluation
Review the agency’s written employee evaluation plan.

3. All staff members receive written performance evaluations by their immediate supervisors during the probationary period and thereafter as specified in personnel policies. Employees have the opportunity to respond to the evaluations.
Review no less than five employee files to verify performance evaluations were conducted according to the plan. From the sample taken, interview staff members to verify that they have the opportunity to respond to their evaluations.

4. Employees participate in setting goals to improve performance.
Review a sample of the evaluations to verify that mutual goals were established by the employee and supervisor and that the evaluations included these goals.
PERSONNEL POLICIES
1. The board has approved personnel policies that include, but are not limited to:
   1. Employment procedures
   2. Evaluation procedures
   3. Opportunities for upward mobility
   4. Lay-off plan
   5. Description of benefits
   6. Causes for termination
   7. Termination
   8. Grievance procedures
   9. Confidentiality

   Review the agenda and the minutes of the board meeting in which the personnel policies were approved.

   Review personnel policies.

2. The agency has a plan for implementing the board-approved policies.

   Review with director the agency’s plan for implementing the personnel policies.

3. The personnel policies are implemented and accessible to each employee.

   Verify that the personnel policies are implemented.

   Interview staff to verify availability and staff awareness of the personnel policies.

4. The agency provides copies of the personnel policies to each employee.

   Ask for a copy of the employees handbook that provides all information on personnel policies. In addition, ask a sampling of approximately 10 percent of the staff members to show their copies to you.

STAFF DEVELOPMENT
1. The agency has an orientation plan for new employees that includes, but is not limited to, statements of:

   1. Philosophy of the agency including program goals and objectives
   2. Policies and procedures, including safety, child health, child abuse reporting, and confidentiality.

   3. Employee benefits and rights.

   Review the orientation plan for the above.

2. The agency has a staff development plan that addresses the following:

   1. Child growth and development
   2. First aid and safety
   3. Discipline
   4. Classroom environment
   5. Child abuse determination
   6. Hygiene and health (adult)
   7. Child health
   8. Cultural awareness
   9. Needs of exceptional children
   10. Nutrition education
   11. Program quality
   12. Child assessments

   Review the staff development plan for the areas listed above.
3. The agency's staff development plan has been implemented.
   Review documentation (agendas, minutes of meetings, and training
   sessions) to verify implementation of the plan.

4. The agency has identified educational resources outside the agency
   that are available to staff for on-site and off-site training.
   Review documentation (memos, letters, minutes of meetings, etc.) to
   verify that the agency has asked colleges, universities, and other
   organizations to provide workshops, conferences, discussion sessions,
   training, or visits from representatives.

5. The staff development plan is periodically reviewed, with staff
   participation, to reflect changing needs of staff and program.
   Review documents (e.g., staff evaluations survey and staff meeting
   discussion) to determine that changing needs were assessed.
   Verify through interviews staff participation in the developmental
   plan.

GOALS AND OBJECTIVES
1. Goals and objectives for the developmental program have been
   formulated and can be articulated by the program director.
   Interview the program director.

2. Goals and objectives reflect the developmental needs of pre-school
   children and can be articulated by the instructional staff.
   Interview instructional staff.

3. Program goals and objectives are implemented
   Review activity plans to determine that the goals and objectives
   articulated are being demonstrated.

4. Program goals and objective are evaluated at least annually by the
   administration, staff, and parents and are modified as needed.
   Review documentation to verify that evaluation by the above groups
   occur at least annually.

IDENTIFICATION OF CHILD'S NEEDS
1. When a child enrolls, information is obtained regarding his or her:
   1. Family background
   2. Physical development
   3. Cognitive development
   4. Social-emotional development
   Review 10% (but not fewer than five) of the children's files for intake
   information. All files should contain information about:
   1. Family background (e.g., language spoken, special dietary concerns,
      parental attitude toward discipline, relationship with relatives.
   2. Physical development
   3. Cognitive development
   4. Social-emotional development.
2. The needs of each child are identified by staff members in the following areas:
   1. Social-emotional
   2. Physical
   3. Cognitive
   4. Communicative

   Interview staff members responsible for identification. Verify that there is an identification process that includes the four areas listed.
   NOTE: Identification process may be formal, including use of standardized tests; or it may be informal, including use of observation.

3. The identification of children’s needs are used to develop:
   1. Activity plans for the group as a whole
   2. Activity plans for individual children

   Review records of child needs and compare to activity plans. Interview instructional staff for individual children.

4. The identification of children’s needs is both an ongoing process by instructional staff and a periodic process by instructional staff or others. Results of the periodic identification are recorded.

   Review record of periodic identification of children’s needs. Interview instructional staff.

5. The goals, objectives, and procedure for identification of children’s needs is evaluated at least annually by the administration, staff, and parents.

   Review documentation to verify that evaluation by the above groups occurs at least annually.

SOCIAL-EMOTIONAL DEVELOPMENT

1. Experiences are provided to promote positive social-emotional development.

   Observe program to determine whether positive social-emotional experiences are occurring.

2. Written activity plans reflect activities specifically related to social-emotional development (sharing, caring, handling emotions, dealing with conflict, self-concept, role modeling, etc.).

   Review the written activity plans for activities specifically related to social-emotional development.

3. The activity plan for social-emotional development is implemented and reflects the identified social-emotional needs of the children. Activities are developmentally and culturally appropriate.

   Sample 10% of the children’s records for identified social-emotional needs.

   Observe program to verify that:
   1. Activity plans are implemented.
   2. Identified social-emotional needs are addressed.
   3. Activities are developmentally and culturally appropriate.
4. Social-emotional development activities are incorporated into all areas of the curriculum.
   Observe program.
   Interview instructional staff regarding the integration of social-emotional development into all areas of the curriculum.

5. The goals, objectives and activities for social-emotional development are evaluated at least annually by the administration, staff, and parents.
   Review documentation to verify that evaluation by the above groups occurs at least annually.

PHYSICAL DEVELOPMENT

1. Activities are provided to promote large-muscle and small-muscle development.
   Observe program to determine whether activities for large and small muscles are provided.

2. Written activity plans reflect specific activities to foster large- and small- muscle development (cutting, jumping, balancing, etc.).
   Review the written activity plan for activities specifically related to physical development.

3. The activity plan for physical development is implemented and reflects the identified physical development needs of the children. Activities are developmentally appropriate.
   Sample 10% of the children's records for identified physical development needs.
   Observe program to verify that:
   1. Activity plans are implemented
   2. Identified physical development needs are addressed.
   3. Activities are developmentally appropriate.

4. Physical development activities are incorporated into all areas of the curriculum.
   Observe program.
   Interview instructional staff regarding the integration of physical development activities into all areas of the curriculum.

5. The goals, objectives, and activities for physical development are evaluated at least annually by the administration, staff, and parents.
   Review documentation to verify that evaluation by the above groups occurs at least annually.

COGNITIVE DEVELOPMENT

1. Activities are provided to promote cognitive development.
   Observe program to determine that activities for cognitive development are provided (seriation, classification skills through the use of table top toys, etc. should be observed).

2. Written activity plans reflect activities specifically related to cognitive development.
   Review the written activity plan for activities specifically related to cognitive development.
3. The activity plans for cognitive development are implemented and reflect the identified cognitive development needs of the children. Activities are developmentally appropriate.
   Sample 10% of the children's records for identified cognitive development needs.
   Observe program to verify that:
   1. Activity plans are being implemented.
   2. Identified cognitive development needs are addressed.
   3. Activities are developmentally appropriate.

4. Cognitive development activities are incorporated into all areas of the curriculum.
   Observe program.
   Interview instructional staff regarding the integration of cognitive development into all areas of the curriculum.

5. The goals, objectives, and activities for cognitive development are evaluated at least annually by the administration, staff, and parents. Review documentation to verify that evaluation by the above groups occurs at least annually.

LANGUAGE DEVELOPMENT
1. Activities are provided to promote language development.
   Observe program to determine that activities for language development are provided (reading books, flannel board stories, finger plays, group and free play, puppets, picture lotto games, etc.)

2. Written activity plans reflect activities specifically related to language development.
   Review the written activity plan for activities specifically related to language development.

3. The activity plan for language development is implemented and reflects the identified language development needs of the children. Activities are developmentally, linguistically and culturally appropriate.
   Sample 10% of the children's records for identified language development needs.
   Observe program to verify that:
   1. Activity plans are being implemented.
   2. Identified language needs are addressed.
   3. Activities are developmentally, culturally, and linguistically appropriate.

4. Language development activities are incorporated into all areas of the curriculum.
   Observe program.
   Interview instructional staff regarding the integration of language development into all areas of the curriculum.

5. The goals, objectives, and activities for language development are evaluated at least annually by the administration, staff, and parents.
   Review documentation to verify that evaluation by the above groups occurs at least annually.
ART
1. Art material and equipment are available (a variety of paper, paste and glue, paint, easels, clay, child-size scissors—both left and right-handed, etc.). 
Observe to determine that art materials and equipment are available and in sufficient quantity for the group being served.
2. Written activity plans reflect a variety of art experiences. Art activities include:
   1. Painting (easel, finger, sponge, etc.)
   2. Cut and paste
   3. Drawing/coloring
   4. Molding (clay, playdough, etc.)
Review the written activity plans for a variety of art experiences.
3. The activity plan for art is implemented, and activities are developmentally appropriate and incorporate children's culture.
   Art activities include multicultural art experiences.
   Interview staff.
Observe program to verify that:
   1. The activity plan for art is implemented.
   2. Activities are developmentally appropriate.
   3. Art activities incorporate the children's culture.
   4. Multicultural art experiences are provided.
4. Art activities are incorporated into all areas of the curriculum.
   Interview program.
Observe program regarding the integration of art into all areas of the curriculum.
5. The goals, objectives and activities for art are evaluated at least annually by the administration, staff, and parents.
Review documentation to verify that evaluation by the above groups occurs at least annually.

MUSIC
1. Music materials and equipment are available (phonographs, variety of music on records, music instruments, etc.).
Observe to determine that music materials and equipment are available and in sufficient quantity for the center.
2. Written activity plans reflect a variety of music experiences. 
   Music activities include:
   1. Listening experiences
   2. Singing
   3. Dancing and movement
Review the written activity plans for the inclusion of a variety of music experiences.
3. The activity plan for music is implemented, and activities are developmentally appropriate and incorporate the children's culture.
   Music activities include multicultural experiences.
   Interview staff.
Observe program to verify that:
1. The activity plan for music is implemented.
2. Activities are developmentally appropriate.
3. Music activities incorporate the children's culture.
4. Multicultural music experiences are provided.

4. Music activities are incorporated into all areas of the curriculum.
   Observe program.
   Interview staff regarding the integration of music into all areas of the curriculum.

5. The goals, objectives, and activities for music are evaluated at least annually by the administration, staff, and parents.
   Review documentation to verify that evaluation by the above groups occurs at least annually.

DRAMATIC PLAY
1. Dramatic play materials and equipment are available (house-keeping area, dress up clothes, mirrors, puppets, blocks, both table blocks and floor blocks, etc.)
   Observe to determine that dramatic play materials and equipment are available and in sufficient supply for the groups being served.

2. Written activity plans reflect a variety of dramatic play experiences (family, community helpers, grocery, airport, zoo, etc.)
   Review the written activity plan for a variety of dramatic play activities

3. The activity plan for dramatic play experiences is implemented.
   Planned activities are developmentally and culturally appropriate.
   Observe program to verify that :
   1. Activity plans for dramatic play are being implemented.
   2. Planned activities are developmentally appropriate.
   3. Planned activities are culturally appropriate.

4. Dramatic play activities are incorporated into all areas of the curriculum.
   Observe program.
   Interview instructional staff regarding the integration of dramatic play into all areas of the curriculum

5. The goals, objectives, and activities for dramatic play are evaluated at least annually by the administration, staff, and parents.
   Review documentation to verify that evaluation by the above groups occurs at least annually.

NUTRITION
1. The program provides nutritious meals and snacks for the children.
   Review menus for nutritional meal planning (review for 4 basic food groups).
   Observe an actual meal.
2. There is a plan to incorporate nutritional concepts, food types and their origin into the curriculum. Determine that a formal nutrition curriculum exists. Review nutrition lessons.

3. There is evidence that the nutritional concept plan has been implemented. Mealtimes are used as learning opportunities. Cultural patterns are incorporated into the curriculum. Observe mealtimes to verify the following:
   1. Staff and children eat together.
   2. Some conversation at table relates to the food being served.
   3. An attempt is made to have children try all foods.
Verify through observation and staff interview that cultural nutrition patterns are incorporated into the curriculum.

4. Children participate in cooking experiences that reinforce nutritional concepts. Verify that the facility includes equipment for children's cooking experiences. Review lesson plans to verify cooking experiences and the reinforcement of nutrition concepts.

5. The goals, objectives and activity plan for nutrition are evaluated at least annually by the administration, staff, and parents. Review documentation to verify that evaluation by the above groups occurs at least annually.

PERSONAL INTERACTION
1. Teaching staff spends time primarily in supervising of and interacting with children. Review daily assignment schedule for instructional staff and observe to determine that their time is spent primarily in supervising of and interacting with children.

2. Teaching staff is flexible and responsive in interaction with children. Observe the program for the following:
   1. Children are allowed to move freely from activity to activity.
   2. A variety of activities are offered from which children may choose.

3. Teaching staff interacts with and responds to each child as an individual.
   1. Each child's questions are encouraged and answered.
   2. Verbal interactions with children are positive.
   3. Children are allowed to choose an individual activity rather than participate in a group activity.
   4. Various learning styles are recognized, and activities are planned accordingly.

4. Teaching staff picks up cues that indicate the child's mood and can alter plans and routine as necessary. Observe the program for the following:
   1. Children are permitted to express their feelings (joy, anger, excitement, sadness, grumpiness, etc.) and activities are altered to meet special needs.

   Notes: Interact with children who show deviant behavior.
5. Teaching staff encourages creativity, allowing playfulness when it occurs and joining in as appropriate.
   Observe the program for the following:
   1. Children are encouraged to use materials and equipment in innovative ways.
   2. Staff lends, jokes, and uses riddles with children.
   3. Children are encouraged to help plan activities.

SELF CONCEPT
1. Each child’s space is identified with the child’s name clearly written or with a personalized symbol.
   Observe individual children’s spaces to determine that names are written clearly or that personalized symbols label spaces.

2. Children’s photographs, art work, and other contributions are displayed, labeled, and visible at eye level.
   Observe to determine that children’s photographs, art work and other contributions are displayed, labeled and visible at eye level.

3. Children are given opportunities to experience success.
   Observe to determine that children are given opportunities to experience success.
   Interview instructional staff for examples.

4. Children are provided opportunities to make decisions and take risks.
   Observe.
   Interview instructional staff.

5. Children’s ideas are accepted and expanded into learning opportunities.
   Interview
   Ask instructional staff for example.

ETHNIC AND CULTURAL RECOGNITION
1. Information is available to staff regarding traditional ethnic and cultural observances.
   Look for program materials in books and media form that are available to staff on ethnic festivals and practices that are applicable to the local community, the nation, and the world.

2. Staff plans for learning opportunities that acknowledge ethnic and cultural backgrounds of the children and the community.
   Review the program plans for ethnic and cultural activities.
   Interview staff members regarding their plans for activities, e.g., dramatic play, festive costumes, cooking activities, dancing.

3. Planned activities are implemented to enhance a sense of cultural pride on the part of all ethnic groups.
   Observe that activities and displays reflect the history and culture of ethnic groups in the community.
4. Teaching staff highlights each child by sharing individual ethnic and cultural backgrounds. Review program displays and plans. Interview staff regarding how families share traditional customs with the program.

5. Staff provides multicultural experiences that enlarge each child's knowledge of other cultures throughout the world. Review program plans and learning materials.

SPECIAL NEEDS
1. Staff observes children to identify special needs. Review observation records and development charts.

2. Staff and parents confer on the staff's observation, and referrals are made as necessary for children with special needs. Review record of parent conferences and documentation of referrals.

3. Staff members are involved in implementing the special needs plan for children. Review curriculum plans or progress charts to verify that plans are being implemented.

4. The process for meeting special needs of children is reviewed and updated annually. Review plans for special needs children and note dates of updates.

STAFF-PARENT COMMUNICATION
1. Staff shares highlights of child's day with parents. Observe to determine whether staff shares information about children when parents bring them to the center or pick them up at the end of the day.

2. At least two scheduled parent conferences are held during the program year. Review records of parent conferences.

3. Staff members are available for parent conferences on request. Interview parents. Ask them whether they can request a conference with staff that is not one of the two regularly scheduled during the program year.

4. The teacher or other staff member visits the child and family at home. Interview parents and staff members.

USE OF CHILD'S HEALTH RECORD
1. A health record is maintained for each child. Review 10% (but not fewer than five) of the children's records.
2. A designated staff member reviews the information in each child's health record annually to update it for age-appropriate immunizations, physical exams, and follow-up health care recommended by the physician. Review 10% of the records to determine that there has been communication with the parent on the need for follow-up. Verify from the record that necessary referrals to health care services have been made.

3. Parents are informed of any need for health care follow-up and are given referrals as necessary. Review 10% of the records to determine that there has been communication with the parent on the need for follow-up. Verify from the record that necessary referrals to health care services have been made.

4. The health record documents that appropriate health care was obtained. Review 10% of the records to verify follow-ups.

5. The agency is successful in getting low-cost or free resources to meet children's health needs. Ask the agency’s representative to show you evidence of efforts made to secure needed health care services especially for children.

FAMILY CONFIDENTIALITY

1. Confidential discussions with parents occur in privacy. Observe to see that space is available.

2. A written policy pertaining to confidentiality of family records and information has been adopted by the governing board and includes provisions for:
   1. Maintenance of eligibility and family service records in secure files.
   2. Limited access to the above information.
   3. Release of information from family records.
   4. Need for written permission to use photographs of children for purposes outside the program, to release confidential information, and to allow children to participate in research.

   Review board approved written policy on family confidentiality.

3. The agency’s confidentiality policy is implemented, and all staff and parents received a copy of the policy.

   Review any documents that would demonstrate that the policy is being implemented.

   Verification might include permission forms, specification of persons who have access to the files, and observation that confidential files, and observation that confidential files are maintained in a secure location.

   Interview a sample of parents and staff to verify their receipt of the written policy on confidentiality.

4. The board annually reviews the agency's confidentiality policy. Ask to see any documentation that this has taken place. Such documentation might include minutes of parents' meetings, minutes of board's review of the policy, etc.
FAMILY/PARENTS ACTIVITIES FOR PROGRAM SUPPORT

1. Information concerning family/parents' resources (time, skills, interests) is requested.
   Review evidence that at the initial enrollment interview, or shortly thereafter, an inventory of parents' skills, time, and interests is compiled.

2. Family/parents are invited to assist in program support activities.
   Review evidence such as admission policies, written materials sent to parents, bulletin boards, and agendas of parents' groups and board of directors.

3. Family/parent work with staff in organizing program support activities.
   Review evidence such as minutes of parents' groups, flyers, and notices to parents.

4. Family/parents are involved in establishing program support activities.
   Review evidence such as minutes of parents' groups, calendars of events, flyers, and notices to families.
   Interview parents or members of the family and staff.

5. Family/parents work with staff in the evaluation of program support activities.
   Review minutes of parents' groups and staff meetings to see whether program support activities organized by staff and parents were evaluated.

PARENTS' INVOLVEMENT WITH CHILDREN IN PROGRAM

1. Parents are invited to the center to visit and observe.
   Review evidence indicating that parents have been invited.

2. There are opportunities for parents to be involved with children in the program.
   Review documentation or interview parents to verify that there are opportunities for parents to be involved in the program.

3. Agency has an open-door policy to encourage parents to participate in program during the daily schedule.
   Review evidence such as: parent participation sign-in-sheet, parent handbook, bulletin board, newsletter, letters to parents.
   Interview staff and parents. Ask for news item which indicates that parents have been involved in activities.
   Observe parent involvement in activities such as the following:
   1. Ethnic food preparation
   2. Cultural activities (drama, dance, art, handicraft)
   3. Assistance in special holidays and multiethnic activities.

4. Parents participate in activities for children in the program.
   Review documentation to verify that parents or families are participating in activities for children in the program.
5. Parents take ideas and activities home for follow-up and reinforcement. Interview staff to verify that parents are provided ideas and activities to be used with their children outside of school. Interview sampling of parents or family members who have participated.

PARENT EDUCATION
1. Parents are invited to attend parent educational activities. Review flyers, notices to parents, bulletin board, and minutes of parents' meetings.

2. Educational interests and needs of parents are identified. Interview parents and review documentation to determine that interests and needs of parents are identified.

3. Educational activities for parents are designed and implemented based on parents' needs and interests. Review notes that parents' educational activities reflect parents' needs and interests as identified.

4. Educational workshops are offered at least three times a year. Review schedule of educational workshops to verify that they are offered at least three times a year. Check dates of announcements and newsletters to parents.

5. Long-term training programs (e.g., language, and vocational skills) are identified, and parents are made aware of the programs. Review examples of information and literature lists made available to parents.
## Child Development Program Evaluation Scale

### Licensing Scale

<table>
<thead>
<tr>
<th>Sub Scale Code</th>
<th>Out in Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>0</td>
</tr>
<tr>
<td>CD</td>
<td>0</td>
</tr>
<tr>
<td>M</td>
<td>0</td>
</tr>
<tr>
<td>ES</td>
<td>0</td>
</tr>
<tr>
<td>CD</td>
<td>0</td>
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<tr>
<td>A</td>
<td>0</td>
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<td>A</td>
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<tr>
<td>T</td>
<td>0</td>
</tr>
<tr>
<td>ES</td>
<td>0</td>
</tr>
</tbody>
</table>

### Program Quality Scale

<table>
<thead>
<tr>
<th>Sub Scale Code</th>
<th>Quality Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>A</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>A</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>CD</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>CD</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>CD</td>
<td>0 1 2 3 4 5</td>
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<td>CD</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>CD</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>

### CDPES Sub Scales:

- **Administrations** (A): 0              24
- **Environmental Safety** (ES): 0            12
- **Child Development Curriculum** (CD): 0              69
- **Health Services** (H): 0                14
- **Nutritional Services** (N): 0            8
- **Social Services** (SS): 0               23
- **Transportation** (T): 0               3
CAREGIVER OBSERVATION FORM AND SCALE (COPAS)

This is the Caregiver Observation Form and Scale (COPAS) for recording behaviors of caregivers while interacting with children in a classroom setting. This form can be used with any age group of children between infancy and 12 years of age.

Please follow the steps listed below for filling out the form and in calculating the scores for the COPAS Scale.

STEP 1:

Fill in the needed information as shown below before beginning your observations of each caregiver.

Example:

<table>
<thead>
<tr>
<th>Caregiver #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of children present at the beginning of caregiver observation:</td>
</tr>
<tr>
<td>No. of adults (excluding yourself) present at the beginning of caregiver observation:</td>
</tr>
<tr>
<td>Time of Observation:</td>
</tr>
<tr>
<td>Name of caregivers observed:</td>
</tr>
</tbody>
</table>

STEP 2:

Observe each caregiver for 10 consecutive two-minute periods, pausing between observations to record. For each two-minute period, observe then record whether or not you observed each behavior listed on the form. Record by using either a "1", "3", or "4" code in the block corresponding to the observation period you are in. Use the "1" code if you did observe the specified behavior, "3" if you did not observe the specified behavior, and the "4" if you are unsure of whether you observed the behavior. Before you go to the next observation period, be sure that each block for that observation period has either a "1", "3", or "4" code in it.

STEP 3:

For each observation period record the type of activity being done by the caregiver during your observation (e.g. listening to records, reading stories, art project).
STEP 4:

After you have recorded all of your observations, it will be necessary to multiply these observations by the weights attached to each of the specific behaviors observed. You will note that in the far right-hand column there are a series of numbers. These numbers are the weights that you multiply the individual observation blocks by. For example, in "Speak unsolicited to a child", let's say you observe this 5 out of 10 observation blocks:

<table>
<thead>
<tr>
<th>Observation Blocks</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speak unsolicited to child</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>+2</td>
</tr>
</tbody>
</table>

To obtain the score for this particular behavior, you do the following:

- add all the (1)'s = 6
- multiply that number (6) by the weight in the right-hand column: 6 x (+2) = +12

That gives you your score (+12) for this specific behavior. Three's and four's (3 & 4) are equal to zero (0) and are not added in. They do not affect the score positively or negatively.

Let's use another example, go to "Use food as reinforcement". Let's say you observe this 2 out of 10 observation blocks:

<table>
<thead>
<tr>
<th>Observation Blocks</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use food as a reinforcement</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>-3</td>
</tr>
</tbody>
</table>

To obtain the score for this particular behavior, you do the following:

- add all the (1)'s = 2
- multiply that number (2) by the weight in the right-hand column: 2 x (-3) = -6

That gives you your score (-6) for this specific behavior. Three's and four's (3 & 4) are equal for zero (0) and are not added in. In this case, by default, they do affect the score positively.

Proceed with all the particular behaviors, as you did above. Then total your scores as follows:

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>+12</td>
</tr>
<tr>
<td>2</td>
<td>+5</td>
</tr>
<tr>
<td>3</td>
<td>+12</td>
</tr>
</tbody>
</table>
Item  |  Score
-----|------
  4  |  +3  
  5  |  0   
  6  |  +1  
  7  |  +3  
  8  |  0   
  9  |  -1  
 10  |  +15 
 11  |  +2  
 12  |  0   
 13  |  -6  
 14  |  0   
 15  |  0   
 16  |  0   
 17  |  0   
 18  |  0   
 19  |  0   
 20  |  0   
 21  |  +5  
 22  |  0   
 23  |  0   
 24  |  0   
 25  |  0   
 26  |  0   
 27  |  0   
 28  |  0   
 29  |  0   

Calculate your total score:

Total score = +50

Now check this total score against the scale for COFAS:

<table>
<thead>
<tr>
<th>RATING</th>
<th>LEVEL</th>
<th>RANGE IN SCORES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>I</td>
<td>(-30) to (+130)</td>
</tr>
<tr>
<td>Fair</td>
<td>II</td>
<td>(-10) to (+29)</td>
</tr>
<tr>
<td>Poor</td>
<td>III</td>
<td>(-99) to (-11)</td>
</tr>
<tr>
<td>Non-optimal</td>
<td>IV</td>
<td>(-1560) to (-100)</td>
</tr>
</tbody>
</table>

CAREGIVER OBSERVATION SCALE
CAREGIVER OBSERVATION FORM AND SCALE (COFAS)

This form is designed to be used by the monitor in recording specific observations of caregivers' child development activities during a 30-minute period.

No. of children present at the beginning of the caregiver observation: 7
No. of adults present at the beginning of a caregiver observation: 2
Time of observation: 9:30 AM
Name of caregiver: Louise Marks

<table>
<thead>
<tr>
<th>During your observation did the caregiver:</th>
<th>Two-minute Observation Periods</th>
<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scream unsolicited to a child</td>
<td>01  0  3  4  1  1  1  1  4  1</td>
<td>+2</td>
</tr>
<tr>
<td>Use the child's dialect</td>
<td>02  3  3  3  3  3  3  3  3  3</td>
<td>+1</td>
</tr>
<tr>
<td>Respond verbally to a child's spec.</td>
<td>03  1  3  5  3  3  3  3  3  3</td>
<td>+2</td>
</tr>
<tr>
<td>Read or identify pictures to a child</td>
<td>04  3  3  3  3  5  3  3  3  3  3</td>
<td>+1</td>
</tr>
<tr>
<td>Sing or play music with a child</td>
<td>05  3  3  3  3  3  3  3  3  3  3</td>
<td>+1</td>
</tr>
<tr>
<td>Snack slowly and clearly to a child at all times</td>
<td>06  3  3  3  3  3  3  3  3  3  3</td>
<td>+1</td>
</tr>
<tr>
<td>Interrupt or cut off a child's verbalization</td>
<td>07  4  3  3  3  3  3  3  3  3  3</td>
<td>-3</td>
</tr>
<tr>
<td>Scream or yell at children</td>
<td>08  3  3  3  3  3  3  3  3  3  3</td>
<td>-30</td>
</tr>
<tr>
<td>Allow noise level to become so high it is hard for observer to understand children</td>
<td>09  3  3  3  3  3  3  3  3  3  3</td>
<td>-1</td>
</tr>
<tr>
<td>Give affectional physical contact to child</td>
<td>10  3  3  3  3  3  3  3  3  3  3</td>
<td>+3</td>
</tr>
<tr>
<td>Make activity suggestion to a child</td>
<td>11  3  3  3  3  3  3  3  3  3  3</td>
<td>+1</td>
</tr>
<tr>
<td>Physically punish a child</td>
<td>12  3  3  3  3  3  3  3  3  3  3</td>
<td>-100</td>
</tr>
<tr>
<td>Use food as reinforcement</td>
<td>13  3  3  3  3  3  3  3  3  3  3</td>
<td>-3</td>
</tr>
<tr>
<td>Make fun of or ridicule a child</td>
<td>14  3  3  3  3  3  3  3  3  3  3</td>
<td>-30</td>
</tr>
<tr>
<td>Let other children make fun of or ridicule a child</td>
<td>15  3  3  3  3  3  3  3  3  3  3</td>
<td>-30</td>
</tr>
<tr>
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<tr>
<td>Isolate a child physically</td>
<td>17  3  3  3  3  3  3  3  3  3  3</td>
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<tr>
<td>Ignore a child's request</td>
<td>18  3  3  3  3  3  3  3  3  3  3</td>
<td>-5</td>
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<td>19  3  3  3  3  3  3  3  3  3  3</td>
<td>-5</td>
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<td>Leave the child alone</td>
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<td>Foster development of child's gross motor skills</td>
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<td>Talk with other adults</td>
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Record the type of activity: (e.g., listening to records, reading a story, art project, etc.)

Snack Cognitive Games
Criteria for Recording Caregiver Observation

01. Speak unsolicited to a child.

Infant, Preschooler & School Age — any time an adult makes any type of verbalization to a child where the child has not initiated or spoken to the adult first. The important aspect here is that the adult is the initiator and not the child.

A ------> C, not C --------> A
(1) (3)

02. Use the child’s dialect.

Infant, Preschooler & School Age — the adult (caregiver) speaks in the child’s appropriate dialect or attempts to use the child’s dialect (e.g., Black Appalachian, creole or pidgins dialects). The important aspect here is that the adult is sensitive to cultural differences as it relates to language. Although there is a standard form of English which is generally used in public schools in a formal setting; sensitivity and acknowledgement of a child’s cultural underpinnings expressed through his dialect should be fostered in the preschool language. There should be an opportunity for both standard English and the child’s particular dialect to be used. Just using standard English with no regard for the child’s dialect should be scored a “3”.

03. Respond verbally to a child’s speech.

Infant — any verbalization, including baby talk, cooing, babbling to the infant is appropriate. The child will initiate with a verbalization and then the adult responds.

C --------> A & A --------> C
(1) C --------> A but the adult does not respond
(3)

The baby talk, cooing and babbling to the infant is appropriate in the first 12-18 months depending on the individual child’s developmental level.

Toddler & Preschooler — from 18 months and above, the adult when she/he responds to the child should not be cooing, babbling, or engaging in baby talk. The adult should be expanding on the child’s speech, acting as a model for the child.

School-Age — the adult should engage in adult-type verbalization with the child.

DEVELOPMENTAL MILESTONES — LANGUAGE

child does:
3 months — spontaneously laughs, attends to voice with smiling/cooing
6 months — croons to music, babbles extensively; turns to sound of bell
9 months — says “da-da”; mocks sounds in the environment
12 months — follows simple instructions; imitates words
15 months — two word vocabulary; indicates wants by pointing
18 months — ten definite words in vocabulary; asks for two things by appropriate words
21 months - combine two words to form short phrase/sentence
24 months - labels any three common objects; "what's this"—cat, dog, etc.
27 months - uses plurals, knows first name when asked
30 months - three word sentences are present; knows concept of "one"
33 months - knows last name and sex; uses "I" or self-reference
36 months - four word sentences are present
39 months - gives first and last name; names most common objects and pictures
42 months - complete sentences used consistently; knows concepts of "animals", "toys"
45 months - identifies three colors; show me the blue one; sings simple song
48 months - comprehends "what do we do when hungry"; grasps number concept "two"
51 months - mastery of Y,J,K,G,P, and D sounds; repeats a five word sentence
54 months - averages five-word sentences; follows a sequence of three directions
57 months - tries to use new words spontaneously; understands some abstract words
60 months - no infantile speech is present; name or labels at least six colors

The adult should be fostering in the child the above developmental areas or at least their attainment. Adult should not be fostering in a child a lower developmental level if the child is operating at a higher level.

04 Read or identify pictures to a child

Infant, Preschooler, School-age - whenever the adult takes time with a child to help the child recognize, pick out, identify, etc. pictures in picture books or help a child to read at the older age ranges. (Code 1)

05 Sing or play music with a child

Infant, Preschooler, School-age - whenever an adult sets up a musical experience either by playing an instrument, singing songs, rhythm band, etc. If the children are actively mobile, i.e., marching then code "1" for (21) gross motor skills. If the children are sitting and listening to music do not code (1) for (21).

06 Speak slowly and clearly to children at all times

Infant, Preschooler and School-age - the adult takes the time in how she/he talks to the child. Concern here is with the speech of the adult, is it clear, well enunciated so that you as an observer can easily understand what she/he is saying. Code "1". If, the adult rushes her/his sentences with little care given to the child's understanding of what is said, code "3".
07 Interrupt or cut off a child's verbalization

Infant, Preschooler & School-age - anytime that an adult does not let a child finish what they started to say. This is not as appropriate with infants because of the egocentric nature of their verbalizations. With toddlers 18 months plus, preschoolers and school-age children, so long as the adult cuts off the child's verbalization, code "1".

08 Scream or yell at children

Infant, Preschooler & School-age - anytime an adult raises his/her voice to get the attention of the classroom, reprimand a child, etc., code "1".

09 Allow noise level to become so high that it is hard for an observer to understand what is being said.

Infant, Preschooler, & School-age - anytime during your observations where it becomes difficult to hear what individual children or caregivers are saying. Anytime that it becomes so noisy that it is disturbing the children and adults and distracting where children and adults are not completing things they have started, code 1.

10 Give affectionate physical contact to a child

Infant, Preschoolers & School-age - anytime the caregiver picks a child up, pats a child on the head, rocks an infant, has a child sit on the caregiver's lap, kisses a child, hugs a child, puts an arm around a child, code "1".

11 Make activity suggestion to a child

Infant, Preschoolers & School-age - the caregiver actually demonstrates or guides the child to another activity, gives suggestions or alternatives for activities, code "1".

12 Physically punish a child

Infants, Preschoolers & School-age - code "1" if you see a caregiver hit, push, shake, pull a child violently.

13 Use food as reinforcement

Infants, Preschoolers & School-age - anytime that the caregiver sets up a contingency that if you don't do this you will not get dessert, or eat, etc. Also, at mealtime, if the caregiver does not give the child dessert for not eating the main meal. Code "1".

14 Make fun or ridicule a child

Infants, Preschoolers & School-age - anytime that the caregiver either takes the child aside or in front of everyone present and brings undue attention to a child's idiosyncrasies, handicaps, etc., which embarrass the child or lower the child's self-image, or to make the child feel that there's something wrong with my. Code "1".
15 Let other children make fun or ridicule a child

Infant, Preschoolers & School-age - if the caregiver makes no attempt to re-direct children who are making fun of another child, to get them interested in another activity, or to work with the children in getting at the roots of the particular problem. Code "1".

16 Verbally criticize, scold or threaten a child

Infant, Preschoolers & School-age - the caregiver does not physically do anything but threatens she/he will, puts a child down through scolding but does not shout nor make fun of the child, but is very direct in his/her criticism. Code "1".

17 Isolate a child physically

Infant - if a child acts up, the caregiver either confines the infant in a crib or playpen by physically removing the child from whatever she/he was doing. Note the length of isolation and place, Code "1". Place your note on reverse side of the observation.

Toddler, Preschooler, School-age - if a child acts up, the caregiver either has the child sit in a chair by himself, removes him from the room, puts him in a time-out bay. This is done physically where the adult tells the child and if no response actually removes the child from the activity. Record the time and place of isolation, Code "1". Place your note on the reverse side of the observation.

18 Ignore a child’s request

Infants, Preschoolers, & School-age - anytime that a child either makes a verbal or non-verbal request (infant tugging at caregiver) and caregiver doesn’t respond. The caregiver doesn’t even acknowledge the child by saying I’ll answer that later or with a pat on the head. Code "1".

19 Interrupt a child’s activity and prevent its completion

Infants, Preschoolers, & School-age - whenever an adult ignores individual skills of children and makes them complete the same activity at the same time. There is no built-in factor for individual differences and having children work at their individual pace--Code "1".

20 Leaves the children alone

Infants, Preschoolers, & School-age - whenever the caregiver, no matter what the reason, leaves the children unattended, Code "1".

(Instruction: If the adult leaves with someone else watching the children and will return shortly, interrupt your observations and continue when she/he returns. If the caregiver will not be returning for a long period of time, then observe the remaining caregiver.)
21 Foster Development of a child's gross motor skills

Infants - any activity which involves rolling, sitting up, pulling up, walking, crawling, etc., Code "1".
Preschoolers & School-age - any activity which involves running, somersaulting, twisting, jumping, calisthenics, etc., gymnastics (supervised by adult), Code "1".

22 Show impatience or annoyance with child's question

Infants, Preschoolers & School-age - anytime that a child asks a question, and the caregiver is quick to answer to get rid of the child or is visibly annoyed that the child asked the question, Code "1".

23 Use terms which are above a child's reasoning ability

Infants - whenever the caregiver uses terms and expects the children to retain the information, i.e., knowledge of colors, numbers, alphabet, sizes and shapes. Using these as descriptions on the caregivers part is o.k., but not to expect the children to use the same descriptions, Code "1".
Preschoolers - whenever the caregiver uses terms and expects the children to retain the information, i.e., knowledge of notions of association, transtivity, conservation of area, numbers, etc., Code "1".
School-age - up to 10 or 11. To expect the children to solve verbal or hypothetical problems, Code "1".

24 Deal in abstract Concepts without concrete examples

Infants, Preschoolers & School-age - (to 11 yrs) presentation of an activity such as shapes without having a two dimensional or three dimensional model for the children to see, touch, manipulate. Counting without the actual physical objects present, Code "1".

25 Show intolerance with a child's mistakes & not accepting faulty thinking

Infants, Preschoolers & School-age - too much emphasis placed upon "there is only one correct answer"! Not sensitive to a child's thinking being very different from an adults. For example, an infant learns about objects by mouthing them. A preschooler is egocentric, cannot transfer learning, centers on one particular perceptual entity, cannot reverse his thinking. A school-age child (more than 11 yrs) cannot solve problems involving the future, Code "1".

26 Prepare or serve food for a child

Infant - preparing baby food, setting up high chair, warming a bottle, feeding a child by bottle or spoon, Code "1".
Preschooler & School-age - setting up table, serving food or helping child serve food, Code "1".
27 Prepare activities and/or arrange the room

Infant, Preschooler, or School-age - whenever the caregiver is engaged in preparing for an upcoming activity (getting materials organized) or arranging room (placement of tables or chairs) or while the activity is going on (helping a child complete the activity), Code "1".

28 Do nothing

Caregiver is detached from children and other adults; staring into space, not on a break. Not responsive, Code "1".

29 Talk with other adults

Conversation is directed to other adults -- while ignoring children--Code "1". If the conversation involves having other adults help out or to plan activities, then code "3".
CAREGIVER OBSERVATION FORM AND SCALE (COFAS)

This form is designed to be used by the monitor in recording specific observations of caregivers' child development activities during a 30-minute period.

No. of children present at the beginning of the caregiver observation  
No. of adults present at the beginning of a caregiver observation  
Time of observation  
Name of caregiver

<table>
<thead>
<tr>
<th>During your observation did the caregiver:</th>
<th>Two-minute Observation Periods</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Weights</th>
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<td>Speak unsolicited to a child</td>
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<td>Use the child’s dialect</td>
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<td>Read or identify pictures to a child</td>
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<td>Sing or play music with a child</td>
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<td>Interrupt or cut off a child’s verbalization</td>
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<td>Scream or yell at children</td>
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<td>Allow noise level to become so high it is hard for observer to understand children</td>
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<td>Give affectionate physical contact to child</td>
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<td>Make activity suggestion to a child</td>
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<td>Physically punish a child</td>
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<td>Use food as reinforcement</td>
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<td>Make fun of or ridicule a child</td>
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DISCLAIMER:
The views expressed in this publication do not necessarily represent the views or policies of the Office of Planning, Research and Evaluation, the Administration for Children and Families or the U.S. Department of Health and Human Services.

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Validation of Quality Rating and Improvement Systems for Early Care and Education and School-age Care

Research-to-Policy, Research-to-Practice Brief  OPRE2012-29

April 2012

Submitted to:
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U.S. Department of Health and Human Services

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Richard Fiene, Pennsylvania State University

Contract Number: GS10F0030R
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Suggested Citation:

This Brief was developed by members of the Quality Initiatives Research and Evaluation Consortium (INQUIRE) which is designed to facilitate the identification of issues and the development and exchange of information and resources related to research and evaluation of quality rating and improvement systems (QRIS) and other quality initiatives. INQUIRE is funded by the Office of Planning, Research and Evaluation through the Child Care and Early Education Policy and Research Analysis and Technical Expertise contract with Child Trends.
Validation of Quality Rating and Improvement Systems for Early Care and Education and School-age Care

Quality Rating and Improvement Systems (QRIS) for early care and education and school-age care programs are designed to collect information about quality and to use that information to produce program-level ratings, which are the foundation of a QRIS. The ratings are intended to make program quality transparent for parents and other stakeholders and to encourage the selection of higher-quality programs. The ratings also provide benchmarks that can support efforts to help programs improve their quality. **Validation of a QRIS is a multi-step process that assesses the degree to which design decisions about program quality standards and measurement strategies are resulting in accurate and meaningful ratings.** Validation of a QRIS provides designers, administrators, and stakeholders with crucial data about how well the architecture of the system is functioning. A carefully designed plan for ongoing validation creates a climate that supports continuous quality improvement at both the program and system level.

To date, QRIS validation efforts have been limited. One reason may be that validation is a complex endeavor that involves a range of activities. In addition, there has been little guidance available that clarifies the purpose of QRIS validation or identifies the activities that comprise validation. At the same time, there is growing pressure to validate these systems as stakeholders seek evidence that QRIS are functioning as intended. The federal government has elevated QRIS validation by including it as a central component of the 2011 Race to the Top Early Learning Challenge and requiring state applicants to develop QRIS validation plans as part of their submissions.

The purpose of this Brief is to help QRIS stakeholders better understand validation and to outline a set of complementary validation activities. The Brief defines validation, describes different types of validation studies, and provides guidance on developing a validation plan, including tools to determine the appropriate scope and timing of validation activities. It also lists references and resources for those who wish to learn more. This Brief is aimed at readers in positions to authorize, finance, design, and refine QRISs and other quality improvement efforts, including state child care administrators, early education policy and program specialists, legislators, and other potential funders.
Validation is a multi-step process that assesses the degree to which design decisions about QRIS program quality standards and measurement strategies are resulting in accurate and meaningful program ratings.\(^1\)

Validation is particularly important for QRISs because these systems at their core rely on ratings of program quality. They are built on the assumption that the quality of early childhood and school-age programs can be reliably measured and that differences in quality across these programs can be identified through the use of a set of quality indicators. Validity data can support conclusions about whether such quality indicators measure quality well and whether the strategies used to combine measures and develop ratings are working as intended (Cizek, 2007).\(^2\) Valid ratings are critical to QRISs because parents and other stakeholders use these ratings to select the highest-quality care that they can afford. The overall quality rating also carries increasingly high stakes for programs. Indeed, the theory underlying QRISs intentionally creates those stakes to motivate both provider and parent behaviors in support of increased quality (e.g., Zellman et al., 2008; Zellman et al., 2011). In addition to attracting more children, programs that score well may receive higher subsidies for subsidy-eligible children, and may qualify for grants, incentives, and tax credits.

Validity is not determined by a single study; instead, validation should be viewed as a continuous process with multiple goals: refining the ratings, improving system functioning, and increasing the credibility and value of rating outcomes and of the QRIS system as a whole. A carefully designed validation plan will promote the accumulation of evidence over time that will provide a sound theoretical and empirical basis for the QRIS (AERA, APA, & NCME, 1999; Kane, 2001). Ongoing validation activities that are carried out in tandem with QRIS monitoring activities (that aim to examine ongoing implementation of the QRIS) and evaluation activities (that examine the outcomes of QRIS) can help a QRIS improve its measures and effectiveness throughout its development and implementation (see Lugo-Gil et al., 2011 and Zellman et al., 2011 for guidance on developing a comprehensive QRIS evaluation).

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\(^1\) The definition of validation has changed over time. Rather than identifying separate types of validity (construct, predictive, face, concurrent and content), the current notion is that construct validity includes all evidence for validity, including content and criterion evidence, reliability, and the wide range of methods associated with theory testing (Messick, 1975, 1980; Tenopyr, 1977; Guion, 1977; Embretson, 1983; Anastasi, 1986). As a consequence, we do not differentiate types of validity in this brief.

\(^2\) Reliability represents the ability of a measure to assess its target behaviors or characteristics consistently. In the case of QRISs, reliability refers to the extent to which independent raters produce similar ratings on individual QRIS elements and on the summary rating (inter-rater reliability) as well as the degree to which raters are consistent over time in their ratings (intra-rater reliability). Such consistency is a prerequisite for validity of any measure.
QRIS validation activities may produce three important benefits. First, validation evidence can promote increased support for the system among parents, ECE-SAC providers and other key stakeholders. Ratings that match the experiences of parents and providers can build trust in the ratings and increase the overall credibility of the system. Second, a system that is measuring quality accurately is better able to target limited quality improvement supports to those programs and program elements most in need of improvement. Third, validation evidence can be used to improve the efficiency of the rating process. If a QRIS is expending resources to measure a component of quality that is not making a unique contribution to a summary quality rating or that is not measuring quality accurately, it can be removed or revised. For example, measures that vary little if at all across providers whose quality varies substantially in other ways make little or no contribution to quality ratings. Measures of family engagement that include parent ratings are particularly prone to this problem, as parents who have chosen to use and continue to rely on a given provider are highly likely to see the care as good and to rate it according to their views (Zellman and Perlman, 2006; McGrath, 2007; Keyes, 2002; Kontos et al., 1987; Shimoni, 1992). If all or almost all programs receive high ratings on the family engagement measure, then that component of the rating may not be working to distinguish between lower-quality and higher-quality programs. It may be considered important to collect measures of family engagement to ensure that providers continue to focus on it. But knowing that a given measure is not contributing to an overall program quality rating may motivate program developers to consider another way to measure the concept, which might both increase the value of the measure and reduce measurement costs. Indeed, understanding the relationships among rating elements through validation studies can save substantial time and effort.

Despite the importance of validation activities to strengthen QRIS, support for these activities may be impeded by limited resources and concern about the value of validation activities. In states with more mature QRISs, there may be reluctance among stakeholders to assess an established system. In newer systems, policymakers may question the need for validation given the arguments recently offered in support of establishing the system. Validation plans can address each of these concerns by providing evidence to help the system run more efficiently and to establish a climate of continuous improvement. A validation plan will clarify that the system is open to change, intent on improvement, and dedicated to increasing the odds of reaching its goals.

**Designing and Implementing Validation Efforts**

A comprehensive validation plan includes multiple studies that rely on different sources of information and ask different but related questions. These can be understood and organized around four complementary and interrelated approaches to validation. In this section we provide details of the four approaches. Summaries of these details are provided in two tables. Table 1 presents an overview of the four approaches including the purpose of each approach, the activities that might be undertaken, the questions that are asked and the limitations of each approach. Table 2 presents the data needed, data sources, and analysis methods for selected studies within each approach.3

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3 The four basic approaches described in the table are very similar to and compatible with those used in the QRIS Evaluation Toolkit (Lugo-Gil et al., 2011).
When reviewing the tables and the remainder of the Brief, it is helpful to be familiar with how three key QRIS terms – component, standard and indicator – are defined. The term quality **component** refers to the broad quality categories used in QRIS (such as staff qualifications, family engagement, and the learning environment). A quality **standard** is defined as a specific feature of quality such as specialized curriculum and assessment training in the staff qualifications component; a set of quality standards comprise each quality component. Quality **indicators** are metrics that can be measured or verified for each of the quality standards. A given quality standard could have one or multiple quality indicators that represent it in a QRIS. For example, in the category of staff qualifications, a standard may be “Teaching staff have specialized training in curriculum and assessment.” An indicator related to this standard may be “At least 50% of teaching staff have completed the two-course statewide curriculum training session on curriculum and assessment.”

### Table 1. Four Related Approaches to Validating a QRIS

<table>
<thead>
<tr>
<th>Approach</th>
<th>Activities and Purpose</th>
<th>Typical Questions Approach Addresses</th>
<th>Issues and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Examine the validity of key underlying concepts</strong></td>
<td>Assess whether basic QRIS quality components and standards are the “right” ones by examining levels of empirical and expert support.</td>
<td>Do the quality components capture the key elements of quality? Is there sufficient empirical and expert support for including each standard?</td>
<td>Different QRISs may use different decision rules about what standards to include in the system.</td>
</tr>
<tr>
<td><strong>2. Examine the measurement strategy and the psychometric properties of the measures used to assess quality</strong></td>
<td>Examine whether the process used to document and verify each indicator is yielding accurate results. Examine properties of key quality measures, e.g., inter-rater reliability on observational measures, scoring of documentation, and inter-item correlations to determine if measures are psychometrically sound. Examine the relationships among the component measures to assess whether they are functioning as expected. Examine cut scores and combining rules to determine the most appropriate ways to combine measures of quality standards into summary ratings.</td>
<td>What is the reliability and accuracy of indicators assessed through program administrator self-report or by document review? What is the reliability and accuracy of indicators assessed through observation? Do quality measures perform as expected? (e.g., do subscales emerge as intended by the authors of the measures?) Do measures of similar standards relate more closely to each other than to other measures? Do measures relate to each other in ways consistent with theory? Do different cut scores produce better rating distributions (e.g., programs across all levels rather than programs at only one or two levels) or more meaningful distinctions among programs?</td>
<td>This validation activity is especially important given that some component measures were likely developed in low-stakes settings and have not been examined in the context of QRIS.</td>
</tr>
<tr>
<td>Approach</td>
<td>Activities and Purpose</td>
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<td>Issues and Limitations</td>
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<tr>
<td><strong>3. Assess the outputs of the rating process</strong></td>
<td>Examine variation and patterns of program-level ratings within and across program types to ensure that the ratings are functioning as intended. &lt;br&gt;Examine relationship of program-level ratings to other quality indicators to determine if ratings are assessing quality in expected ways. &lt;br&gt;Examine alternate cut points and rules to determine how well the ratings distinguish different levels of quality.</td>
<td>Do programs with different program-level ratings differ in meaningful ways on alternative quality measures? &lt;br&gt;Do rating distributions vary by program type, e.g., ratings of center-based programs compared to ratings of home-based programs? Are current cut scores and combining rules producing appropriate distributions across rating levels?</td>
<td>These validation activities depend on a reasonable level of confidence about the quality components, standards and indicators as well as the process used to designate ratings.</td>
</tr>
<tr>
<td><strong>4. Examine how ratings are associated with children’s outcomes.</strong></td>
<td>Examine the relationship between program-level ratings and selected child outcomes to determine whether higher program ratings are associated with better child outcomes.</td>
<td>Do children who attend higher-rated programs have greater gains in skills than children who attend lower-quality programs?</td>
<td>Appropriate demographic and program level control variables must be included in analyses to account for selection factors. &lt;br&gt;Studies could be done on child and program samples to save resources. &lt;br&gt;Findings do not permit attribution of causality about QRIS participation but inferences can be made about how quality influences children’s outcomes.</td>
</tr>
<tr>
<td>Approach</td>
<td>Data needed</td>
<td>Data sources</td>
<td>Analysis methods</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Examine the validity of key underlying concepts</td>
<td>Evidence about the relationship between key quality standards and desired outcomes.</td>
<td>Empirical literature on how proposed components contribute to high quality care and improved child outcomes.</td>
<td>Synthesis of available data relating to each component; Analysis of degree to which evidence meets criteria for relatedness; Consensus process; Decision rules that specify the value of components without an established evidence base.</td>
</tr>
<tr>
<td></td>
<td>Expert opinions about proposed quality standards and indicators.</td>
<td>Experts in early childhood education who can provide input on the quality standards and indicators.</td>
<td></td>
</tr>
<tr>
<td>2. Examine the measurement strategies and psychometric properties of the measures used to assess quality.</td>
<td>Rating data from participating programs.</td>
<td>Most such data are collected as part of program ratings.</td>
<td>Distribution of provider scores on a given component; Correlations among components; Correlations of selected components with other measures.</td>
</tr>
<tr>
<td></td>
<td>Data from additional quality measures.</td>
<td>Additional quality measures may be collected to allow comparisons with measures being used in the QRIS.</td>
<td></td>
</tr>
<tr>
<td>3. Assess the outputs of the rating process</td>
<td>Program-level ratings from participating programs.</td>
<td>Most of the necessary data are collected as part of program ratings.</td>
<td>Examination of rating distributions by program type; Correlations of program ratings with other measures; Changes in rating distributions using different cut scores.</td>
</tr>
<tr>
<td></td>
<td>Raw scores from measures of quality that are included in the rating.</td>
<td>Another measure of quality may be administered to allow comparisons with program ratings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data from additional quality measures that are not included in the rating.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Relate ratings to expected child outcomes.</td>
<td>Program rating data from participating programs.</td>
<td>Program rating data are collected as part of program ratings.</td>
<td>Estimate the relationship between program ratings and child outcomes.</td>
</tr>
<tr>
<td></td>
<td>Assessments of child functioning.</td>
<td>Trained, reliable independent assessors collect data from individual children (may be a designated sample).</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Teacher reports on individual children.</td>
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</tbody>
</table>

**Approach 1: Examine the validity of key underlying concepts.** This approach involves examination of the elements or concepts that are to be included in program ratings. It is an important validation activity because it provides the foundation for the quality components, standards and indicators that together will produce program-level ratings and that will be the focus of quality improvement activities. Together, the components included in ratings, (e.g., staff qualifications, learning environment, family engagement) define quality for the QRIS. This validation activity provides justification and support for the elements of the QRIS. If the examination includes stakeholders, the process can also promote buy-in for the QRIS.
This validation approach asks whether quality components, standards and indicators included in a QRIS are the “right” ones, and is similar to what is proposed in the Toolkit, under Validating Quality Standards (Lugo-Gil et al., 2011). Because this effort addresses the cornerstone concepts and measures of the QRIS, it ideally would be conducted prior to the implementation of the QRIS.

For QRISs, the key concept is quality of care. The quality of care in early childhood education and school-aged care (ECE-SAC) programs is a complex, multi-dimensional construct; this complexity is amplified in centers by the fact that programs are comprised of multiple classrooms staffed by multiple individuals. Quality can be operationalized using a number of specific quality components. However, most QRISs have adopted similar ones. The QRIS Compendium found that six quality components were included in the majority of the 26 QRIS that were examined (Tout et al., 2010). These categories include licensing compliance (26 QRISs), classroom environment (24 QRISs), staff qualifications (26 QRISs), family partnership (24 QRISs), administration and management (23 QRISs) and accreditation (21 QRISs). Three categories—curriculum (14 QRISs), ratios and group size (13 QRISs), and child assessment (11 QRISs)—are included in half or just under half of the QRISs assessed. However, while similarities exist in the general quality components included in QRISs, the way in which each of these components of quality is measured varies substantially.

One activity that can help to validate a QRIS’ underlying concepts involves assessing the degree to which the quality components in the QRIS rating include standards and indicators that have an empirical base linking them to key program, family and child outcomes. This assessment might include an examination of the degree to which each element as operationalized in the QRIS is viewed by experts as a valid measure of the component. A number of states (including Delaware, Rhode Island, Minnesota and Virginia) have used a systematic expert review process to help identify which quality components (and the standards and indicators that comprise each component) to include in their QRIS. Attention might also be paid to the views of programs and parents about the degree to which selected components reflect their priorities. For example, focus groups with parents were conducted in Minnesota to inform the development of the final rating tool used in the QRIS pilot (Minnesota Department of Education and Minnesota Department of Human Services, 2007)

Another activity which is part of this approach involves examining the research literature to determine the level of empirical support for each proposed component. This review would examine the research base on the proposed standards and indicators selected to represent program quality. The review would weigh the existing evidence and provide arguments for why a particular quality component should be included or excluded from the QRIS.

Purdue University’s scientific review of the quality standards contained in Paths to Quality, Indiana’s QRIS, demonstrates this approach. The overall goal of the review was to conduct an “external evaluation of the scientific validity” of the Paths to Quality standards (Elicker et al., 2007). The study included review of available evidence for the importance of each of the four quality components—Health and Safety, Learning Environment, Planned Curriculum, and National Accreditation— and the relationship of the standards and indicators of each component to other measures of quality and to children’s development and well-being. The review used standards of evidence to classify each proposed indicator. For example, one or two well-designed studies that supported the indicator was classified as “some evidence;” “substantial evidence” required more than five such studies. For three-quarters of the indicators, researchers found “substantial evidence” that they supported children’s development.
Like many validation activities, such reviews ideally would be updated from time to time to determine if revisions to the QRIS would be advisable in light of new research findings. Such a review might utilize such tools as the *QRS Compendium* (Tout et al., 2010) or *Caring for Our Children* (AAP/APHA/NRC, 2011) as well as other recently published findings.

**Approach 2: Examine the measurement strategies and the psychometric properties of the measures used to assess quality.** A second type of validation effort focuses on the attributes of the individual measures in the QRIS as well as on the way in which the measures are combined to produce the summary rating of program quality. This approach is similar to what is discussed in the QRIS Evaluation Toolkit under *Validating the Construction of Quality Levels* (Lugo-Gil et al., 2011). This approach addresses how well the measures are working in the context of the QRIS. These efforts ask questions such as, “is there evidence that a given indicator measures what it purports to measure?” “If it claims to have a specific number of dimensions, do we find those dimensions in our data?” “Is there sufficient variance in scores on this indicator to justify its inclusion in the QRIS?” “Do scores on the indicator covary in expected ways with other measures of quality?”

Efforts to address these issues might involve an assessment of the distribution of participating provider scores on a given rating element. For example, in Zellman et al.’s (2008) evaluation of Colorado’s QRIS, initial work revealed that the measure of family engagement then in use produced very little variation across programs; all programs achieved the highest score possible on this measure. This meant that the QRIS was expending substantial resources to collect data on a measure that did not differentiate among programs. Another validation activity might involve an assessment of the relationship of a given indicator to other indicators of quality, both those included in the QRIS and others. In such studies, it is important to look at the degree of correlation found: ideally, measures would be moderately correlated so that each measure provides some non-redundant program quality information (see Zellman et al., 2008 for an example). Correlation patterns also should make sense. For example, two measures of interaction quality should be more closely related to each other than to a measure of ratios. If such studies reveal for example that the correlation between ratios and interaction processes is very high, this result might argue for eliminating one or the other indicator from the QRIS, as they may not be providing additional information (although some QRISs include certain elements to ensure that they are paid attention to, even if their psychometric properties are not ideal).

The research literature provides limited guidance concerning the most appropriate ways to combine measures of quality elements into summary ratings (Lugo-Gil et al., 2011; Tout et al., 2009; Zellman et al., 2008). Yet this process is crucial to producing meaningful program quality ratings, which are the key output of the rating process. States that are collecting and combining data could use these data to conduct studies that examine the effects of altering cut scores or combination rules, much as Karoly and Zellman (2012) have done in a “virtual pilot” for California’s QRIS, using data collected for another purpose, or as was done in studies in Minnesota (Tout et al., 2011) and Kentucky (Isner et al., 2012). These efforts will help QRIS designers and policy makers consider how well indicators are working, which indicators appear to be picking up variations in quality, and how closely different indicators relate to each other.

A number of other existing studies examine the properties of proposed QRIS indicators and can provide guidance to QRIS validation efforts (Scarr, Eisenberg, & Deater-Decker, 1994; Zellman & Perlman, 2008; Tout et al, 2011; McWayne & Melzi, 2011). Additionally, tools exist to help QRIS stakeholders review the options for QRIS measures and to support decision-making about the inclusion of new measures. For example, a Quality Measures Compendium is available and updated on a regular basis (Halle, Vick-Whittaker, & Anderson, 2010). If promising new measures are developed, it might be worthwhile to examine the performance of a new measure against the measure in current use.
**Approach 3: Assess the outputs of the rating process.** A third validation approach focuses on assessing the outputs of the rating system: the scores and levels that are assigned to providers who undergo a rating. Studies conducted under this approach examine the degree to which the quality levels in the QRIS are meaningfully distinct from each other. The results of these studies may indicate that measures, cut scores, or rules for combining measures need changing in order to distinguish quality levels effectively. Because these studies can result in proposals for significant changes to the composition of QRIS levels, it is helpful for these studies to occur prior to studies that examine associations between quality levels and children’s development.

Output studies may focus on individual indicator scores, such as how providers score on an environmental rating, as well as on the program-level score that is the final output of the rating process. Studies conducted as part of this approach ask questions like, “are providers that received four stars actually providing higher quality care than those that earned three stars?” Studies using this approach may also address questions about cut scores, e.g., “do different cut scores produce dramatically different program-level ratings, and if so, which cut scores produce distributions that most closely relate to other measures of quality?” These studies typically rely on a measure of quality not included in the QRIS to make this assessment, and examine whether assessments on both measures vary in predictable ways.

The University of Southern Maine is conducting a validation study of Maine’s QRIS to assess similarities and differences across program ratings; the study is also examining what if any differences exist between similar types of programs at different step levels (see Lahti et al., forthcoming, for further details on this study and several others.) For example, researchers in Maine administer the Environment Rating Scales (ERS; Harms & Clifford; 1989; Harms, Clifford & Cryer, 2005; Harms, Cryer & Clifford, 2006; Harms, Cryer & Clifford, 2007 ), which are not used to establish a rating in Maine’s QRIS, and examine whether there are statistically significant differences in ERS scores between programs at different rating levels. These findings help program designers determine if the quality levels determined by QRIS ratings relate in expected ways to an external measure of global quality.

As a second example of validation studies using this approach, Karoly and Zellman (2012) used data collected for another purpose to model some of the features of a newly-designed California QRIS. The data come from a 2007 survey of center-based providers that is representative of the state. Observations were conducted in 251 centers serving children birth to 5. The purpose of this “virtual pilot” study was to determine the likely distribution of programs across QRIS tiers using specified cut points, examine the association among quality components, and to identify “outlier” quality elements on which otherwise well-rated programs tend to score poorly. This information is very valuable at the design phase; data on “outlier” elements is particularly helpful in understanding what it will take for programs to improve their rating in a QRIS that uses a block design to designate ratings (in which all indicators at one level must be met before a rating at the next level is possible). By examining such things as the relationship between scores on the Classroom Assessment Scoring System (CLASS; Pianta, La Paro & Hamre, 2008) and the Early Childhood Environment Rating Scale - Revised (ECERS-R; Harms, Clifford & Cryer, 2005), and the relationship between staff education and training and other measures of quality, the work can help policymakers assess the value of different measures of quality, provide input into establishing cut scores, and suggest targets for technical assistance efforts.
Other states also have conducted validation studies that focus closely on differences in QRIS levels. For example, Pennsylvania has studied programs participating in the Keystone STARS QRIS (Fiene, Greenberg, Bergsten, Fegley, Carl, & Gibbons, 2002; Barnard, Smith, Fiene, & Swanson, 2006; OCDEL (Office of Child Development and Early Learning), 2010; Manlove, Benson, Strickland, & Fiene, 2011) to determine if their program ratings were indicative of quality differentials across program types and services. Similarly, recent work in Indiana (Elicker, Langill, Ruprecht, Lewsader & Anderson, 2011) found that ERS scores varied with program-level ratings, while research in Minnesota found significantly higher scores on the ERS and CLASS only between the highest level (4-star) of the QRIS and the other rating levels (2- and 3-stars) (Tout et al., 2011). These findings are being used by program developers to make needed adjustments to quality indicators, metrics and cut scores.

**Approach 4: Relate ratings to children’s development.** A fourth approach to validation focuses on children’s development. It is similar to the Toolkit’s Linkages between quality levels and desired outcomes, although it focuses more narrowly on child outcomes. For QRISs, the logic model asserts that higher quality care will be associated with better child outcomes. Therefore, one important piece of validation evidence concerns whether children make greater developmental gains in programs with higher program-level ratings than in programs with lower ratings.

Studies using this approach do not attempt to identify causal linkages between QRIS participation and children’s outcomes. Instead, they examine whether the QRIS ratings and quality components that comprise the ratings are related in expected ways to measures of children’s development. Appropriate designs and controls could allow causal inferences to be made about how quality (as measured and rated by the QRIS) influences children’s outcomes.

To date, few QRIS validation studies have incorporated children’s outcomes as they are costly and difficult to conduct. As Elicker and Thornburg (2011) note, results from such studies are mixed, at least in part because of the challenges of conducting them. A primary challenge is the inability to control for all the factors that may vary between children whose families have selected different programs. Additional challenges include recruitment of programs and children across all quality levels; availability of appropriate outcome measures for children of diverse ages, abilities, cultures and linguistic backgrounds; and, lack of variation in the quality of participating QRIS programs.

In Missouri, children who participated in programs with higher quality ratings showed significantly greater gains on measures of social-emotional development compared to children in programs with lower ratings (Thornburg et al., 2009). These effects were even more pronounced for low-income children. However, in an evaluation of Colorado’s QRIS, linkages between the ratings and children’s outcomes were not found (Zellman et al., 2008). Recent reports from Indiana (Elicker, Langill, Ruprecht, Lewsader, & Anderson, 2011) and Minnesota (Tout et al., 2011) found no consistent relationships between program ratings and measures of child outcomes. A number of possible explanations were offered for the lack of expected linkages, including overall low levels of quality in participating QRIS programs (perhaps not meeting a threshold of quality necessary to detect linkages with child outcomes; see Zaslow et al., 2010 for further discussion of quality thresholds) and a lack of variation among participating programs and families. Yet, even with these limitations, program administrators in both Indiana and Minnesota have used the findings to recommend changes to the structure and content of the QRIS.
Developing a Validation Plan

Given the complexity of validation, it is advisable to develop a plan for system validation as early as possible in the QRIS design process. Ideally, the validation plan will be part of a larger evaluation plan designed to address a wider range of important questions the answers to which will guide refinement of the QRIS and its implementation. The plan should include the key questions that will be addressed and the methods to be used to address each one. One advantage of developing a plan early is that it may highlight opportunities to conduct a number of the proposed efforts as part of the implementation of the QRIS itself or as part of planned evaluation activities. A comprehensive approach to validating a QRIS ideally will include studies under each of the four approaches described above. Table 3 outlines issues in the timing of validation studies, discusses their relative cost, and suggests strategies for addressing validation questions if resources do not permit the implementation of validation studies.

Table 3. Considerations in Developing a Validation Plan

<table>
<thead>
<tr>
<th>Approach</th>
<th>Timing and Duration</th>
<th>Cost considerations</th>
<th>Options to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Examine the validity of key underlying concepts</td>
<td>Ideally conducted prior to QRIS implementation. Study should be able to be completed within 3-6 months.</td>
<td>Relatively inexpensive. This work can be contracted to a local university, consultant or research firm.</td>
<td>Many states are using similar concepts and measures; their efforts will provide useful information.</td>
</tr>
<tr>
<td>2. Examine the measurement strategies and psychometric properties of the measures used to assess quality</td>
<td>Must wait until ratings are implemented, although individual measures themselves might be available from other sources and could be examined earlier.</td>
<td>Depends on data quality and amount of analysis. Additional measures will increase costs, particularly if the measure is observational.</td>
<td>Can rely to some extent on existing research on each of the components. Consider using available data for a “virtual pilot.”</td>
</tr>
<tr>
<td>3. Assess the outputs of the rating process</td>
<td>Must wait until ratings are implemented. Once data are available, several studies could be conducted using the same data set.</td>
<td>Depends on data quality and amount of analysis. Additional measures will increase costs, particularly if the measure is observational.</td>
<td>This work is state system-dependent so is not readily borrowed, though lessons learned about structure and cut-points can be shared across QRISs.</td>
</tr>
<tr>
<td>4. Relate ratings to children’s development</td>
<td>Best to launch these studies when the QRIS rating process is stable and adequate numbers of programs have been rated.</td>
<td>Costs for the collection of child data are very high. Study could be done just with one cohort of children and two rounds of data collection (fall and spring) to assess developmental gains.</td>
<td>Requires significant funds, a powerful research design, and research expertise. Sampling children and programs will substantially reduce costs.</td>
</tr>
</tbody>
</table>
Summary and Conclusions

Validation is a complex, ongoing, iterative process. The objective of validation activities is to understand whether the rating process is able to distinguish among programs of different quality levels and whether program ratings are associated in meaningful ways to children’s outcomes.

Validation activities help to determine whether key design decisions are working well in practice. States and localities that have implemented QRISs are expending substantial resources to train raters, fund ratings, support various forms of technical assistance, and provide a range of improvement incentives. All of these efforts assume that the ratings are accurate and the system is performing as intended. QRIS design decisions often rely heavily on the judgments of experts and on colleagues in other states, because there is limited empirical data on which to base them. For this reason, it is critical for states to set in place a process for assessing how well the design decisions underlying the system are working. Validation activities do this.

Ideally, validation is an ongoing process based on a carefully designed validation plan. The plan should include all four validation approaches, although resource constraints may limit these efforts, and may particularly limit studies that include child outcomes. A good validation plan, thoughtfully developed and implemented, can provide information critical to improving the system at many points in the process, and increase the odds of its ultimate success. Validation is unquestionably challenging, but no more so than the launch and operation of a QRIS or its evaluation. The networks and references in the next section can help states develop a deeper understanding of validation approaches and help them construct and implement validation plans that address stakeholder and system needs and produce timely and valuable information.

Resources and References

Resources

INQUIRE – Quality Initiatives Research and Evaluation Consortium
The purpose of INQUIRE is to support high quality, policy-relevant research and evaluation on Quality Rating and Improvement Systems and other quality initiatives by providing a learning community and resources to support researchers and evaluators. INQUIRE also provides input and information to state administrators and other policymakers and practitioners on evaluation strategies, new research, interpretation of research results, and implications of research for practice. Research briefs are available on topics related to QRIS evaluation issues and strategies.

CCEERC – Child Care and Early Education Resource Connections
http://www.childcareresearch.org/ search under Quality Rating and Improvement Systems.
This site has many additional reports and resources, such as:

This resource list is an annotated bibliography of selected research focused on the design, implementation, and evaluation of Quality Rating Systems and Quality Rating and Improvement Systems in early childhood and after school settings.
The Child Care Quality Rating System (QRS) Assessment


Describing 26 Quality Rating Systems nationwide (19 statewide and 7 local or pilot), the Compendium presents comprehensive information through cross-QRS matrices and individual QRS profiles.


The QRS Assessment Toolkit will provide guidance, recommendations and evaluation support on a range of topics including: development of a logic model and research questions, evaluation design and methods, and selection of measures.

QRIS National Learning Network

http://qrisnetwork.org/

The Network provides information, learning opportunities, and direct technical assistance to states that have a QRIS or that are interested in developing one. Its National Resource Library assists states in learning more about QRIS and their elements and in QRIS planning. The library contains, toolkits, handouts and published documents on a variety of searchable topic areas.

The Networks’ State Resource Library contains detailed QRIS implementation information, including training guides, forms, and technical assistance materials that individual states have developed for their QRIS.

State QRIS Contacts who have agreed to serve as peer resources for one another are listed, as are Technical Assistance Providers.

Additional Resources


This report will provide case studies of four states that have undertaken validation studies in their respective states. This report provides validation and evaluation approaches, identification of similar QRIS standards amongst the four states, description of cross case analysis QRIS validity issues and the results of the validation conceptual model from this brief examining the following: concepts of quality, measures used to assess quality, outputs or scores of the rating process, and if ratings are related to expected outcomes. It is the companion document to supplement this guide in which four states validation experiences are highlighted.
The Quality in Early Childhood Care and Education Settings: A Compendium of Measures, Second Edition was compiled by Child Trends for the Office of Planning, Research and Evaluation of the Administration for Children and Families, U.S. Department of Health and Human Services, to provide a consistent framework with which to review the existing measures of the quality of early care and education settings. The aim is to provide uniform information about quality measures. It is hoped that such information will be useful to researchers and practitioners, and help to inform the measurement of quality for policy-related purposes.

References


Endnotes

I Validity is not attached to a measure, but to a measure used for a particular purpose in a particular context. This means that measures which may be valid for one use must be validated again for use in a different context (AERA, APA, & NCME, 1999). Measures developed in low-stakes contexts, e.g., for use in research or program self-assessments, must be validated again in high-stakes contexts because those being assessed may react in high-stakes contexts in ways that could undermine the meaningfulness of interpretations derived from those measures (AERA, APA, & NCME, 1999).

II Some components such as parent involvement have been included in QRISs even when strong empirical support of the ability of measures to distinguish among programs of different quality was lacking because designers believed that if they were not, programs would ignore these components in favor of measured ones.

III Random assignment of children to programs with different quality ratings is not possible in QRIS. Alternative analytic approaches must be used that employ adequate controls for selection bias. See Zellman and Karoly (2012) for further discussion of this approach.

IV This column recognizes that state budgets are limited and validation is rarely seen as the highest priority. Ideally, states might combine data and efforts to conduct some of these studies.

V Ideally, states might combine data and efforts to conduct some of these studies.

VI However, as noted above, measures collected in low-stakes and high-stakes settings cannot be assumed to be comparable.

VII It may be possible to use existing data to test assumptions and measures. See, for example, Karoly and Zellman (2012), for a description of such work in California.
A Comparison of International Child Care and US Child Care Using the Child Care Aware – NACCRRRA (National Association of Child Care Resource and Referral Agencies) Child Care Benchmarks

Richard Fiene, Ph.D.
Affiliated Faculty
Prevention Research Center
The Pennsylvania State University

This is a first of its kind study comparing the USA to other world countries utilizing the Child Care Aware – NACCRRRA Child Care Benchmarks related to health and safety rules and regulations. A team of researchers analyzed the child care/early care & education rules and regulations from the USA and a selected group of countries to do a comparative analysis using the Child Care Aware – NACCRRRA benchmarking scoring protocol. The results from the analyses were somewhat unexpected in that the scores between the USA and the other countries were not as statistically significant in the overall scores. However, when more specific benchmarks were compared statistically significant differences did appear in the health & safety and professional development areas.

Key words: Child Care Quality, Comparisons of USA and International Child Care, Child Care Regulations.

Introduction

The purpose of this paper is to compare several countries (N =20) and the United States on the Child Care Aware – formerly NACCRRRA (National Association of Child Care Resource and Referral Agencies) Child Care Benchmarks that have used extensively in the USA to compare state regulatory and monitoring policy and implementation. The use of these benchmarks has been very useful in comparing states in the USA on an agreed upon series of child care benchmarks that have a great deal of support in the research literature (AAP/APHA, 2012, 2013; NACCRRRA 2007, 2009, 2011). Previous research (OCED, 2006) has focused on early care and education policies in other countries which was a very important
first step in making comparisons across countries. This paper will expand upon this comparison in order to begin applying the NACCRRA benchmarks to other countries and establish a baseline between the USA and other countries related to regulatory review and analysis. This study is important because it provides a common rubric for making comparisons between the USA and other countries that is reliable and valid (NACCRRA 2007, 2009, 2011) related to regulatory analysis. As far as the author can determine from his extensive review of the literature, similar studies of this type have not been attempted utilizing a standardized rubric created by a major national child care organization. There have been other studies completed in which comparisons were made of other countries, the OCED (2006) Starting Strong II study and report is an excellent example of this type of

DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

CI x PQ => RA + KI => DM

Definitions of Key Elements:
CI = Comprehensive Licensing Tool (Health and Safety) (Caring for Our Children)
PQ = ECERS-R, FDCRS-R, CLASS, CPDES (Caregiver/Child Interactions/Classroom Environment)
RA = Risk Assessment, (High Risk Rules) (Stepping Stones)
KI = Key Indicators (Predictor Rules) (13 Key Indicators of Quality Child Care) (NACCRRA Benchmarks)
DM = Differential Monitoring (How often to visit and what to review)

Figure 1.
A Comparison of International Child Care and US Child Care Using the Child Care Aware – NACCRRA Child Care Benchmarks

analysis and is recommended reading for anyone interested in reviewing public policy analyses.

The child care benchmarks\(^1\) utilized in this study are based upon the following key indicators: prevention of child abuse, immunizations, staff child ratio, group size, staff qualifications and training, supervision/discipline, fire drills, medication administration, emergency plan/contact, outdoor playground, inaccessibility of toxic substances, and proper hand washing/diapering (NACCRRA 2007, 2009, 2011). These benchmarks are more based upon the structural aspects of quality rather than on the process aspects of quality. This is an important distinction between the USA approach and the other countries approaches that becomes important in the explanation of results later in this paper.

This paper also supports and expands the development of an Early Childhood Program Quality Indicator Model (ECPQIM)(Fiene & Nixon, 1985) which is in a 4th generation (Fiene, 2013) as a differential monitoring logic model & algorithm helping to guide the program monitoring of child care/early care & education programs (see Figure 1).

Method

Data Collection Process

Data collection was done on a 100 point scale which is delineated in Appendix 1 as developed by the Child Care Aware – NACCRRA Research Team. The same scoring protocol that was utilized in developing the 2007, 2009, and 2011 Reports and comparisons of states by Child Care Aware - NACCRRA was employed in this study in comparing the average scores of the states and the 20 countries. The 100 point scale consisted of 10 child care benchmarks each worth 10 points: ACR = Staff child ratios NAEYC Accreditation Standards met (R1); GS = Group size NAEYC Accreditation Standards met (R2); Director = Directors have bachelor’s degree (R3); Teacher = Lead teacher has CDA or Associate degree (R4); Pre = Initial orientation training (R5); Inservice = 24 hours of ongoing training (R6); Clearance = Background check (R7); Devel = Six developmental domains (R8); Health = Health and safety recommendations (R9); and Parents = Parent Involvement (R10).

Data Scoring

The scoring protocol employed a total raw score approach of 100 points that was used to compare the countries on the 10 child care benchmarks in the aggregate. The scoring protocol also employed a standardized scoring approach (0 to 2 points) on each of the 10 child care benchmarks utilizing the following scale: 0.0 = Does not meet the Child Care Aware – NACCRRA Benchmarks; 0.5 = Marginally meets the Child Care Aware – NACCRRA Benchmarks; 1.0 = Partially meets the Child Care Aware – NACCRRA Benchmarks; 1.5 = Substantially meets the Child Care Aware – NACCRRA
Benchmarks; 2.0 = Fully meets the Child Care Aware – NACCRRRA Benchmarks.

Data Collectors
A team of undergraduate and graduate research assistants at the Pennsylvania State University were the data collectors in which each of them reviewed the child care/early childhood rules/regulations/standards from a specific country and scored the rules/regulations/standards on the Child Care Aware – NACCRRRA 100 point raw score protocol and the standardized (0 – 2) scoring approach.

Data Sources
The child care regulations selected were for preschool age children only in child care center setting in the 20 countries. Geographically the governmental jurisdiction closest to the national capital was used if applicable national regulations could not be found. More than the final 20 countries selected were reviewed but several countries needed to be dropped because they did not meet the above criteria or the regulations could not be found in English. This was more a convenience sample rather than a stratified scientific sample, a limitation of this study.

Results
The results from this study and analysis were totally unexpected. The results indicated no statistically significant differences between the USA and the other countries selected (Australia, Belgium, Norway, Finland, Sweden, Ireland, United Kingdom, Italy, France, New Zealand, Mexico, Greece, Canada, Austria, Portugal, Philippines, Turkey, Pakistan, Nigeria, Denmark, and Spain – these countries were selected because of their availability of child care/early care & education rules and regulations as described previously above in Data Sources) when comparing the total scores on the 100 point scale; the USA average for all 50 states scored 58 while the 20 countries average score was 56. However, a very different scenario occurs when looking at the ten individual child care benchmarks using the standardized 0 – 2 scoring protocol. The 20 countries selected in this study scored statistically higher on the following child care benchmarks: Director (t = 7.100; p < .0001) and Teacher (t = 7.632; p < .0001) qualifications. The USA scored statistically higher on the following child care benchmarks: Health/Safety (t = 6.157; p < .0001), Staff Clearances (t = 3.705; p < .01), and Pre-Service (t = 4.989; p < .001) /In-Service training (t = 2.534; p < .02) (See Table 1 & Figure 2).

The results showed that both the USA and all other countries mean scores were 58 and 56 respectively on the 100 point scale – this is a raw scale score and not the standardized score (0 – 2 – see Table 1 and Figure 2) which was used in the comparisons for each benchmark. This is not a particularly good score if you think in terms of exams, but for states and countries with
A Comparison of International Child Care and US Child Care Using the Child Care Aware – NACCRRA Child Care Benchmarks

Table 1
Mean Comparisons between USA and Twenty Countries on Child Care Aware – NACCRRA Benchmarks

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Countries</th>
<th>USA</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACR (R1)</td>
<td>1.122</td>
<td>0.8462</td>
<td>not significant</td>
</tr>
<tr>
<td>GS (R2)</td>
<td>0.4063</td>
<td>0.5865</td>
<td>not significant</td>
</tr>
<tr>
<td>Director (R3)</td>
<td>1.5625</td>
<td>0.5</td>
<td>t = 7.100; p &lt; .0001</td>
</tr>
<tr>
<td>Teacher (R4)</td>
<td>1.6563</td>
<td>0.4038</td>
<td>t = 7.632; p &lt; .0001</td>
</tr>
<tr>
<td>Preservice (R5)</td>
<td>0.9375</td>
<td>1.6731</td>
<td>t = 4.989; p &lt; .001</td>
</tr>
<tr>
<td>Inservice (R6)</td>
<td>0.6563</td>
<td>1.0481</td>
<td>t = 2.534; p &lt; .02</td>
</tr>
<tr>
<td>Clearances (R7)</td>
<td>0.6094</td>
<td>1.2404</td>
<td>t = 3.705; p &lt; .01</td>
</tr>
<tr>
<td>Development (R8)</td>
<td>1.6406</td>
<td>1.4519</td>
<td>not significant</td>
</tr>
<tr>
<td>Health (R9)</td>
<td>0.9844</td>
<td>1.7404</td>
<td>t = 6.157; p &lt; .0001</td>
</tr>
<tr>
<td>Parent (R10)</td>
<td>1.5000</td>
<td>1.5385</td>
<td>not significant</td>
</tr>
</tbody>
</table>

Legend:
Child Care Aware - NACCRRA Benchmarks:
Parent = Parent Involvement (R10)
Health = Health and safety recommendations (R9)
Development = Six developmental domains (R8)
Clearances = Background check (R7)
Inservice = 24 hours of ongoing training (R6)
Preservice = Initial orientation training (R5)
Teacher = Lead teacher has CDA or Associate degree (R4)
Director = Directors have bachelor’s degree (R3)
GS = Group size NAEYC Accreditation Standards met (R2)
ACR = Staff child ratios NAEYC Accreditation Standards met (R1)

Scoring:
0.0 = Does not meet Child Care Aware – NACCRRA Benchmarks.
0.5 = Marginally meets Child Care Aware – NACCRRA Benchmarks.
1.0 = Partially meets Child Care Aware – NACCRRA Benchmarks.
1.5 = Substantially meets Child Care Aware – NACCRRA Benchmarks.
2.0 = Fully meets Child Care Aware – NACCRRA Benchmarks.

vastly complex bureaucracies maybe this isn’t as bad as it looks. Could it be that the USA is better than we think or is it that the USA and all other countries are providing just mediocre child care?!

The reason for using aggregate data in this study was to be consistent in how data have been collected in the USA utilizing the Child Care Aware – NACCRRA Scoring Protocol. This did delimit the potential analyses for this study and the recommendation would be made in future studies to unbundle the results so that more detailed comparisons could be made. As mentioned in the introduction, the purpose of this study was to provide an initial baseline comparison between the USA and other countries on the Child Care Aware – NACCRRA Scoring Protocol.
Discussion

The purpose of this study was to extend the Child Care Aware - NACCRRRA Child Care Benchmarks Scoring Protocol to an international sample comparison. As has been done by the National Science Foundation with math and science testing, these same types of comparisons have been made with the USA not fairing all that well on the math and science comparisons.

It appears that when it comes to child care benchmarks the USA actually appears to be in better shape than many advocates and experts would have thought when compared to other countries or is it that the other countries are providing the same form of mediocre care as it relates to these child care benchmarks. Remember that these benchmarks are heavily weighted towards the structural side of quality.

Legend:
Child Care Aware - NACCRRRA Benchmarks:
Parents = Parent Involvement (R10)
Health = Health and safety recommendations (R9)
Devel = Six developmental domains (R8)
Clearance = Background check (R7)
Inservice = 24 hours of ongoing training (R6)
Pre = Initial orientation training (R5)
Teacher = Lead teacher has CDA or Associate degree (R4)
Director = Directors have bachelor’s degree (R3)
GS = Group size NAEC Accreditation Standards met (R2)
ACR = Staff child ratios NAEC Accreditation Standards met (R1)

Scoring:
0.0 = Does not meet Child Care Aware – NACCRRRA Benchmarks.
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1.5 = Substantially meets Child Care Aware – NACCRRRA Benchmarks.
2.0 = Fully meets Child Care Aware – NACCRRRA Benchmarks.

Figure 1. Mean Comparisons between USA and Twenty Countries on Child Care Aware – NACCRRRA Benchmarks
rather than the process side of quality. However, when the individual benchmarks are analyzed then certain patterns occur which seem very consistent with the previous research literature. The 20 countries scored higher on the staffing benchmarks while the USA scored higher on the training and health/safety benchmarks. Clearly this is an indication reflecting public policy in the other countries as versus the USA. Many other countries place more emphasis on the process aspects of quality which involve staff and staff interactions with children. The USA has focused more on the structural aspects of quality which involve health & safety especially in the state licensing of child care. These structural aspects of quality are more easily quantifiable in state rules and regulations which is the locus of control for the licensing of child care. Since the USA does not have national standards that are required (the USA does have national health and safety standards that are recommended practice, such as Caring for Our Children (2012)) as is the case in so many of the countries in this study, this may provide a possible explanation for the results of this study. It will be interesting to see how Quality Rating and Improvement Systems (QRIS) which usually have some process standards impact this overall balance of structural and process aspects of quality. This is an area that needs additional research and more in-depth analysis.

So what does this tell us. I think it is a warning call as has been put forth by Child Care Aware - NACCRRA that we still have a lot of additional work to do in improving child care, not only in the USA, but worldwide. Just as the Child Care Aware -NACCRRA Report Cards (2007, 2009, 2011) have played a role in making positive change in the child care benchmarks over time; we need to expand this reporting and change to a world wide focus. There is clearly the need to expand from the present analysis of 20 countries and the USA to other countries throughout the world and to track changes over time as Child Care Aware/NACCRRA has done.

Another area of concern within the USA and I am sure in other countries as economies have begun their slow recovery from the economic downturn of 2008 – 2010 is to do more with less. One such approach being explored in the USA is called differential monitoring which helps to re-allocate limited resources in a more cost effective and efficient manner via a risk assessment and key indicator approach. I hope that this comparison utilizing the Child Care Aware – NACCRRA Benchmarking Scoring Protocol and introducing the Early Childhood Program Quality Indicator Model/Differential Monitoring Logic Model and Algorithm (Fiene, 2013) within an international context as first steps in making that happen.
References


Notes

1 In the licensing literature these child care benchmarks are usually referred to as key indicators (Fiene, 2013). Please see Figure 1 which delineates where within a program monitoring system these benchmarks would appear and could be utilized.

2 The following individuals played key data collection roles as research assistants in the compilation of this study: Melissa Cave, Ashley Le, Breanna Green, Corrie Podschline, Sherrie Laporta, Ashley Edwards, Laura Hartranft, Gissell Reyes, Janet Lazur, Kayma Freeman, Jessica White, Karen Mapp, and Lindsay Bitler.
Appendix 1

Benchmark criteria for *We Can Do Better: NACCRRRA Ranking of State Child Care Center Regulations:2011 Update* were developed by Child Care Aware - NACCRRRA and have been used for the 2007, 2009 and 2011 We Can Do Better reports. The rationale for each standard, including research evidence of its importance in quality care, is noted in each section of the report and in previous reports. Each of the 10 regulation benchmarks were scored with a value ranging from one to 10 points, depending on how closely the state met the benchmark, for a maximum total of 100 points. In cases where states permit several different options for complying (e.g., complying with director or teacher qualifications), the minimum allowed was used. This information was used to generate state sheets with scores for each standard.

<table>
<thead>
<tr>
<th>Question</th>
<th>Scoring method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regulation 1. Staff:child ratio requirements comply with NAEYC accreditation standards.</strong></td>
<td>Number of ratios in compliance with NAEYC standards</td>
</tr>
<tr>
<td>6 mo 9 mo 18 mo 27 mo 3 yr 4 yr 5 yr</td>
<td>7 ratios</td>
</tr>
<tr>
<td>1:4 1:4 1:4 1:4 1:9 1:10 1:10</td>
<td>6 ratios</td>
</tr>
<tr>
<td>5 ratios</td>
<td>8</td>
</tr>
<tr>
<td>4 ratios</td>
<td>7</td>
</tr>
<tr>
<td>3 ratios</td>
<td>5</td>
</tr>
<tr>
<td>2 ratios</td>
<td>3</td>
</tr>
<tr>
<td>1 ratios</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>R2. Group size requirements are in compliance with NAEYC accreditation standards.</strong></th>
<th>Number of group sizes in compliance with NAEYC standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mo 9 mo 18 mo 27 mo 3 yr 4 yr 5 yr</td>
<td>7 ratios</td>
<td>10</td>
</tr>
<tr>
<td>8 8 8 8 18 20 20</td>
<td>6 ratios</td>
<td>9</td>
</tr>
<tr>
<td>5 ratios</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>4 ratios</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>3 ratios</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2 ratios</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1 ratios</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
**R3.** Center directors are required to have a bachelor’s degree of higher in early childhood education or a related field.

<table>
<thead>
<tr>
<th>Director education requirement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s degree in any field</td>
<td>10</td>
</tr>
<tr>
<td>College directors certification</td>
<td>7</td>
</tr>
<tr>
<td>Any associate degree</td>
<td>5</td>
</tr>
<tr>
<td>CDA</td>
<td>5</td>
</tr>
<tr>
<td>Clock hours/less than associate degree</td>
<td>2</td>
</tr>
<tr>
<td>High school or less</td>
<td>0</td>
</tr>
</tbody>
</table>

**R4.** Lead teachers are required to have a Child Development Associate (CDA) credential or an associate degree in early childhood education or related field.

<table>
<thead>
<tr>
<th>Lead teacher education requirement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDA/associate degree or better</td>
<td>10</td>
</tr>
<tr>
<td>State Credential</td>
<td>5</td>
</tr>
<tr>
<td>Clock Hours in ECE</td>
<td>2</td>
</tr>
<tr>
<td>High School/GED</td>
<td>2</td>
</tr>
<tr>
<td>Less than High School</td>
<td>0</td>
</tr>
</tbody>
</table>

**R5.** Lead teachers are required to have initial training, including:
- Orientation.
- Fire safety.
- Other health and safety issues.
- At least one staff member certified in first aid must be present when children are in care.
- At least one staff member who is certified in CPR must be present when children are in care.

<table>
<thead>
<tr>
<th>Number of areas training is required</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five areas</td>
<td>10</td>
</tr>
<tr>
<td>Four areas</td>
<td>8</td>
</tr>
<tr>
<td>Three areas</td>
<td>6</td>
</tr>
<tr>
<td>Two areas</td>
<td>4</td>
</tr>
<tr>
<td>One area</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
</tbody>
</table>

**R6.** Lead teachers are required to have 24 hours or more of annual training.

<table>
<thead>
<tr>
<th>Ongoing training ≥</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hours</td>
<td>10</td>
</tr>
<tr>
<td>18 hours</td>
<td>7</td>
</tr>
<tr>
<td>12 hours</td>
<td>5</td>
</tr>
<tr>
<td>6 hours</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
</tbody>
</table>

**R7.** A comprehensive background check is required for child care providers.
- Use of fingerprints to check state records.
- Check FBI records.
- Check state child abuse registry
- Check sex offender registry.
- Criminal history check.

<table>
<thead>
<tr>
<th>Number of Background checks completed</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five checks</td>
<td>10</td>
</tr>
<tr>
<td>Four checks</td>
<td>8</td>
</tr>
<tr>
<td>Three checks</td>
<td>6</td>
</tr>
<tr>
<td>Two checks</td>
<td>4</td>
</tr>
<tr>
<td>One check</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
</tbody>
</table>
## Appendix 2

These were the countries included in these analyses: Australia, Belgium, Norway, Finland, Sweden, Ireland, United Kingdom, Italy, France, New Zealand, Mexico, Greece, Canada, Austria, Portugal, Philippines, Turkey, Pakistan, Nigeria, Denmark, Spain, and the USA which included all 50 states.
Approaches to validating child care quality rating and improvement systems (QRIS): Results from two states with similar QRIS type designs

Michel Lahti\textsuperscript{a,}\textsuperscript{*}, James Eicker\textsuperscript{b}, Gail Zellman\textsuperscript{c}, Richard Fiene\textsuperscript{a,b,c,1}

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\textsuperscript{b} Purdue University, United States
\textsuperscript{c} RAND Corporation, United States

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QRIS
Study design
Methodology

\textbf{A B S T R A C T}

In recent years, child care quality rating and improvement systems (QRIS) have become an increasingly popular policy tool to improve quality in early childhood education and care (ECEC) settings and have been adopted in many localities and states. The QRIS National Learning Network reports that 40 statewide QRISs have launched or piloted, including the District of Columbia (QRIS National Learning Network, 2014). The immediate goal of a QRIS is to raise the quality of care in early learning settings. Existing research suggests that care in higher-quality settings will improve child functioning, including school readiness (Burchinal et al., 2009; Burger, 2010; Howes et al., 2008), especially for children from lower-income families. QRIS logic models that guide these large-scale interventions focus on improving various dimensions of ECEC quality, with the ultimate goal of improving system outcomes, namely, child care program quality, training and technical assistance for child care providers, information and support for families, and, therefore, improvements to children’s cognitive, language, social, emotional, and physical development.

The perceived need for QRIS has grown out of documented gaps in quality in existing ECEC programs, especially those serving children from lower-income families (Fuller, Loeb, Kagan, & Carrol, 2004; NICHD ECCRN, 2000) and the inability of the current ECEC system to promote uniformly high quality (Cochran, 2007). QRISs produce program-level quality ratings based on multi-component assessments designed to make ECEC quality transparent and easily understood to parents and other stakeholders. Most also include feedback, technical assistance, and incentives to both motivate and support providers’ efforts toward quality improvement (Tout et al., 2010). To make program quality transparent, QRISs typically rely on a multi-tiered rating system with one to five levels of program quality. Therefore, it is important that these ratings show evidence of validity, so that higher-quality programs are rated higher, and lower-quality programs are rated lower.

Recent research has documented the importance of both specificity and thresholds when testing hypotheses about child care quality impacts on children’s developmental outcomes (Burchinal, Peisner-Feinberg, Bryant, & Clifford, 2000; Burchinal, Vandergrift, Pianta, & Mashburn, 2010; Howes, Whitebook, & Phillips, 1992; NICHD ECCRN, 2000, 2002). However, common global measures of classroom quality such as the Early Childhood Environment

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Rating Scale-Revised (ECERS-R; Harms, Clifford, & Cryer, 2005) are not always significantly associated with specific child outcomes (Burchinal, Kainz, & Cat., 2011). This may be because these global quality scales do not focus enough on the particular child care quality processes most likely to bring about improved child outcomes (specificity) or they do not provide guidance for the level of quality required to produce improved child outcomes (thresholds). As states implement QRISs, they are using observational measures such as the ECERS-R, and they may also combine other quality measures such as the Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008) or locally specified quality indicators. Because QRIS quality standards are often complex, including many components and measures at several quality levels, and because they vary from state to state, it is especially important for states to carefully validate their quality rating systems and match measures specifically to the stated outcome goals of the QRIS. For example, if a particular QRIS places more emphasis on the health aspects of children's development, then the ECERS-R and CLASS would not be appropriate tools; but a tool measuring child care health indicators, such as the National Health and Safety Tool being developed by the California Child Care Health Program (Alkon, 2013) would be more appropriate.

Validity data can also enable researchers to test conclusions about whether the quality indicators embedded in QRIS standards lead to adequate quality assessment and whether the methods used to assign quality ratings are working as intended (Cizek, 2007). This paper defines operationally the concept of QRIS validity, presents four general approaches to assessing validity in the context of large-scale QRISs, and critically examines the efforts of two states, Maine and Indiana, to assess the validity of recently implemented QRISs using these approaches.

Validation of a QRIS is a developmental and multi-step process that assesses the degree to which design decisions about program quality standards and measurement strategies are resulting in accurate and meaningful quality ratings. Validation of a QRIS provides designers, administrators, and stakeholders with crucial data about how well the system is functioning. A carefully designed plan for ongoing QRIS validation creates confidence in the system and a climate that supports continuous quality improvement at both the child care provider and system levels (Zellman & Fiene, 2012).

To date, QRIS validation research efforts have been limited, for a number of reasons. First, validation is complex and involves a range of activities, which should include validating standards, measures, and rating protocols. Second, there has been little information available in the field that clarifies the importance and purpose of QRIS validation or identifies recommended strategies. Third, child care quality advocates and policy makers have been extremely busy designing and implementing these statewide systems, often with limited resources. Given these constraints, validation may seem like an abstract luxury that can wait until later. Further, in states with more mature QRISs, there may be some reluctance among stakeholders to assess the validity of an established and accepted quality improvement system. In newer state systems, policymakers may question the need for validation, given arguments recently offered in support of establishing a QRIS system (Zellman & Fiene, 2012; Zellman, Brandon, Boller, & Kreader, 2011). Yet early and ongoing validation research is essential to the long term success of any system.

One challenge is that QRIS validation cannot be determined by a single study. Instead, validation should be viewed as an iterative process with several equally important goals: refining the QRIS quality standards and ratings, improving system functioning, and increasing the credibility and value of rating outcomes and the QRIS system as a whole. A carefully designed validation plan can promote the accumulation of evidence over time that will provide a sound theoretical and empirical basis for the QRIS (AERA, APA, & NCME, 1999; Kane, 2001; Zellman & Fiene, 2012). Ongoing validation activities, carried out in tandem with QRIS monitoring activities (those that examine ongoing implementation processes) and evaluation activities (those that examine specific outcomes) can help a QRIS improve throughout its development, implementation, and maturation (Lugo-Gil et al., 2011; Zellman et al., 2011).

QRIS validation research may produce three important benefits. First, validation evidence can promote increased support for the system among parents, ECEC providers, and other key stakeholders. Ratings that mirror the experiences of parents and providers can build trust and increase the overall credibility of the system. Second, a system that is measuring quality accurately and specifically should better able to target limited quality improvement resources to programs and program elements most in need of improvement. This should result in more targeted and effective supports for programs striving to offer higher-quality services. Third, validation evidence can be used to improve the efficiency of the rating process. If a QRIS is expending resources to measure a component of quality that is not making a unique contribution to a summary quality rating, is not measuring quality accurately, or is not contributing to desired program outcomes, that component can be removed or revised. For example, measures that vary little across providers, whose quality varies substantially in other ways, make little or no contribution to overall quality ratings (Zellman & Fiene, 2012).

Four approaches to validation

A comprehensive QRIS validation plan includes multiple studies that rely on different sources of information and ask different but related questions. We suggest QRIS validation research be organized around four complementary approaches: key quality concepts; quality measurement; ratings outputs; and links to child outcomes (Zellman & Fiene, 2012). Summaries of these approaches are provided in Table 1, which includes the purpose of each validation approach, the types of research that can be undertaken, the questions that are asked, and some limitations of each approach. The four approaches are also elaborated later in the paper, as we summarize results of validation research in Indiana and Maine.

In reviewing the table, and throughout this paper, we use three key QRIS terms: component, standard, and indicator. The term ‘quality component’ refers to broad quality categories used in QRIS (such as staff qualifications, family engagement, or learning environment). A ‘quality standard’ is defined as a specific feature of quality, such as specialized training in the use of developmentally appropriate curriculum or developmental assessment training within the staff qualifications component. A set of quality standards comprises each quality component. ‘Quality indicators’ are the specific metrics used for each quality standard. A given quality standard may have one or more quality indicators. An indicator related to the curriculum/assessment staff training standard may be, for example, “At least 50% of teaching staff have completed the two-course statewide training session on developmentally-appropriate curriculum.”

QRIS validation in Indiana and Maine

This section will describe efforts at QRIS validation in two states in order to explore current validation efforts using these four approaches and to identify the successes and challenges experienced in these early QRIS validation studies. In Indiana and Maine, the QRIS designs are similar, but some aspects of the states’ child care contexts, specific QRIS quality components, standards, and rating processes employed are somewhat different. Both states launched their QRIS statewide in 2008, and both systems have four quality tiers, referred to as “levels” in Indiana and “steps” in Maine, organized into a “building block” framework, meaning that child

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care providers must enter at the lowest level and meet all quality standards and indicators at each level in order to advance to the next higher level. The focus on these two states in this paper is to help illustrate the application of these four approaches to operationalizing validation in a QRIS. While the QRIS evaluations in Maine and Indiana have resulted in other kinds of information disseminated for policy makers in these states and publications for other audiences, this paper is unique in that it is only intended to focus on these four concepts of validation.  

Both states partnered with university-based researchers to conduct validation research, after piloting aspects of their QRIS design. However, there are also key differences between these two states. For example, the Indiana QRIS standards were developed based on a local community-based model that was then modified by a state stakeholder committee for statewide expansion. The Maine quality standards were developed to align with program-type-specific national accreditation standards. The Maine standards were also vetted through review and comment by many stakeholders and technical assistance was provided by University researchers based on reviews of the scientific literature. Maine QRIS ratings are generated by provider self-report, then verified by state agency staff, while Indiana employs independent raters who directly assess the standards by visiting child care settings. Provider voluntary participation rates are higher among state-licensed providers in Indiana. However, Indiana also has significant numbers of license-exempt child care providers, whereas license exemption is not a prominent feature of the Maine child care system. The key features of each state QRIS are summarized in Table 2. These two states provide useful examples, because while the state child care contexts are different, they each used strategies contained in the four validation approaches discussed above and outlined in Table 1. The successes and limitations of these states’ approaches will inform future validation research on QRIS.

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http://dx.doi.org/10.1016/j.ecresq.2014.04.005
Table 2
Key features of Indiana and Maine QRISs.

<table>
<thead>
<tr>
<th>QRIS feature</th>
<th>Indiana</th>
<th>Maine</th>
</tr>
</thead>
<tbody>
<tr>
<td>System name</td>
<td>Paths to QUALITY (2008); Licensed centers (890); Licensed homes (623)</td>
<td>Quality for ME (2008); Required for programs participating in federal</td>
</tr>
<tr>
<td>Eligible child care types (participation rate)</td>
<td>Unlicensed registered ministry centers (12%)</td>
<td>participation</td>
</tr>
<tr>
<td>Participation rules</td>
<td>Voluntary for all providers (Not required for CCDF participation)</td>
<td>Building Block; 4 quality levels</td>
</tr>
<tr>
<td>QRIS structure</td>
<td>Building Block; 4 quality levels</td>
<td>Step 1 – Meets all regulatory standards, in operation for</td>
</tr>
<tr>
<td>QRIS standards (examples)</td>
<td>Level 1 – Licensed, or completes voluntary certification program</td>
<td>more than one year, and all staff registered in Maine Roads</td>
</tr>
<tr>
<td>QRIS standards development process</td>
<td>Level 2 – Learning environment and materials requirements; daily literacy activities; 25% of staff have CDA or equivalent; 15 hrs. in-service training/yr; etc.</td>
<td>Quality Registry (MRTQ).</td>
</tr>
<tr>
<td>QRIS rating procedure</td>
<td>Level 3 – Written curriculum focused on whole child; provision for special needs; 50% of staff have CDA or equivalent; 20 hrs. in-service training/yr; etc.</td>
<td>Step 2 – Learning Environment/Developmentally</td>
</tr>
<tr>
<td></td>
<td>Level 4 – National accreditation; Provide mentoring to other QRIS providers (see <a href="http://www.in.gov/fssa/carefinder/2554.htm#">www.in.gov/fssa/carefinder/2554.htm#</a>).</td>
<td>Appropriate Practice requirements; program improvement plan in place; 50% of staff at level 5 on MRTQ career lattice; etc.</td>
</tr>
<tr>
<td></td>
<td>Aligned with national accreditation standards, expansion of community pilot program, modified by state stakeholder committee</td>
<td>Step 3 – Documented use of Early Childhood Learning Guidelines and/or Infant-Toddler Learning Guidelines; Evidence collected at least three times per year on child’s development; etc.</td>
</tr>
<tr>
<td></td>
<td>Independent ratings contractor, annual site visits, using Paths to QUALITY standards checklist</td>
<td>Step 4 – National accreditation; written parent involvement plan; etc. (See: <a href="https://www.maine.gov/dhhs/ocfs/ocsfhsc/qualityform.htm">https://www.maine.gov/dhhs/ocfs/ocsfhsc/qualityform.htm</a>).</td>
</tr>
</tbody>
</table>

Method

Indiana

The Indiana QRIS is called “Paths to QUALITY™.” The validation research reported here includes a preliminary literature review and an empirical field study including a stratified random sample of 276 child care providers who had voluntarily entered the QRIS during 2008–2009, including 135 classrooms in 95 licensed child care centers, 169 licensed family child care homes, and 14 classrooms in 12 unlicensed registered child care ministry centers. Independent, on-site assessments were completed by university researchers approximately one year after QRIS entry and included: observational global quality assessments of the child care environment using the Environmental Rating Scales (ERS: ITERS-R, ECERS-R, FCCERS-R; Harms et al., 2005); observations of adult–child interaction quality (Caregiver Interaction Scale, CIS; Arnett, 1989); surveys and interviews with child care providers; and interviews with parents whose children had been placed with QRIS providers. Observers were trained to reliability level of 80% exact agreement (Kappa = .70) or higher, and maintained reliability during the study. Child development assessments were completed using standardized research-validated measures, with two randomly selected children from each participating child care center classroom or family child care home. For children under three years, measures included the Mullen Scales of Early Learning (Mullen, 1995) for cognitive and language development and the Brief Infant Toddler Social Emotional Assessment (BITSEA; Briggs-Gowan & Carter, 2002) for social-emotional development. For children three to five years, the measures included the Peabody Picture Vocabulary Test (PPVT-4; Dunn & Dunn, 1997) and Woodcock–Johnson Applied Problems and Letter–Word Identification subtests (Berry, Bridges, & Zaslow, 2004) for language and cognitive development and the Social Competence and Behavior Evaluation (SCBE; LaFreniere & Dumas, 1997) for social–emotional development. (For a detailed description of the Indiana evaluation methodology, see Elicker et al., 2013; Elicker, Langill, Ruprecht, Lewsader, & Anderson, 2011.)

Maine

The Maine QRIS is called “Quality for ME.” The Maine validation research reported in this paper is based on a literature review of quality variables, focus group interviews with providers and parents, and a field study including a stratified random sample of 255 providers who enrolled in the QRIS in 2008 through 2011, including: 153 classrooms in 105 licensed child care centers; 113 licensed family child care homes; and 41 classrooms in 37 Head Start sites. Assessments were completed as soon as possible after a program enrolled into the QRIS, however, this varied based on the length of time required for the state agency to verify enrollment information and schedule on-site observations. Like Indiana, Maine researchers used the ERS global quality assessment scales and conducted surveys with providers and parents. Unlike Indiana, Maine did not collect any child-level outcome data. Assessors were trained to reliability annually by authors of the ERS scale and maintained an 85% inter-rater reliability during the study. (For a detailed description of the evaluation methodology, see Lahti et al., 2011.)

Results

Results of the QRIS validation research in Indiana and Maine are presented in relation to the four approaches to validation recommended by Zellman and Fiene (2012; refer to Table 1).

Approach 1: examine the validity of key underlying concepts

As noted above, the quality components included in a QRIS (e.g., staff qualifications, learning environment, family engagement) essentially define how child care quality will be viewed in each state. Conceptual validation provides justification and support for these chosen elements. This first validation approach asks whether the quality components, standards, and indicators included in a QRIS are the “right” ones; that is, if together they define quality of care. Many state QRISs have adopted similar, though not identical, concepts and program quality standards (Smith, Robbins, Stagman, & Kreader, 2012).
One approach that can help to validate the underlying concepts of quality in a QRIS involves assessing the degree to which the quality components used in the QRIS ratings include standards and indicators that are based on empirical evidence that links them to desired program, family and child outcomes. A literature review weighs the existing research evidence and on that basis provides a judgment about whether a particular quality component should be included or excluded from the QRIS. Like many validation activities, such reviews ideally would be updated from time to time to determine if revisions to the QRIS are advisable in light of new research findings. As noted in Table 1, this approach may be limited by available data. Further, available data may be subject to more than one interpretation. Politics can also play a role; supporters of particular elements, e.g., nutrition, accreditation, may want to ensure that such measures are included, regardless of the strength of the research evidence. This literature review approach of conceptual validation was a key method used in developing both Indiana’s and Maine’s QRIS quality standards.

**Indiana: examining the validity of underlying concepts**

Standards and indicators for each QRIS level in Indiana were drafted by a state committee of child care providers and stakeholders. The standards were based on an existing community-level Paths to QUALITY model, but also made accommodations for statewide use and integration into the existing state child care licensing and training/technical assistance systems. The highest level quality goal for QRIS in Indiana is national accreditation, so proposed quality standards and criteria at each QRIS level were constructed to help child care providers work toward accreditation in steps.

The Purdue University research team conducted a review of previous evaluations of the Indiana QRIS community-level pilot programs and an in-depth analysis of the proposed QRIS quality standards based on the published child development and child care literature. This literature-based analysis is summarized here. (For a full report, see Elicker, Langill, Ruprecht, & Kwon, 2007; Elicker et al., 2013.)

First, the evaluators looked at each proposed QRIS quality standard and indicator for each type of child care. Ten broad quality components were identified that encompassed all of the proposed quality indicators: regulation; teacher education/training; structural/environmental quality; process quality/interactions; assessment; provisions for children with special needs; program policies; director/owner professional development; parent/teacher communication; and national accreditation. These ten components were then used as key terms to guide an extensive search of the research literature to collect and weigh the available evidence that each component was: (1) generally considered a valid aspect of quality; and (2) empirically associated with children’s well-being or positive developmental outcomes. Based on the amount and quality of evidence, each quality component was the rated as follows: (1) some or limited evidence (one or two well-designed studies); (2) moderate evidence (3–5 well-designed studies); or (3) substantial evidence (more than five well-designed studies). The results of this analysis were reported to the state QRIS planning committee, including a conclusion that most of the proposed quality indicators had “substantial evidence” for their validity.

**Maine: examining the validity of underlying concepts**

Researchers at the University of Southern Maine worked with state agency leaders and other key stakeholders through a process that involved the use of Concept Mapping (The Concept System®, 2012). This process allows for the development of a conceptual framework that can guide planning, and in this case led to the selection of the underlying quality concepts and standards for Maine’s QRIS. Similar to what was done in Indiana, University of Southern Maine research staff identified key quality concepts from the literature and national accreditation standards. In addition, concepts emerged from results of eight focus groups with parents and ECEC professionals across the state, including participants from various types of settings, e.g., family child care homes, after school programs, centers, etc. Statements of program quality were developed; these statements were the focus of a mapping process which involved more than twenty-four experts reviewing and rating the statements. The Concept Maps that result from this process allowed participants to visually identify which concepts of program quality were most favored by specific key stakeholder groups. In addition, the mapping software illustrated how closely related the concepts were to each other, based on reviews from the select experts. From this process, a set of components and standards was developed. The final step in selecting program quality standards involved a formal review and comment process that the state agency implemented in various locations across the state (Maine DHHS, 2008).

**Approach 2: examine measurement strategies and psychometric properties of quality measures**

A second type of validation focuses on the attributes of the individual quality measures used in the QRIS and the way these measures are combined to produce a summary rating of program quality. This approach addresses how well measures are working in the context of the QRIS. These efforts attempt to answer questions such as, “Is there evidence that a given indicator measures what it purports to measure?” “If the QRIS claims to have a specific number of dimensions, do we find those dimensions in the output data?” “Is there sufficient variance in scores on this quality indicator to justify its inclusion in the QRIS?” Addressing these issues involves an examination of the distribution of participating provider quality scores and the internal consistency of multi-item measures.

The research literature provides limited guidance concerning the most appropriate ways to combine measures of quality indicators into summary ratings (Lugo-Gil et al., 2011; Tout, Zaslows, Halle, & Forry, 2009; Zellman, Perlman, Le, & Setodji, 2008). Yet this process is crucial to producing meaningful overall program quality ratings, the key output of the rating assessment process. At minimum, it is important to consider whether certain elements should be treated as more important, and if so, how this can be assured in the process of combining them. If this issue is not addressed, unexamined weighting may occur anyway. For example, if measures of individual quality elements are combined without any weighting, then those measures that are longer (e.g., include more items) will count for more in a final rating.

At the time both the Maine and Indiana QRISs were being designed, in the mid-2000s, the predominant global quality measures in use in both states were the Environmental Rating Scales (ERS) (Harms et al., 2005; Harms, Cryer, & Clifford, 2006; Harms, Cryer, & Clifford, 2007). ERS use was predominant in the accreditation quality improvement efforts in both child care centers and child care homes. So there was some familiarity with the measures on the part of providers. This was an important political consideration in terms of developing and promoting the design of the QRIS. In addition, in reviewing emerging QRIS work from other states, it appeared that the ERSs were the predominant global classroom quality measure in use at that time. While ERS was influential in the design of the QRIS quality standards in both Maine and Indiana, it is important to note that the ERS are not used to determine the step or level quality ratings. Many other quality indicators are included in the QRIS standards of both states, including staff qualifications, annual staff training hours, and other indicators that help providers make progress toward the ultimate quality goal of national accreditation.
Choosing the points at which individual measures (in block design QRISs) and summary ratings are assigned to rating levels is another exercise that has received limited attention. Cut scores can be assessed in a number of ways. One relatively simple one is to use existing data to conduct a “virtual pilot” (Zellman & Karoly, 2012a) in which existing data are used and cut scores are altered and the effects are examined in terms of distributions of summary ratings across programs. A downward limit on cut scores is the need for some variation within each quality component; without it, a component provides no useful information in overall ratings. Designers may compare program distributions using different cut scores, although it is not always clear what an appropriate rating levels distribution should be. However, it is reasonable to assume that an appropriate distribution in the early phase of a QRIS would be one in which there are programs placed at all levels, with decreasing numbers of programs at each succeeding higher level.

Another validation activity might involve an assessment of the relationship of a given indicator to other indicators of quality included in the QRIS. In studies that examine measures to be included together in a QRIS, it is important to look at the degree of correlation found among these measures: ideally, measures will be moderately correlated so that each measure both contributes to an overall assessment of quality yet also provides some non-redundant program quality information (Zellman et al., 2008). Correlation patterns should make sense. For example, two measures of interaction quality should be more closely related to each other than to a measure of adult–child ratios. If such studies reveal for example that the correlation between ratios and interaction process is very high ($r = .90+)$ this result might argue for eliminating one or the other indicator from the QRIS, as they may not be providing unique information (although some QRISs include certain quality elements to ensure that they are paid attention to for other policy related reasons, even if their psychometric properties are not ideal). To date, the Maine and Indiana validation research has not included a comparison of measures internal to the QRIS rating systems, but this is recommended in future research as the systems mature and stabilize.

Measurement error presents another potential challenge in assessing QRIS validity. Most QRISs assume that observational measures are relatively stable over time absent quality improvement efforts. This assumption is consistent with empirical evidence for at least one widely used instrument, the ERS (Clifford, 2005).

A related measurement issue concerns inter-rater reliability. In the twenty systems reviewed by Tout et al. (2010), nearly all QRISs require 80–85% agreement with a master coder (either exact agreement or agreement within one scale point) on ERS; this degree of reliability does not eliminate errors in ERS measurement (Bryant, 2010; Bryant, Burchinal, & Zaslow, 2011). For instance, two raters could be 100% reliable under a standard of 85% agreement within one scale point, but one might give a classroom a score of 3.5 and the other a score of 4.5, a difference that is large enough to affect an overall program rating (Karoly, Zellman, & Perlman, 2013). Based on the range and degree of variability in ERS quality scores at each rated level in both Maine and Indiana QRISs (see Tables 3 and 4), we recommended that program managers strive to increase the reliability of the rating process by clearly defining quality indicators and rating procedures, and conducting regular reliability checks.

Approach 3: assess the outputs of the rating process

A third validation approach focuses on assessing the outputs of the rating system: the scores and levels assigned to providers who undergo a rating, and the distributions of those scores within and across different types of providers. Studies conducted under this approach examine the degree to which the quality levels in the QRIS are meaningfully distinct from each other. The results of these studies may provide data that suggest that measures, cut scores, or rules for combining measures need to be changed in order to distinguish the rated quality levels effectively. Because these studies can result in proposals for significant changes to the standards for QRIS levels, it is helpful for these studies to occur prior to studies that examine associations between quality levels and children’s development.

Output studies may focus on individual indicator scores, such as how providers score on an environmental rating, as well as on the overall quality level that is the final output of the rating process. These studies may also utilize a measure of quality not included in the QRIS rating process to make an evaluation of concurrent validity, by examining whether assessments on both measures co-vary in predictable ways. The following section provides examples of the two states’ examinations of the distribution of quality ratings and rating-level advancement patterns for each program type enrolled in the state QRIS.

Examine uncer QRIS rating distributions and cut points

While evaluators in Indiana and Maine did not conduct a detailed examination of the weighting or internal consistency of specific quality indicators, they did analyses to reveal the distribution of quality levels. After three years of system implementation, both Indiana and Maine QRIS child care providers were predominately rated at Level 1 or Level 2 (see Fig. 1). It is important to note that in Indiana, all providers enter the system at Level 1, and in Maine, providers can enter the system at any level based on their program rating, and then may advance at will from that level. A recent in-depth study of five state quality rating and improvement systems that were fully implemented found a similar pattern, with four of the five states reporting 40–76% of all programs enrolled in the lower tiers of the system (Mathematica Policy Research, 2011).

In Indiana, licensed child care centers were evenly distributed across the four QRIS levels approximately two years after the program inception. However licensed family child care homes were most frequently found at Level 1, with steeply declining numbers at the other three levels. This higher proportion of Indiana licensed centers rated at Level 3 or Level 4 may have been due to a greater historical emphasis in child care centers than in homes on regulation and attaining national accreditation, greater organizational capacity to complete the requirements of advancement in QRIS, or possibly that QRIS standards more closely reflect center quality than family child care home quality. Unlicensed registered child care ministries, a unique type of child care center in Indiana that is not licensed due to religious affiliation, participated at a much lower rate, and none had yet attained Level 4, reflecting significant challenges facing these unlicensed centers in meeting the Level 1 standards needed to enter the QRIS. These data patterns in Indiana

Fig. 1. Percent enrolled providers rated at four quality levels, by state and type of child care.
supported the validity of the QRIS rating system in that they showed variation in quality ratings across participating providers, they reflected the increasing effort necessary to meet quality standards at higher levels, and they were interpretable within the state’s child care context.

Another gauge of overall quality rating system utility is the amount of program advancement to higher rated levels. It is reasonable to expect, if the QRIS is viable, that at least some providers will advance in quality level. In the Indiana evaluation, 19% of the licensed centers, 24% of the licensed homes, and 27% of the unlicensed ministry centers had advanced at least one QRIS quality level in a 6-month period between assessments, during which mentoring was provided by local training providers. This advancement pattern, if maintained over time, suggests that even though attaining the highest levels may be challenging, quality improvement is feasible.

For Maine, as Fig. 1 illustrates, center-based programs and family child care type programs are most frequently found at Step or Level One. A disproportionately small number of family child care programs have attained Step Four, the highest quality level, and a disproportionately large number of child care centers and Head Start programs are enrolled at Step Four. This pattern of fewer family child care homes enrolled at higher Step levels has existed throughout QRIS implementation in Maine. Maine family child care home providers argued that some of the program standards were not “a good fit,” despite designers’ beliefs that standards were well-matched to setting type. The large number of center-based and Head Start programs at the higher Step levels was expected, given that QRIS quality standards closely align with accreditation standards, and center-based programs are more likely to be nationally accredited than family child care homes.

An assumption of the designers of the QRIS in Maine was that programs engaged with QRIS will improve their tier levels consistently over time (Lahti et al., 2011). Approximately 80% of all programs (n = 1118) in the QRIS observed during the study period 2008 through 2011 did not experience a move up from one Step Level to the next. Results indicated that 95 of the 103 events or changes in Step Level from level one to two occurred during the first 23 months of enrollment. Moving from a Step One to Two, center-based care programs had a hazard probability of just .02, while family child care homes stayed virtually flat during this early period of enrollment in the QRIS. For movement from Step Two to Three, neither program type (p = .290) nor regional location (p = .195) appear to be significant in explaining Step level movement. For movement from Step Three to Four, the highest tiers in Maine’s QRIS, the analysis indicated that only type of program is a significant covariate explaining advancement. Family child care homes appeared to have a significantly lower probability of advancing a Step Level at this highest quality tier, compared with center-based and Head Start programs. These types of analyses of program movement in the system are relevant to the validation of a QRIS as they illustrate whether or not the way the system as designed is meeting its goals of supporting program advancement, leading to statewide improvement of program quality.

Studies may also be conducted to examine the degree to which given measures relate to other measures that purportedly assess the same concept. Here, strong correlation is desired, as they suggest that measures are measuring the concepts that they purport to measure in ways that are consistent with other measures of the same concepts.

Indiana: assessing the output of the rating process

The Indiana evaluation research included one validation test of state committee-generated quality standards, indicators, and levels by comparing the outputs of the QRIS rating system with independently gathered assessments of quality using validated quality measures, the environmental rating scales (ERS, Harms et al., 2005, 2006, 2007) and the Caregiver Interaction Scale (CIS; Arnett, 1989). The results, originally published by Elicker et al. (2011) and shown in Table 3, indicate that ERS scores co-varied as expected with QRIS level ratings, with a significant mean difference in global scores of 1.1 scale points between Level 1 and Level 4. Table 5 shows that caregiver interaction as observed using the CIS was less related to the rated QRIS quality levels. The overall correlation between the 4-level QRIS ratings and global ERS quality scores was moderate (r = .42, p < .01). The correlation between CIS adult–child positive interaction scores and QRIS level was more modest, but positive and significant (r = .24, p < .01).

Taken together, and looking across all types of providers, these results suggest that the QRIS ratings distinguish levels of quality in somewhat similar ways as two time-tested, validated measures of child care quality. However, mean quality levels at Level 4 were mostly found to be below the “good” rating threshold, suggesting the need to strengthen standards and/or rating procedures at the highest QRIS levels. In addition, finer analysis of the data suggested specific recommendations about quality standards and rating procedures that might be improved for each type of child care. Summaries of individual ERS item means for Level 3- and 4-rated providers led to the identification of a number of ERS items with scores below 4. Program planners are currently improving standards and QRIS rating procedures in light of these findings (Elicker et al., 2013).

In Indiana, patterns of association between QRIS ratings and ERS ratings were not the same for all types of child care. While the

Table 3
Indiana QRIS: mean global quality ERS scores as a function of program type and rated quality level.

<table>
<thead>
<tr>
<th></th>
<th>Level one (n = 84)</th>
<th>Level two (n = 90)</th>
<th>Level three (n = 74)</th>
<th>Level four (n = 66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All providers (N = 314)</td>
<td>3.2 (.87)</td>
<td>3.7 (.76)</td>
<td>3.8 (.73)</td>
<td>4.3 (.80)</td>
</tr>
<tr>
<td>Family child care homes (n = 167)</td>
<td>2.9 (.64)</td>
<td>3.4 (.75)</td>
<td>3.6 (.67)</td>
<td>4.0 (.89)</td>
</tr>
<tr>
<td>Licensed child care centers (n = 133)</td>
<td>4.0 (.77)</td>
<td>4.0 (.68)</td>
<td>4.3 (.66)</td>
<td>4.5 (.67)</td>
</tr>
<tr>
<td>Unlicensed registered child care ministries (n = 14)</td>
<td>3.2 (.95)</td>
<td>4.1 (.45)</td>
<td>4.0 (.18)</td>
<td>NA</td>
</tr>
</tbody>
</table>

* Possible range = 1–7.

Table 4
Maine QRIS: mean global quality ERS scores as a function of program type and rated quality level.

<table>
<thead>
<tr>
<th></th>
<th>Step one (n = 82)</th>
<th>Step two (n = 99)</th>
<th>Step three (n = 79)</th>
<th>Step four (n = 82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All providers (N = 342)</td>
<td>3.7 (.77)</td>
<td>3.9 (.84)</td>
<td>4.0 (.80)</td>
<td>4.3 (.79)</td>
</tr>
<tr>
<td>Family child care homes (n = 129)</td>
<td>3.3 (.67)</td>
<td>3.5 (.80)</td>
<td>3.8 (.91)</td>
<td>4.2 (.83)</td>
</tr>
<tr>
<td>Licensed child care centers (n = 165)</td>
<td>3.9 (.72)</td>
<td>4.1 (.80)</td>
<td>4.2 (.68)</td>
<td>4.4 (.84)</td>
</tr>
<tr>
<td>Head start centers (n = 48)</td>
<td>NA</td>
<td>NA</td>
<td>4.1 (.75)</td>
<td>4.5 (.71)</td>
</tr>
</tbody>
</table>

* Possible range = 1–7.

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global ratings were significantly correlated in both licensed centers and licensed family child care homes, the strength of association was stronger for homes, meaning QRIS level ratings in homes more clearly distinguished levels of ERS–related quality, meaning at each QRIS–rated level, the ERS quality differences were generally greater than they were for centers. Second, the overall ERS quality levels for center–based preschool classrooms (using ECECRS–R; M = 4.6 at Level 4) were somewhat higher than for center–based infant classrooms (ITERS–R; M = 4.4 at Level 4) and family child care homes (FCCERS–R; M = 4.0 at Level 4). While the equivalence of quality scores across these three ERS scales is not supported by research evidence, the results taken together suggest the need to strengthen quality standards and assessment procedures for all types of care, so that child care providers at the highest rated levels are providing care that is at or above threshold levels recommended to impact children’s developmental outcomes (Zaslow, Martinez–Beck, Tout, & Halle, 2011).

**Maine: assessing the output of the rating process**

As in Indiana, differences in program quality were measured using Environmental Rating Scales (ERS) mean scores at the classroom level, and these scores were not part of the QRIS standards or ratings. The results presented here are from factorial ANOVAs to examine the effects of Step Level, ERS scale type and child care program type on the dependent variable ERS mean score. Table 4 provides the adjusted mean scores for all 307 classrooms and by each program type by Step Level. Table 4 is extracted from the full report on Maine’s QRIS (see Lahti et al., 2011). The results show an overall significant difference between Step Level and ERS mean score at the classroom/setting level (F = 5.02; df = 3, 307; p = .002). Results of post hoc Bonferroni tests showed a significant difference between Step One and Step Four programs (p = .001) and between Step Two and Step Four programs (p = .001). The total variance of the mean ERS score explained by Step Level was only 5%, indicating weak relationships between the variables. Comparisons of the program type mean ERS quality scores indicated a difference only between the family child care homes and the center–based scores (p < .001). The family child care home mean scores were lower at each Step Level than the center–based setting scores with the exception of scores at Steps Three and Four. There did not appear to be any significant differences at Step Three or Four between the center–based and Head Start type settings (p = .97). The results provide some evidence for differences in rated quality, with higher ERS means for higher tier or step programs, most distinctly for family child care homes. Overall these mean scores suggest the need for considerable efforts at quality improvement, considering that the majority of settings are scoring below the “5” or “good” level on the ERS measures.

**Maine: parent level data on QRIS program quality**

In the Maine validation study, parents in programs selected for observation were asked to complete an anonymous survey that focused on services received by the parent and the parent’s perceptions of the quality of the program. The belief was that parents served by higher Step level programs should be receiving more supports and services and therefore may rate the program higher in level of quality. The response rate over the three–year study period was approximately 26% (N = 1478). These results are extracted from the full report on Maine’s QRIS (see Lahti et al., 2011).

Parental perception of program quality was measured by the 15–item Emlen scale, see Emlen, Koren, and Schulze (2000), and was found not to be correlated to Step Level rating (Pearson’s r = .010, p = .68). In terms of services parents should have received according to program standards, a majority of parents reported not receiving: information about other government services for their child; opportunities for parent engagement with the program; daily communication from the program about their child; and being provided an up to date written parent hand–book from their provider. There did not appear to be any difference in step level in terms of parents not consistently receiving these types of services as required by the program quality standards according to parent reports. The use of these data by QRIS administrators was primarily for monitoring purposes focused on services and or supports parents should have received based on requirements in the QRIS standards. While parents were asked about perceptions of program quality, due to a strong desire to reach out to parents as a key stakeholder in the QRIS, that information was not relied upon for program planning or program improvement.

**Approach 4: relate ratings to children’s development**

The fourth approach to validation focuses on children’s development. In many respects, this is the final step in validating a QRIS, and one that arguably should be delayed until the questions raised in the earlier approaches are addressed and changes made to the system as necessary. It may even be possible that new data will emerge that makes the costly and difficult effort involved in assessing child outcomes unnecessary. For example, if studies begin to show consistently that certain inputs, e.g., ratings–based coaching lead to substantial improvements in indicators such as instructional support, and if instructional support or other indicators is found to consistently promote improved child outcomes, it may be possible to argue that the inclusion of those inputs and measures of those outputs may suffice.

The logic models that underlie QRISs typically assert that higher quality care will be associated with improved child outcomes. Therefore, one important piece of validation evidence concerns whether children make greater developmental gains in programs with higher program–level QRIS ratings than in programs with lower ratings. While a definitive evaluation of QRIS impact on child outcomes would consist of an experimental study with random assignment of providers and children to QRIS levels, ethical and practical considerations often make experiments impractical, at least on a state–level scale. Instead, current studies evaluating QRIS validity in terms of child outcomes using this approach do not attempt to evaluate causal linkages. Instead, they examine whether the QRIS ratings and the quality components that comprise the ratings are associated in expected ways to measures of children’s development. Showing significant associations between QRIS–rated quality would be a first step, a necessary but not sufficient result to demonstrate causal inferences about how QRIS quality influences children’s outcomes.
To date, few QRIS validation studies have incorporated children’s outcomes. Maine did not include this approach to validation. As Elicker and Thornburg (2011) note, results from such studies are mixed, at least in part because of the challenges of conducting them. A primary challenge is the inability to control for all the factors that may confound the quality-outcome correlations for children whose families have selected programs in a non-random way. Additional challenges include the difficulty of recruiting of programs and children across all quality levels; lack of information about the amount of care children received in each setting (dosage); lack of appropriate outcome measures for children of diverse ages, abilities, cultures and linguistic backgrounds; and, lack of variation in the quality of participating QRIS programs. As noted above in the discussion of Approach 3, measurement error remains a problem.

**Indiana: examination of ratings associated with children’s outcomes**

To examine validity-related questions about children’s development in the context of the Indiana QRIS, the evaluators assessed the developmental status of 557 children (249 infants/toddlers; 308 preschoolers) who were in the care of QRIS providers. Two children per classroom or home were randomly selected in approximately equal numbers at all four QRIS levels. Data from parent interviews describing annual family income and parents’ education levels and participation in the CCDF voucher program were used as control covariates in the analyses. The basic validity question explored was: are children in higher-rated QRIS care functioning at higher levels, socially and cognitively, than children in lower rated care?

It is important to point out that this study of quality and child outcome associations was cross-sectional, with all data collected at one point in time. As mentioned earlier, exploring these correlational relationships does not substitute for longitudinal or experimental designs that can better evaluate the causal impact of the QRIS on child outcomes. However, in the implementation phase of QRIS, it is useful to explore the developmental status of participating children, how they are distributed in the child care system, and whether associations between quality measures and measures of children’s functioning are occurring in the expected direction (Elicker & Thornburg, 2011).

Bivariate correlations and multiple regression models were used to explore the associations between children’s development and the three measures of child care quality: QRIS ratings (4 levels); ERS global quality scores; and a CIS composite rating of positive adult–child interactions. All regression models included parent education, household income, and type of child care. No significant correlations were found between the four-level QRIS quality ratings and either infant/toddler or preschooler developmental status. Some of the researcher–observed quality measures were mildly but significantly correlated with child development measures. For preschoolers, CIS positive interactions were correlated with social competence ($r = .17^{* *}$) and receptive language ability ($r = .17$, $p < .01$). For infants and toddlers, ERS global quality scores were associated with social competence ($r = .15$, $p < .01$), and total CIS positive interactions were associated with cognitive/language competence ($r = .17$, $p < .01^{* *}$). These significant correlations were entered as predictors in regressions of child outcomes on the quality variables, controlling for the family SES variables (parent education level and household income) that were also significantly correlated with the child outcome variables. As a result, for preschoolers, CIS positive adult–child interactions significantly predicted children’s receptive language ability, after controlling for family SES ($b = .12$, $p < .05$). For infants and toddlers, CIS positive adult–child interactions significantly predicted children’s cognitive/language competence, after controlling for family SES ($b = .14$, $p < .05$).

Family income was also a significant predictor, $b = .23$, $p = .009$.

Therefore while QRIS rated levels were not significantly associated with any child development measures for either infants/toddlers or for preschoolers, ERS and CIS quality measures were moderately associated with aspects of children’s development. Specifically, after controlling for family SES, it was the positive quality of interaction between adults and children that was associated with language and cognitive functioning, for both preschoolers and infants and toddlers.

Therefore it appeared that the specific aspects of child care quality assessed by the ERS and CIS measures are more likely to be associated with children’s development than are the composite of quality indicators represented by the 4-level QRIS ratings. This was true even though the QRIS ratings and the ERS and CIS were significantly correlated with each other. As a result, in Indiana, further refinement of QRIS standards and procedures is taking account of these findings, especially by identifying ways to strengthen QRIS standards and ratings to include the quality of adult–child interactions.

**Discussion**

**Limitation to validation study designs**

Both of these state studies provide results that describe linear associations among variables. The study designs are limited due to the fact that the investigators have no control over how the QRIS systems are implemented which affects enrollment and therefore sample sizes and selection of measurement strategies were also not in the sole control of the investigator. It will be interesting as additional studies are done and where non-linear associations are found to determine the impact this has on outcomes. These field studies were conducted with all the limitations associated with working in a developing system with multiple stakeholders. While the design presents a limitation in terms of arguing for causality and application of more sophisticated analytic approaches, it should be noted that the state agency program managers and other stakeholders in both states found the information generated from these studies of high value in terms of system planning, program improvements, and resource allocation. Depending upon context and resources, limitations to these two study designs can be remedied in future studies by such design choices as having programs that are on a waiting list be compared to programs already participating in their state’s QRIS.

**Validation of QRIS is a process that needs attention over time, using more than one approach**

The examples from Indiana and Maine illustrate how these validation approaches can work in practice, with tangible benefits for system improvement. These validation activities are specific to the design and implementation of each state QRIS. We believe it is important to stress to QRIS policy leaders that each of the four validation approaches needs to be used appropriately, considering the developmental stage of the QRIS and the unique features of the setting and QRIS. For example, states with QRIS in development can use the four approaches as a framework for planning how to validate their system. Developmentally then, an initial focus of QRIS design would be to validate the key concepts used in the QRIS design. The four approaches highlighted in this paper need to be considered as part of an ongoing process, not a one-time event. As states progress in their implementation of QRISs, more descriptive research is necessary to understand better how these validation approaches work in other settings, for example with point-based QRISs (rather than “building block” QRISs, like those in Indiana and Maine). Use of these approaches enables cross system comparisons.

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which will allow for the identification of common threats to validity and useful strategies to enhance the validity of a state QRIS.

Validation and early care and education system constraints

A QRIS is not merely a program-level quality-improvement intervention, it is a policy lever for strengthening a state’s over-all early care and education system that reaches beyond child care (Schaack, Tarrant, Boller, & Tout, 2012). The two state validation efforts highlighted in this paper reflect the challenges and constraints common to other state experiences with validation activities (Lahti, Sabol, Starr, Langill, & Tout, 2013). On-site observations of global program quality and establishing and maintaining inter-rater reliability for QRIS raters is a time consuming and costly endeavor. Keen interest in school readiness may pressure program administrators to collect child outcome level data before a QRIS is well established. Current research on the measures that are in the widest use to predict child outcomes appear to do so consistently, especially for children at-risk, but with modest levels of association with program quality as measured by the ERS’s (for example, Burchinal et al., 2011). We recommend to policy makers to always take into account that any validation study is occurring within a dynamic system. System-level constraints such as varying resources available to programs, different type and design of programs, and challenges to measuring quality and reliably collecting information about program quality all influence the design and implementation of state-level QRIS validation studies.

Validation research is critical for performance measurement and improvement for a state QRIS

The 2012 Child Care Development Fund (CCDF) Plan preprint for fiscal years 2014–2015 includes a much larger focus on QRISs (U.S. Department of Health & Human Services, Administration for Children and Families, 2011). In this document, a QRIS is defined as a “...systematic framework for evaluating, improving, and communicating the level of quality in early childhood programs.” States are expected to provide a self-assessment based on current program quality initiatives from a set of questions that are also organized according to a “QRIS framework.” Validation of program standards or assessment tools is mentioned specifically in relation to information states must provide about data and performance measures on program quality. The information generated from QRIS validation activities can be used to inform efforts for continuous quality improvement. For example, both Indiana and Maine found that, for at least some types of providers, enrollment patterns in the QRIS, and lack of movement by programs once they are in the QRIS, is resulting in a large proportion of providers at the lower-rated quality levels of the quality tiers. System-level, quality-improvement responses to this information could be to re-assess the design of the system in terms of the ability of programs to meet standards at each tier, or to focus training/technical assistance on specific quality standards that are most challenging for providers to meet. At the same time, care should be taken to ensure that standards reflect current knowledge about the specific indicators and levels of quality most likely to produce the desired child outcomes. Findings from validation studies can be part of the information that state child care administrators use to assess the overall performance of the state early care and education system. The performance data could then be used by program administrators in making decisions about monitoring programs in a differential manner by visiting those programs more often who are having difficulty meeting QRIS standards (Fiene, 2013). We recommend that one focus of future research be learning more about whether and how information from the results of validation studies are used to improve system and program level performance in QRIS.

It will be interesting to determine as more validation studies are completed to analyze the differences between levels and how often lower quality is present in the top level which is the case with measuring compliance with licensing standards (Fiene & Nixon, 1985). Key areas to look at will be the movement of programs from one level to another, how long this takes, and are the increments equal or not in terms of quality improvement.

Another area to be explored which may have an impact on overall QRIS implementation are the fiscal constraints that many states are experiencing due to the recent recession and lower levels of federal funding. It would be interesting to note differences amongst states with large investments in quality improvement initiatives and those states with smaller investments.

It is important to remember that the QRIS is a policy lever and the validation of child care quality standards in a QRIS is a new phenomenon in early care and education policy-making. These four recommended approaches for QRIS validation, illustrated by validation research in these two states, even with their limitations, did provide policy makers and program administrators with information that guided efforts at system quality improvement. The use of these approaches in other studies will create a common nomenclature for better understanding threats to validity in a QRIS and ultimately increase our understanding of how best to design a QRIS that meets the needs of the parents, providers and children it serves.

References


Developing a valid and reliable BASICS Health and Safety Checklist

PI: Abbey Alkon, UCSF School of Nursing

Co-PIs: Richard Fiene and Beth DelConte, Pennsylvania’s American Academy of Pediatrics Chapter

High quality child care is built on the foundation of meeting standards for health and safety. 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). 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. Research has shown that children who are in poor health at two and four years of age have low cognitive skills in kindergarten. 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.

Young children’s physical and mental health is related to their readiness for school. Approximately 20% of children entering kindergarten have a health or developmental problem that potentially may interfere with their readiness to learn, 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.\textsuperscript{7-10} Children who attend high quality early care and education (ECE) programs are better prepared for kindergarten compared to children in lower quality programs.\textsuperscript{11,12}

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.\textsuperscript{13} 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.\textsuperscript{14-17}

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.\textsuperscript{18} 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.\textsuperscript{18} 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.\textsuperscript{19} 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.\textsuperscript{20} 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.\textsuperscript{18,19,21}

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.\textsuperscript{22,23}

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 8th 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 program’s 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.

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

**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. 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, 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. (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. 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. In a study of 77 child care programs, the rate of medically-attended injuries was 0.05 per year. 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. 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.

Child Care Aware (formerly NACCRRA) has produced health and safety benchmarking reports We CAN Do Better every two years, since 2007 (NACCRRA 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. 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.\(^3\) (2) Include health and safety more prominently in QRIS since quality child care starts with a foundation of health and safety.\(^1\) (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\(^31,32\) 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\(^33\) (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,\(^22\) California Childcare Health Program (CCHP),\(^34\) ECELS-Healthy Child
Care PA, Indiana’s Child Care Health Consultant Program, and recently the Health and Safety Checklist for ECE programs based on CFOC3.

**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. 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 2nd Ed. of SS and CFOC. The 66-item Checklist included a 3-point rating scale: ‘0’ does not completely meet standard, ‘1’ partially meets standard, ‘2’ completely meets standard. 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. The CCHP Health and Safety Checklist was designed 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). 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. 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). The 124-item Checklist includes 72 CFOC3 standards and it was written at the 8th 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. 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.
CFOC3 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 CFOC3 standards. The **BASICS Health and Safety Checklist** will assess both written health policies, immunization records, staff training records, and health and safety practices. The policies will be based on the Model Child Care Health Policies, 5th 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* (CFOC3) Standards.

**Data Collection Procedures**

1. **A. Develop Checklist with items written at the 8th grade reading level.**
2. **B. Create the mobile application of the Checklist.**
3. **C. Establish psychometrics.** We will establish the validation of the NHS Checklist 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.
References


Validating the Georgia Child Care Center Regulations by Crosswalking to *Stepping Stones 3rd Edition*

Richard Fiene, Ph.D.

**Introduction**
This analysis is part of the overall Validation Study of the Georgia Licensing System. This is an in-depth comparison in which the key risk assessment standards of the 3rd Edition of *Stepping Stones to Caring for Our Children* were crosswalked to the Georgia Child Care Center Regulations in order to validate their relevance and content. This is a continuation of the first approach to validation (Zellman & Fiene, 2012) that was initiated in the first phase of this Validation Study (see Fiene, 2013 for the results of the first phase of the study). This is a necessary analysis that all states should complete in order to validate their child care regulations. By having *Stepping Stones (AAP, APHA, NRC, 2013) and Caring for Our Children (AAP, APHA, NRC, 2011)*, we now have national health and safety performance standards as a benchmark for regulatory development.

For additional information regarding this analysis, please contact:
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**References:**


Validating the Georgia Child Care Center Regulations

LEGEND:

STEPPING STONES STANDARD = STEPPING STONES ARE THE SUBSET STANDARDS FROM CARING FOR OUR CHILDREN.

DECAL LICENSING RULE = GEORGIA CHILD CARE LICENSING RULE/REGULATION.

ANALYSIS = EXCEEDS, MEETS, PARTIALLY MEETS, DOES NOT MEET, NOT ADDRESSED.

ANALYSIS CLARIFICATION = PROVIDES DETAILS OF THE ANALYSIS, WHAT IT MEANS TO DECAL.

RECOMMENDATION = BASED UPON THE ANALYSIS CLARIFICATION, RECOMMENDATION(S) ARE MADE REGARDING CHANGES TO DECAL RULE FORMULATION.

NEXT STEPS = STEPS THAT DECAL WILL FORMULATE BASED UPON THE CROSSWALK AND ANALYSES.

FOOTNOTE: It should be noted that the Core Rules are all contained within the crosswalk to Stepping Stones which validates their selection as key risk assessment rules.

October 2013
### Stepping Stones Standard

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum Child:Staff Ratio</th>
<th>Maximum Group Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 12 months</td>
<td>2:1</td>
<td>6</td>
</tr>
<tr>
<td>13-23 months</td>
<td>2:1</td>
<td>8</td>
</tr>
<tr>
<td>24-35 months</td>
<td>3:1</td>
<td>12</td>
</tr>
<tr>
<td>3-year-olds</td>
<td>7:1</td>
<td>12</td>
</tr>
<tr>
<td>4- to 5-year-olds</td>
<td>8:1</td>
<td>12</td>
</tr>
<tr>
<td>6- to 8-year-olds</td>
<td>10:1</td>
<td>12</td>
</tr>
<tr>
<td>9- to 12-year-olds</td>
<td>12:1</td>
<td>12</td>
</tr>
</tbody>
</table>

### DECAL Licensing Rule

**591-1-1.32 Staff:Child Ratios and Supervision.**

1. A center must establish groupings of children for care and maintain staff:child ratios as follows:
   - Ages of Children Staff:Child Ratio and Maximum Group Size
   - Infants less than one (1) year old or children under eighteen (18) months who are not walking: 1:6 12
   - One (1) year olds who are walking: 1:8 16
   - Two (2) year olds: 1:10 20
   - Three (3) year olds: 1:15 30
   - Four (4) year olds: 1:18 36
   - Five (5) year olds: 1:20 40
   - Six (6) years and older: 1:25 50

### Analysis

Does not Meet.

### Analysis Clarification

None of the ratios or group sizes meet the Stepping Stones standard.

### Recommendation

Revise rules according to the ratios and group sizes within Stepping Stones. If DECAL cannot revise all the ratios to start with then it is recommended to start with infants and toddlers followed by preschoolers and school age children. One always wants to start with our most vulnerable children who would be the youngest age children.

### Next Steps

Revise rules according to the ratios and group sizes within Stepping Stones. Look at the potential inconsistency between (3)(b) and (4)(a) of the Transportation rule related to ratios and then revise rules according to the ratios within Stepping Stones for the ratios not met.

### STANDARD 1.1.1.4: Ratios and Supervision During Transportation

Child:staff ratios established for out-of-home child care should be maintained on all transportation the facility provides or arranges. Drivers should not be included in the ratio. No child of any age should be left unattended in or around a vehicle, when children are in a car, or when they are in a car seat. A face-to-name count of children should be conducted prior to leaving for a destination, when the destination is reached, before departing for return to the facility and upon return. Caregivers/teachers should also remember to take into account in this head count if any children were picked up or dropped off while being transported away from the facility.

**591-1-1.36 Transportation**

(a) When more than thirty-six (36) children under the age of five (5) occupy the vehicle, the regular staff:child ratios contained in rule .32(1) shall be met.

(b) When more than thirty-six (36) children five (5) years and older are transported with no children under the age of five (5), there must be one staff for each additional twenty children. This means a third staff member would be required if transporting thirty-seven (37) to fifty-six (56) children five (5) years and older.

(c) Staffing Requirements for Transportation of Children.
   - Driver. Whenever the center transports children for any reason, the driver of the vehicle shall be at least eighteen (18) years of age and possess a valid driver's license.
Validating the Georgia Child Care Center Regulations

2013

as required for the class of vehicle that the driver will be operating for the center.

(b) Additional Staff. When transporting children, the following supervision must be maintained: Driver + One (1) Staff Member must be at least 18 years of age or older when transporting three (3) or more children under three years of age or when seven (7) or more children under five (5) years of age occupy vehicle; When eighteen (18) or more children five (5) years of age or older occupy the vehicle. Driver + Two (2) Staff + Two (2) Staff Members [One (1) of the under three (3) years of age occupant additional staff must be at the vehicle with other children; least eighteen (18) years of age or older] When more than twenty (20) children under five years of age. Do not meet. Does not meet. Does not meet. None of the adult-child ratios meet Stepping Stones Standard for ratios for swimming, wading and water play. Revise rules according to the ratios within Stepping Stones starting with infants and toddlers.

STANDARD 1.1.1.5: Ratios and Supervision for Swimming, Wading, and Water Play
The following child:staff ratios should apply while children are swimming, wading, or engaged in water play:

<table>
<thead>
<tr>
<th>Developmental Levels</th>
<th>Child:Staff Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>1:1</td>
</tr>
<tr>
<td>Toddlers</td>
<td>1:1</td>
</tr>
<tr>
<td>Preschoolers</td>
<td>4:1</td>
</tr>
<tr>
<td>School-age Children</td>
<td>6:1</td>
</tr>
</tbody>
</table>

Constant and active supervision should be maintained when any child is in or around water (4). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an

591-1.1.35 Swimming Pools and Water-related Activities.
(2) Accessibility of Pools. All swimming and wading pools shall be inaccessible to children except during supervised activities.

(3) Supervision of Children in Water Over Two (2) Feet Deep. For water-related activity (such as swimming, fishing, boating or wading) in water over two (2) feet deep, continuous supervision of children must be provided as follows:

- Ages of Children Staff:Child Ratio*
  - Under two and one-half (2 1/2) yrs. 1:2
  - Two and one-half (2 1/2) to four (4) yrs. 1:5
  - Four (4) yrs. and older who cannot swim a distance of fifteen (15) yards unassisted ** 1:6
  - Four (4) yrs. and older who can swim a distance of fifteen (15) yards unassisted ** 1:15

None of the adult-child ratios meet Stepping Stones Standard for ratios for swimming, wading and water play. Revise rules according to the ratios within Stepping Stones starting with infants and toddlers.
Validating the Georgia Child Care Center Regulations

**Infant at all times during swimming or water play (4).** Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm’s length providing “touch supervision” (6). The attention of an adult who is supervising children of any age should be focused on the child, and the adult should never be engaged in other distracting activities (4), such as talking on the telephone, socializing, or tending to chores. A lifeguard should not be counted in the child:staff ratio.

<table>
<thead>
<tr>
<th>Age of Children</th>
<th>Staff:Child Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants less than one (1) year old or children under eighteen (18) months who are not Walking</td>
<td>1:6</td>
</tr>
<tr>
<td>One (1) year olds who are walking</td>
<td>1:8</td>
</tr>
<tr>
<td>Two (2) year olds</td>
<td>1:10</td>
</tr>
<tr>
<td>Three (3) year olds</td>
<td>1:15</td>
</tr>
<tr>
<td>Four (4) year olds</td>
<td>1:18</td>
</tr>
<tr>
<td>Five (5) year olds</td>
<td>1:20</td>
</tr>
<tr>
<td>Six (6) years and older</td>
<td>1:25</td>
</tr>
</tbody>
</table>

* At least one person must have current evidence of having completed successfully a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or YWCA or other recognized standard-setting agency for water safety instruction. Such person may be a center staff member or an employee of a water facility (e.g., local swimming pool).

** In lieu of requiring each child to take a swimming test to determine whether the child can swim a distance of fifteen (15) yards unassisted, center staff may accept copies of certificates or cards from a recognized water-safety instruction organization showing that the child has successfully completed a swimming class which required the child to swim a distance of fifteen (15) yards unassisted.

(4) Supervision of Children in Water Less than Two (2) Feet Deep. For water-related activity (such as swimming, fishing, boating or wading) in water less than two (2) feet deep (such as a wading pool), continuous supervision must be provided in accordance with normal staff:child ratios which are as follows:

- Infants less than one (1) year old or children under eighteen (18) months who are not Walking: 1:6
- One (1) year olds who are walking: 1:8
- Two (2) year olds: 1:10
- Three (3) year olds: 1:15
- Four (4) year olds: 1:18
- Five (5) year olds: 1:20
- Six (6) years and older: 1:25

(5) Additional Supervision. At least one (1) additional staff member above the required staff:child ratios for any water-related activity (such as swimming, fishing, b}
Validating the Georgia Child Care Center Regulations

<table>
<thead>
<tr>
<th>STANDARD 1.2.0.2: Background Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors of centers and caregivers/teachers in large family child care homes should conduct a complete background screening before employing any staff member (including substitutes, cooks, clerical staff, transportation staff, bus drivers, or custodians who will be on the premises or in vehicles when children are present). The background screening should include:</td>
</tr>
<tr>
<td>a) Name and address verification;</td>
</tr>
<tr>
<td>b) Social Security number verification;</td>
</tr>
<tr>
<td>c) Education verification;</td>
</tr>
<tr>
<td>d) Employment history;</td>
</tr>
<tr>
<td>e) Alias search;</td>
</tr>
<tr>
<td>f) Driving history through state Department of Motor Vehicles records;</td>
</tr>
<tr>
<td>g) Background screening of:</td>
</tr>
<tr>
<td>1) State and national criminal history records;</td>
</tr>
<tr>
<td>591-1-1-.09 Criminal Records Check.</td>
</tr>
<tr>
<td>The director and employees of a center must submit to criminal records checks in connection with any application for a license and before a person may become a director or an employee in a center. No person having an unsatisfactory criminal records check determination may be a director or employee of a center.</td>
</tr>
<tr>
<td>Partially meets.</td>
</tr>
<tr>
<td>The DECAL Rule calls for a criminal records check for directors and employees but does not provide any of the detail as delineated in the Stepping Stone Standard.</td>
</tr>
<tr>
<td>Revise the Rule so that a comprehensive background screening with all the items in the Stepping Stones standard are included.</td>
</tr>
</tbody>
</table>

boating, or wading) shall be available to rotate among the age groups as needed when any of the following circumstances are present:
(a) the majority of the children in a group are not accustomed to or are afraid of the water;
(b) the majority of the children in a group comprised of children who cannot swim a distance of 15 yards unassisted cannot touch the bottom of the water facility without submerging their heads;
(c) the water facility is particularly crowded;
(d) the children have special needs which impact on their ability to participate safely in the water-related activity.

(6) Parental Permission. No child shall participate in a swimming activity without the parents' written permission.
(7) Use of Wading Pools. Wading pools shall be cleaned and filled with clean water for each day's usage and emptied when not in use.

STANDARD 1.2.0.2: Background Screening

Directors of centers and caregivers/teachers in large family child care homes should conduct a complete background screening before employing any staff member (including substitutes, cooks, clerical staff, transportation staff, bus drivers, or custodians who will be on the premises or in vehicles when children are present). The background screening should include:

- Name and address verification;
- Social Security number verification;
- Education verification;
- Employment history;
- Alias search;
- Driving history through state Department of Motor Vehicles records;
- Background screening of:
  - State and national criminal history records;

591-1-1-.09 Criminal Records Check.

The director and employees of a center must submit to criminal records checks in connection with any application for a license and before a person may become a director or an employee in a center. No person having an unsatisfactory criminal records check determination may be a director or employee of a center.

| The DECAL Rule calls for a criminal records check for directors and employees but does not provide any of the detail as delineated in the Stepping Stone Standard. |
| Revise the Rule so that a comprehensive background screening with all the items in the Stepping Stones standard are included. |
2) Child abuse and neglect registries;
3) Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.);
4) Fingerprints; and
5) Sex offender registries;
   a) Court records;
   b) References.

All family members over age ten living in large family child care homes should also have background screenings. Drug tests may also be incorporated into the background screening. Written permission to obtain the background screening (with or without a drug screen) should be obtained from the prospective employee. Consent to the background investigation should be required for employment consideration.

When checking references and when conducting employee or volunteer interviews, prospective employers should specifically ask about previous convictions and arrests, investigation findings, or court cases with child abuse/neglect or child sexual abuse. Failure of the prospective employee to disclose previous history of child abuse/neglect or child sexual abuse is grounds for immediate dismissal.

Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having physically or sexually abused children, or are known to have committed such acts.

Background screenings should be repeated periodically taking into consideration state laws and/or requirements. Screenings should be repeated more frequently if there are additional concerns.

**STANDARD 1.3.2.2: Qualifications of Lead Teachers and Teachers**

Lead teachers and teachers should be at least twenty-one years of age and should have at least the following education, experience, and skills:

a) A Bachelor’s degree in early childhood education, school-age care, child development, social work, nursing, or other child-related field, or an associate’s degree in early childhood education and currently working towards a bachelor’s

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<tr>
<th>591-1-1-.31 Staff.</th>
<th>Partially Meets.</th>
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<tr>
<td>(2) Teacher/Lead Caregiver.</td>
<td>The DECAL Rule specifies a bachelor’s degree but has other options for meeting the qualifications of lead teachers and teachers such as CDA and other credentials not equivalent to a bachelor’s degree. Age requirement is different in that the DECAL Rule states 18 yrs of age while Stepping</td>
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<tr>
<td>a) A center must have a designated teacher/lead caregiver for each group of children.</td>
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<tr>
<td>b) Qualifications of Teacher/Lead Caregiver. The teacher/lead caregiver must meet the minimum qualifications listed below. (Note: The educational and qualifying child care experience requirements contained in 591-1-1-</td>
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DECAL should align their Rule with the Stepping Stone standard placing emphasis on having a bachelor’s degree.
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degree;
b) A minimum of one year on-the-job training in providing a nurturing indoor and outdoor environment and meeting the child’s out-of-home needs;
c) One or more years of experience, under qualified supervision, working as a teacher serving the ages and developmental abilities of the children in care;
d) A valid certificate in pediatric first aid, including CPR;
e) Thorough knowledge of normal child development and early childhood education, as well as knowledge of indicators that a child is not developing typically;
f) The ability to respond appropriately to children’s needs;
g) The ability to recognize signs of illness and safety/ injury hazards and respond with prevention interventions;
h) Oral and written communication skills;
i) Medication administration training (8).

Every center, regardless of setting, should have at least one licensed/certified lead teacher (or mentor teacher) who meets the above requirements working in the child care facility at all times when children are in care.

Additionally, facilities serving children with special health care needs associated with developmental delay should employ an individual who has had a minimum of eight hours of training in inclusion of children with special health care needs.

.31(2)(b)2. will remain in effect through November 30, 2012. These requirements will change effective December 1, 2012, and the new educational and qualifying child care experience requirements for teachers/lead caregivers are listed in 591-1-1-.31(2)(b)3.(i) through (xii) below:

1. Be at least eighteen (18) years of age;
2. Have either a high school diploma or a general education diploma (G.E.D.) or one (1) year of qualifying child care experience if hired after the effective date of these rules;
3. Effective December 1, 2012, the qualifications listed in 591-1-1-.31(2)(b)2. above will no longer be valid. Effective December 1, 2012, and thereafter, all teachers/lead caregivers must possess at least one of the following sets of minimum academic requirements and qualifying experience at the time of employment:
   (i) Child Development Associate (CDA) credential issued by the Council for Professional Recognition; Child Development and Related Care diploma from a vocational institute accredited by the Commission on Colleges of the Southern Association of Colleges and Schools; or similar credential where the course of study includes an intensive practicum in child care as part of the curriculum and which is approved by the Department;
   (ii) Technical Certificate of Credit (TCC) in Early Childhood Education or Child Development;
   (iii) Technical Certificate of Credit (TCC) in Infant and Toddler;
   (iv) Technical Certificate of Credit (TCC) in Program Administration;
   (v) Technical Certificate of Credit (TCC) in School Age and Youth Care;
   (vi) Technical College Diploma (TCD) in Early Childhood Education or Child Development;
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<tr>
<th>Development; (vii) Associate’s degree in Early Childhood Education or Child Development (AA, AAS, AAT); (viii) Paraprofessional Certificate issued by the Georgia Professional Standards Commission; (ix) Twenty-five (25) quarter hours or fifteen (15) semester hours from an accredited college or university in Early Childhood Education or Child Development; (x) Bachelor's degree from an accredited college or university in a field other than Early Childhood Education or Child Development and three (3) months of qualifying child care experience; (xi) Bachelor's degree from an accredited college or university in Early Childhood Education or Child Development; (xii) Master’s degree from an accredited college or university in Early Childhood Education or Child Development.</th>
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<tr>
<td>4. Have current evidence of successful completion of a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid provided by certified or licensed health care professionals and which covers the provision of emergency care to infants and children if the caregiver is to be counted as part of the fifty percent (50%) of the child care staff with the required current evidence of CPR and first aid training;</td>
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<td>5. Participate in the orientation and training required by these rules;</td>
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<td>6. Not be suffering from any physical handicap or mental health disorder that would interfere with the person’s ability to perform assigned job duties adequately and in accordance with these rules;</td>
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<td>7. Never have been shown by credible evidence, e.g., a court or jury, a</td>
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Department investigation or other reliable evidence to have abused, neglected or deprived a child or adult or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct. The Department may request an oral or written statement to this effect at the time of application or at any other time. Upon said request, the teacher/lead caregiver or staff shall provide this statement to the Department.
8. Not have a criminal record; and
9. Not have made any material false statements concerning qualifications requirements either to the Department or to the proposed or current licensee or commission holder.

(c) Required Records. Effective December 1, 2012, a copy and/or written verification of the credential or degree awarded to the lead teacher by the technical college, university, school or Department-approved trainer listed in 591-1-1-.31(2)(b)3.(i) through (xii) shall be maintained by the center in the lead teacher’s file, and such documentation shall be available for inspection and provided to Department staff upon request.

(3) Qualifications of Teacher/Lead Caregiver Hired After November 30, 2012.
(a) The teacher/lead caregiver must meet the minimum qualifications, educational and qualifying child care experience requirements contained in 591-1-1-.31(2)(b)1. through 9.
(b) If the newly hired lead teacher does not possess one of the educational and qualifying child care experience requirements listed in 591-1-1-.31(2)(b)3.(i) through (xii), the center may hire this individual as lead teacher if the following requirements are met:
1. The lead teacher enrolls in a program of study to obtain one of the educational credentials and qualifying experience requirements listed in 591-1-1-.31(2)(b)(i) through (xii), within six (6) months after becoming employed at the center and completes the credential or degree within eighteen (18) months after enrollment;
2. The center prepares a written plan outlining the newly hired lead teacher’s professional development in obtaining one of the credentials or degrees listed in 591-1-1-.31(2)(b)(i) through (xii). Such plan must include the following information:
   (i) Individual’s identifying information (name, address and telephone numbers);
   (ii) Technical college, university or school where enrolled (name, address and telephone number) or Department-approved trainer providing credential coursework (name, address and telephone number);
   (iii) Credential or degree individual is seeking;
   (iv) Content area of credential or degree;
   (v) Anticipated date for completion of credential or degree;
   (vi) Names and numbers of courses to be completed during the current year and ongoing updates of the names and numbers of courses to be completed for the following year(s);
   (vii) Documentation of course work successfully completed throughout process (i.e., completion of quarter, semester or component of course work); and
   (viii) A copy of the credential or degree awarded by the technical college, university, school or Department-approved trainer for specified credential upon completion.
3. This professional development plan
**STANDARD 1.4.1.1: Pre-service Training**

In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements.

All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:

a) Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility;

b) Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;

c) Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children’s unique developmental needs;

d) Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;

e) Teaching child care staff and children about infection control and injury prevention through role modeling;

f) Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant

| must be maintained in the lead teacher’s file, and such plan shall be available for inspection and provided to Department staff upon request. |
| Does not Meet. |
| DECAL has orientation training but no pre-service training. |
| DECAL should see about developing a pre-service training rule addressing the Stepping Stones Standard. |
sleep position and crib safety);
  g) Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant;
  h) Poison prevention and poison safety;
  i) Immunization requirements for children and staff;
  j) Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness;
  k) Reduction of injury and illness through environmental design and maintenance;
  l) Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports;
  m) Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
  n) Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;
  o) Promotion of health and safety in the child care setting, including staff health and pregnant workers;
  p) First aid including CPR for infants and children;
  q) Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment;
  r) Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;
  s) Physical activity, including age-appropriate activities and limiting sedentary behaviors;
  t) Prevention of childhood obesity and related chronic diseases;
  u) Knowledge of environmental health issues for both children and staff;
  v) Knowledge of medication administration policies and practices;
  w) Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA);
  x) Strategies for implementing care plans for
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- children with special health care needs and inclusion of all children in activities;
- y) Positive approaches to support diversity;
- z) Positive ways to promote physical and intellectual development.

<table>
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<tr>
<th>STANDARD 1.4.2.2: Orientation for Care of Children with Special Health Care Needs</th>
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<tr>
<td>When a child care facility enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child’s special health care needs and have the skills to work with that child in a group setting. Caregivers/teachers in small family child care homes, who care for a child with special health care needs, should meet with the parents/guardians and meet or speak with the child’s primary care provider (if the parent/guardian has provided prior, informed, written consent) or a child care health consultant to ensure that the child’s special health care needs will be met in child care and to learn how these needs may affect his/her developmental progression or play with other children. In addition to Orientation Training, Standard 1.4.2.1, the orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child’s primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child’s care. A template for a care plan for children with special health care needs can be found in Appendix O. Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics: a) Positioning for feeding and handling, and risks for injury for children with physical/mental disabilities; b) Toileting techniques; c) Knowledge of special treatments or therapies (e.g., PT, OT, speech, nutrition/diet therapies,</td>
</tr>
<tr>
<td>Does not meet.</td>
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<tr>
<td>(1) Orientation. Prior to assignment to children or task, all employees must receive initial orientation on the following subjects: (a) The center's policies and procedures; (b) The portions of these rules dealing with the care, health and safety of children; (c) The employee’s assigned duties and responsibilities; (d) Reporting requirements for suspected cases of child abuse, neglect or deprivation; communicable diseases and serious injuries; (e) Emergency weather plans; (f) Childhood injury control; (g) The administration of medicine; (h) Reducing the risk of Sudden Infant Death Syndrome (SIDS); (i) Hand washing; (j) Fire Safety; (k) Water Safety; (l) Prevention of HIV/Aids and blood borne pathogens.</td>
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<tr>
<td>The Staff Training rule covers orientation but does not address children with special health care needs and their specific training topics included in the Stepping Stones standard.</td>
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<tr>
<td>DECAL needs to address the specific needs of children with special health care.</td>
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emotional support and behavioral therapies, medication administration, etc.) the child may need/receive in the child care setting;
d) Proper use and care of the individual child’s adaptive equipment, including how to recognize defective equipment and to notify parents/guardians that repairs are needed;
e) How different disabilities affect the child’s ability to participate in group activities;
f) Methods of helping the child with special health care needs or behavior problems to participate in the facility’s programs, including physical activity programs;
g) Role modeling, peer socialization, and interaction;
h) Behavior modification techniques, positive behavioral supports for children, promotion of self-esteem, and other techniques for managing behavior;
i) Grouping of children by skill levels, taking into account the child’s age and developmental level;
j) Health services or medical intervention for children with special health care problems;
k) Communication methods and needs of the child;
l) Dietary specifications for children who need to avoid specific foods or for children who have their diet modified to maintain their health, including support for continuation of breastfeeding;
m) Medication administration (for emergencies or on an ongoing basis);
n) Recognizing signs and symptoms of impending illness or change in health status;
o) Recognizing signs and symptoms of injury;
p) Understanding temperament and how individual behavioral differences affect a child’s adaptive skills, motivation, and energy;
q) Potential hazards of which staff should be aware;
r) Collaborating with families and outside service providers to create a health, developmental, and behavioral care plan for children with special needs;
s) Awareness of when to ask for medical advice and recommendations for non-emergent issues that arise in school (e.g., head lice, worms, diarrhea);
t) Knowledge of professionals with skills in various conditions, e.g., total communication for children with deafness, beginning orientation and mobility.
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<tr>
<th>Training for children with blindness (including arranging the physical environment effectively for such children), language promotion for children with hearing-impairment and language delay/disorder, etc.;</th>
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<tr>
<td>u) How to work with parents/guardians and other professionals when assistive devices or medications are not consistently brought to the child care program or school;</td>
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<td>v) How to safely transport a child with special health care needs.</td>
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**STANDARD 1.4.2.3: Orientation Topics**

During the first three months of employment, the director of a center or the caregiver/teacher in a large family home should document, for all full-time and part-time staff members, additional orientation in, and the employees' satisfactory knowledge of, the following topics:

a) Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility;

b) Exclusion and readmission procedures and policies;

c) Cleaning, sanitation, and disinfection procedures and policies;

d) Procedures for administering medication to children and for documenting medication administered to children;

e) Procedures for notifying parents/guardians of an infectious disease occurring in children or staff within the facility;

f) Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease;

g) Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters;

h) Procedure for accessing the child care health consultant for assistance;

i) Injury prevention strategies and hazard identification procedures specific to the facility.

<table>
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<tr>
<th>591-1-1-33 Staff Training.</th>
<th>Partially meets.</th>
<th>The staff training rule meets certain aspects of the Stepping Stones standard, such as: proper hand hygiene, injury prevention, and administering medication; but there are some omissions, such as: procedure for accessing the child care health consultant for assistance; and exceeds the standard, such as: reducing the risk of SIDS.</th>
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<tr>
<td>(1) Orientation. Prior to assignment to children or task, all employees must receive initial orientation on the following subjects:</td>
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<tr>
<td>(a) The center's policies and procedures;</td>
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<tr>
<td>(b) The portions of these rules dealing with the care, health and safety of children;</td>
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<tr>
<td>(c) The employee's assigned duties and responsibilities;</td>
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<tr>
<td>(d) Reporting requirements for suspected cases of child abuse, neglect or deprivation; communicable diseases and serious injuries;</td>
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<td>(e) Emergency weather plans;</td>
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<td>(f) Childhood injury control;</td>
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<td>(g) The administration of medicine;</td>
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<tr>
<td>(h) Reducing the risk of Sudden Infant Death Syndrome (SIDS);</td>
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<tr>
<td>(i) Hand washing;</td>
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<td>(j) Fire Safety;</td>
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<td>(k) Water Safety;</td>
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<tr>
<td>(l) Prevention of HIV/Aids and blood borne pathogens.</td>
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DECAL could see about adding the few additional items listed in the Stepping Stones standard to this rule.
Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child care home caregivers/teachers should not commence operation before receiving orientation on these topics in pre-service training.

**STANDARD 1.4.3.1: First Aid and CPR Training for Staff**

The director of a center or a large family child care home should ensure all staff members involved in providing direct care have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training. At least one staff person who has successfully completed training in pediatric first aid that includes CPR should be in attendance at all times with a child whose special care plan indicates an increased risk of needing respiratory or cardiac resuscitation.

Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.

**591-1-1-.14 First Aid and CPR.**

(1) Training. The center director must successfully complete a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid. The first aid program must be done by certified or licensed health care professionals and must deal with the provision of emergency care to infants and children. In addition, at least fifty percent (50%) of the caregiver staff shall have completed such training. Whenever children are present, there must always be an employee on the center premises who is trained in CPR and first aid.

**STANDARD 1.4.3.2: Topics Covered in First Aid Training**

First aid training should present an overview of Emergency Medical Services (EMS), accessing EMS, poison center services, accessing the poison center, safety at the scene, and isolation of body substances. First aid instruction should include, but not be limited to, recognition and first response of pediatric emergency management in a child care setting of the following situations:

- a) Management of a blocked airway and rescue breathing for infants and children with return demonstration by the learner (pediatric CPR);
- b) Abrasions and lacerations;
- c) Bleeding, including nosebleeds;
- d) Burns;

Not addressed.

Director qualifications match. DECAL only requires 50% of teachers (compared to 100%); though DECAL requires a CPR trained caregiver when children are present.

DECAL may want to increase the percentage of teachers who have completed first aid and CPR training.

DECAL may want to address this specific standard and add it to their rules.
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e) Fainting;
f) Poisoning, including swallowed, skin or eye contact, and inhaled;
g) Puncture wounds, including splinters;
h) Injuries, including insect, animal, and human bites;
i) Poison control;
j) Shock;
k) Seizure care;
l) Musculoskeletal injury (such as sprains, fractures);
m) Dental and mouth injuries/trauma;
n) Head injuries, including shaken baby syndrome/abusive head trauma;
o) Allergic reactions, including information about when epinephrine might be required;
p) Asthmatic reactions, including information about when rescue inhalers must be used;
q) Eye injuries;
r) Loss of consciousness;
s) Electric shock;
t) Drowning;
u) Heat-related injuries, including heat exhaustion/heat stroke;
v) Cold related injuries, including frostbite;
w) Moving and positioning injured/ill persons;
x) Illness-related emergencies (such as stiff neck, inexplicable confusion, sudden onset of blood-red or purple rash, severe pain, temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or above 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method, and looking/acting severely ill);
y) Standard Precautions;
z) Organizing and implementing a plan to meet an emergency for any child with a special health care need;
aa) Addressing the needs of the other children in the group while managing emergencies in a child care setting;
ab) Applying first aid to children with special health care needs.

STANDARD 1.4.3.3: CPR Training for Swimming and Water Play

591-1-1-.35 Swimming Pools and Water-related Activities.
(3) Supervision of Children in Water Over

Partially meets.

This rule states that at least one person must have current evidence of having

DECAL may want to add the specific language regarding infant and child CPR training.
Facilities that have a swimming pool should require at least one staff member with current documentation of successful completion of training in infant and child (pediatric) CPR (Cardiopulmonary Resuscitation) be on duty at all times during business hours.

At least one of the caregivers/teachers, volunteers, or other adults who is counted in the child:staff ratio for swimming and water play should have documentation of successful completion of training in basic water safety, proper use of swimming pool rescue equipment, and infant and child CPR according to the criteria of the American Red Cross or the American Heart Association (AHA).

For small family child care homes, the person trained in water safety and CPR should be the caregiver/teacher. Written verification of successful completion of CPR and lifesaving training, water safety instructions, and emergency procedures should be kept on file.

| STANDARD 1.4.5.1: Training of Staff Who Handle Food | Two (2) Feet Deep. For water-related activity (such as swimming, fishing, boating or wading) in water over two (2) feet deep, continuous supervision of children must be provided as follows: Ages of Children Staff:Child Ratio* Under two and one-half (2 1/2) yrs. 1:2 Two and one-half (2 1/2) to four (4) yrs. 1:5 Four (4) yrs. and older who cannot swim a distance of fifteen (15) yards unassisted ** 1:6 Four (4) yrs. and older who can swim a distance of fifteen (15) yards unassisted ** 1:15 * At least one person must have current evidence of having completed successfully a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or YWCA or other recognized standard-setting agency for water safety instruction. Such person may be a center staff member or an employee of a water facility (e.g., local swimming pool). ** In lieu of requiring each child to take a swimming test to determine whether the child can swim a distance of fifteen (15) yards unassisted, center staff may accept copies of certificates or cards from a recognized water-safety instruction organization showing that the child has successfully completed a swimming class which required the child to swim a distance of fifteen (15) yards unassisted. |
| 591-1.1-.33 Staff Training. (3) First Year Training - Food Preparation. Within the first year of employment, the director and the person primarily responsible for food preparation hired after the effective date of these rules shall receive four (4) clock hours of training in | completed a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross but it does not address specifically training in infant and child CPR. | Partially meets. The rule addresses having food handling training but does not address being certified as a food protection manager or equivalent as demonstrated by completing an accredited food protection manager course. | DECAL may want to add this additional language. |
## STANDARD 1.4.5.2: Child Abuse and Neglect Education

Caregivers/teachers should use child abuse and neglect prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. The dangers of shaking infants and toddlers and repeated exposure to domestic violence should be included in the education and prevention materials. Caregivers/teachers should also receive education on promoting protective factors to prevent child maltreatment. Caregivers/teachers should be able to identify signs of stress in families and assist families by providing support and linkages to resources when needed. Children with disabilities are at a higher risk of being abused. Special training in child abuse and neglect and children with disabilities should be provided. 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. Child abuse reporting requirements are known and available from the child care regulation department in each state.

### 591-1-1-33 Staff Training.

1. **Orientation.** Prior to assignment to children or task, all employees must receive initial orientation on the following subjects:
   - (d) Reporting requirements for suspected cases of child abuse, neglect or deprivation; communicable diseases and serious injuries;
   - (b) Two clock hours of training in identifying, reporting and meeting the needs of abused, neglected or deprived children.

<table>
<thead>
<tr>
<th>Partially meets.</th>
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</thead>
<tbody>
<tr>
<td>The rule addresses orientation on reporting requirements for suspected cases of child abuse, neglect or deprivation and for two hours of training in identifying, reporting and meeting the needs of abused, neglected or deprived children, but does not go into any details regarding this orientation training.</td>
</tr>
</tbody>
</table>

**DECAL may want to add the additional language from the Stepping Stones standard.**

---

## STANDARD 1.5.0.2: Orientation of Substitutes

The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program’s policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.

All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be

### 591-1-1-31 Staff

6. **Substitute Employees.** The center shall provide for substitute staff when regular staff is absent from work. All substitute employees shall be at least eighteen (18) years of age. Substitute caregiver staff shall be informed of these rules and the center's policies and procedures for the age group for which they will be providing care. Substitute service staff shall be informed of the center's policies and procedures necessary to the proper performance of their job duties in compliance with these

<table>
<thead>
<tr>
<th>Partially meets.</th>
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<tbody>
<tr>
<td>The rule addresses the need for substitutes to receive orientation training but provides not details of what this orientation should be.</td>
</tr>
</tbody>
</table>

**DECAL may want to add the specifics from this standard.**
oriented on the following topics:
   a) Safe infant sleep practices if an infant is enrolled in the program;
   b) Any emergency medical procedure/medication needs of the children;
   c) Any nutrition needs of the children.

All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:
   a) The names of the children for whom the caregiver/teacher will be responsible, and their specific developmental needs;
   b) The planned program of activities at the facility;
   c) Routines and transitions;
   d) Acceptable methods of discipline;
   e) Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies);
   f) Emergency health and safety procedures;
   g) General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:
      1) Hand hygiene techniques, including indications for hand hygiene;
      2) Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves;
      3) The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages;
      4) Correct food preparation and storage techniques, if employee prepares food;
      5) Proper handling and storage of human milk when applicable and formula preparation if formula is handled;
      6) Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles;
      7) Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
      8) Injury prevention and safety including the role of mandatory child abuse reporter to report rules. A substitute employee must have a satisfactory criminal records check determination and receive orientation training. If any substitute serves in any one (1) position longer than six (6) months, the substitute so employed must meet all staffing requirements for that position.
any suspected abuse/neglect.

b) Emergency plans and practices;
i) Access to list of authorized individuals for releasing children.

<table>
<thead>
<tr>
<th>STANDARD 2.1.1.4: Monitoring Children’s Development/Obtaining Consent for Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child care settings provide daily indoor and outdoor opportunities for promoting and monitoring children’s development. Caregivers/teachers should monitor the children’s development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations, and early intervention and treatment. Caregivers/teachers should work in collaboration to monitor a child’s development with parents/guardians and in conjunction with the child’s primary care provider and health, education, mental health, and early intervention consultants. Caregivers/teachers should utilize the services of health and safety, education, mental health, and early intervention consultants to strengthen their observation skills, collaborate with families, and be knowledgeable of community resources. Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child’s placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The use of authentic assessment and curricular-based assessments should be an ongoing part of the services provided to all children (5-9). The facility’s formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation. Parents/guardians should be explicitly invited to:</td>
</tr>
<tr>
<td>a) Discuss reasons for a health or developmental assessment;</td>
</tr>
<tr>
<td>b) Participate in discussions of the results of their child’s evaluations and the relationship of their child’s needs to the caregivers/teachers’ ability to serve that child appropriately;</td>
</tr>
<tr>
<td>c) Give alternative perspectives;</td>
</tr>
<tr>
<td>d) Share their expectations and goals for their child and have these expectations and goals integrated</td>
</tr>
</tbody>
</table>

Not addressed. 

DECAL may want to address this specific standard and add it to their rules.
with any plan for their child:
e) Explore community resources and supports that might assist in meeting any identified needs that child care centers and family child care homes can provide;
f) Give written permission to share health information with primary health care professionals (medical home), child care health consultants and other professionals as appropriate;

The facility should document parents’/guardians’ presence at these meetings and invitations to attend.

If the parents/guardians do not attend the screening, the caregiver/teacher should inform the parents/guardians of the results, and offer an opportunity for discussion. Efforts should be made to provide notification of meetings in the primary language of the parents/guardians. Formal evaluations of a child’s health or development should also be shared with the child’s medical home with parent/guardian consent.

Programs are encouraged to utilize validated screening tools to monitor children’s development, as well as various measures that may inform their work facilitating children’s development and providing an enriching indoor and outdoor environment, such as authentic-based assessment, work sampling methods, observational assessments, and assessments intended to support curricular implementation (5,9). Programs should have clear policies for using reliable and valid methods of developmental screening with all children and for making referrals for diagnostic assessment and possible intervention for children who screen positive. All programs should use methods of ongoing developmental assessment that inform the curricular approaches used by the staff. Care must be taken in communicating the results. Screening is a way to identify a child at risk of a developmental delay or disorder. It is not a diagnosis. If the screening or any observation of the child results in any concern about the child’s development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may also be required.
<table>
<thead>
<tr>
<th>STANDARD 2.1.2.2: Interactions with Infants and Toddlers</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers/teachers should provide consistent, continuous and inviting opportunities to talk, listen to, and otherwise interact with young infants throughout the day (indoors and outdoors) including feeding, changing, playing with, and cuddling them.</td>
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</table>

<table>
<thead>
<tr>
<th>STANDARD 2.2.0.1: Methods of Supervision of Children</th>
<th>Partially meets.</th>
<th>This rule addresses supervision but lacks specificity, such as: regularly counting children at transitions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside. School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity. Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times. Developmentally appropriate child:staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child:staff ratio. Although centers often downsize the</td>
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591-1-1-32 Staff:Child Ratios and Supervision
(6) Supervision. Children shall be supervised at all times. "Supervision" means that the appropriate number of staff members are physically present in the area where children are being cared for and are providing watchful oversight to the children, chaperons and students in training. The persons supervising in the child care area must be alert, able to respond promptly to the needs and actions of the children being supervised, as well as the actions of the chaperons and students in training, and provide timely attention to the children's actions and needs. DECAL may want to address the additional language from the Stepping Stones standard to be more specific regarding supervision of children.
number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.

<table>
<thead>
<tr>
<th>STANDARD 2.2.0.10: Using Physical Restraint</th>
<th>591-1-11 Discipline.</th>
<th>Partially meets.</th>
<th>This rule addresses the use of physical restraints but does not address a behavioral plan.</th>
<th>DECAL may want to add the development and use of a behavioral plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a child with special behavioral or mental health issues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child's primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint.</td>
<td>(2) Personnel shall not:</td>
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<td></td>
<td>(f) Use mechanical or physical restraints or devices to discipline children;</td>
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<tr>
<td></td>
<td>a) An indication and documentation of the use of other behavioral strategies before the use of restraint and a precise definition of when the child could be restrained;</td>
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<td></td>
<td>b) That the restraint be limited to holding the child as gently as possible to accomplish the restraint;</td>
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<td></td>
<td>c) That such child restraint techniques do not violate the state's mental health code;</td>
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<td></td>
<td>d) That the amount of time the child is physically restrained should be the minimum necessary to control the situation and be age-appropriate; reevaluation and change of strategy should be used every few minutes;</td>
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<td></td>
<td>e) That no bonds, ties, blankets, straps, car seats, heavy weights (such as adult body sitting on child), or abusive words should be used;</td>
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<tr>
<td></td>
<td>f) That a designated and trained staff person, who should be on the premises whenever this specific child is present, would be the only person to carry out the restraint.</td>
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</tr>
<tr>
<td>STANDARD 2.2.0.4: Supervision Near Bodies of Water</td>
<td>591-1-35 Swimming Pools and Water-related Activities.</td>
<td>Partially meets.</td>
<td>The rule addresses supervision in water related activities but does not meet the ratios suggested in the Stepping Stones standard for infants or toddlers, nor is there specific language regarding the Virginia Graeme Baker Act.</td>
<td></td>
</tr>
<tr>
<td>Constant and active supervision should be maintained when any child is in or around water (1). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one</td>
<td>(1) Local Approval. When permanent swimming or wading pools are located on the center premises, applicable local regulations regarding the design.</td>
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</tbody>
</table>
Validating the Georgia Child Care Center Regulations

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adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm’s length providing “touch supervision”. Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and spas to prevent underwater entrapment of children in such locations with strong suction devices that have led to deaths of children of varying ages.

construction, operation and maintenance shall be followed.

(2) Accessibility of Pools. All swimming and wading pools shall be inaccessible to children except during supervised activities.

(3) Supervision of Children in Water Over Two (2) Feet Deep. For water-related activity (such as swimming, fishing, boating or wading) in water over two (2) feet deep, continuous supervision of children must be provided as follows:

<table>
<thead>
<tr>
<th>Ages of Children</th>
<th>Staff:Child Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under two and one-half (2 1/2) yrs</td>
<td>1:2</td>
</tr>
<tr>
<td>Two and one-half (2 1/2) to four (4) yrs</td>
<td>1:5</td>
</tr>
<tr>
<td>Four (4) yrs. and older who cannot swim a distance of fifteen (15) yards unassisted</td>
<td><strong>1:6</strong></td>
</tr>
<tr>
<td>Four (4) yrs. and older who can swim a distance of fifteen (15) yards unassisted</td>
<td><strong>1:15</strong></td>
</tr>
</tbody>
</table>

* At least one person must have current evidence of having completed successfully a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or YWCA or other recognized standard-setting agency for water safety instruction. Such person may be a center staff member or an employee of a water facility (e.g., local swimming pool).

** In lieu of requiring each child to take a swimming test to determine whether the child can swim a distance of fifteen (15) yards unassisted, center staff may accept copies of certificates or cards from a recognized water-safety instruction organization showing that the child has successfully completed a swimming class which required the child to swim a distance of fifteen (15) yards unassisted.

regarding the Virginia Graeme Baker Pool and Spa Safety Act.
(4) Supervision of Children in Water Less than Two (2) Feet Deep. For water-related activity (such as swimming, fishing, boating or wading) in water less than two (2) feet deep (such as a wading pool), continuous supervision must be provided in accordance with normal staff:child ratios which are as follows:

<table>
<thead>
<tr>
<th>Ages of Children</th>
<th>Staff:Child Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants less than one (1) year old or children under eighteen (18) months who are not walking</td>
<td>1:6</td>
</tr>
<tr>
<td>One (1) year olds who are walking</td>
<td>1:8</td>
</tr>
<tr>
<td>Two (2) year olds</td>
<td>1:10</td>
</tr>
<tr>
<td>Three (3) year olds</td>
<td>1:15</td>
</tr>
<tr>
<td>Four (4) year olds</td>
<td>1:18</td>
</tr>
<tr>
<td>Five (5) year olds</td>
<td>1:20</td>
</tr>
<tr>
<td>Six (6) years and older</td>
<td>1:25</td>
</tr>
</tbody>
</table>

(5) Additional Supervision. At least one (1) additional staff member above the required staff:child ratios for any water-related activity (such as swimming, fishing, boating, or wading) shall be available to rotate among the age groups as needed when any of the following circumstances are present:

(a) the majority of the children in a group are not accustomed to or are afraid of the water;
(b) the majority of the children in a group comprised of children who cannot swim a distance of 15 yards unassisted cannot touch the bottom of the water facility without submerging their heads;
(c) the water facility is particularly crowded;
(d) the children have special needs which impact on their ability to participate safely in the water-related activity.

(6) Parental Permission. No child shall participate in a swimming activity without the parents' written permission.

(7) Use of Wading Pools. Wading pools
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STANDARD 2.2.0.6: Discipline Measures
Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers should care for children without ever resorting to physical punishment or abusive language. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult’s guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. This process should include:

- a) Forming a positive relationship with the child. When children have a positive relationship with the adult, they are more likely to follow that person’s directions. This positive relationship occurs when the adult spends time talking to the child, listening to the child, following the child’s lead, playing with the child, and responding to the child’s needs;
- b) Basing expectations on children’s developmental level;
- c) Establishing simple rules children can understand (e.g., you can’t hurt others, our things, or yourself) and being proactive in teaching and supporting children in learning the rules;
- d) Adapting the physical indoor and outdoor learning/play environment or family child care home to encourage positive behavior and self-regulation by providing engaging materials based on children’s interests and ensuring that the learning environment promotes active participation of each child. Well-designed child care environments are ones that are supportive of appropriate behavior in children, and are designed to meet the needs of the children;
- 591-1-.11 Discipline.
  (1) Disciplinary actions used to correct a child’s behavior, guidance techniques and any activities in which the children participate or observe at the center shall not be detrimental to the physical or mental health of any child.
  (2) Personnel shall not:
    (a) Physically or sexually abuse a child or engage or permit others to engage in sexually overt conduct in the presence of any child enrolled in the center;
    (b) Inflict corporal/physical punishment upon a child;
    (c) Shake, jerk, pinch or handle a child roughly;
    (d) Verbally abuse or humiliate a child which includes, but is not limited to, the use of threats, profanity or belittling remarks about a child or his family;
    (e) Isolate a child in a dark room, closet or unsupervised area;
    (f) Use mechanical or physical restraints or devices to discipline children;
    (g) Use medication to discipline or control children’s behavior without written medical authorization issued by a licensed professional and given with the parent’s written consent;
    (h) Restrict unreasonably a child from going to the bathroom;
    (i) Punish toileting accidents;
    (j) Force-feed a child or withhold feeding a child regularly scheduled meals and/or snacks;
    (k) Force or withhold naps;
    (l) Allow children to discipline or

Meets
In some areas the Discipline rule exceeds the Stepping Stones standard and in other areas it does not; therefore, I even it out by saying the standard was met.

DECAL should look at the exact wording from Stepping Stones to determine where this rule can be strengthened. The major change should be in more positive language. Right now the rule is written in more negative language while the Stepping Stones standard is more positively worded.
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- to help children learn about what to expect in that environment and to promote positive interactions and engagement with others;
- e) Modifying the learning/play environment (e.g., schedule, routine, activities, transitions) to support the child’s appropriate behavior;
- f) Creating a predictable daily routine and schedule. When a routine is predictable, children are more likely to know what to do and what is expected of them. This may decrease anxiety in the child. When there is less anxiety, there may be less acting out. Reminders need to be given to the children so they can anticipate and prepare themselves for transitions within the schedule. Reminders should be individualized such that each child understands and anticipates the transition;
- g) Using encouragement and descriptive praise. When clear encouragement and descriptive praise are used to give attention to appropriate behaviors, those behaviors are likely to be repeated. Encouragement and praise should be stated positively and descriptively. Encouragement and praise should provide information that the behavior the child engaged in was appropriate. Examples: “I can tell you are ready for circle time because you are sitting on your name and looking at me.” “Your friend looked so happy when you helped him clean up his toys.” “You must be so proud of yourself for putting on your coat all by yourself.” Encouragement and praise should label the behaviors, not the child (e.g., good listening, good eating, instead of good boy);
- h) Using clear, direct, and simple commands. When clear commands are used with children, they are more likely to follow them. The caregiver/teacher should tell the child what to do rather than what NOT to do. The caregiver/teacher should limit the number of commands. The caregiver/teacher should use if/ then and when/then statements with logical and natural consequences. These practices help children understand they can make choices and that choices have consequences;
- i) Showing children positive alternatives rather than just telling children “no”;
- j) Modeling desired behavior;
- k) Using planned ignoring and redirection. Certain
- (m) Confine a child for disciplinary purposes to a swing, highchair, infant carrier, walker or jumpseat;
- (n) Commit any criminal act, as defined under Georgia law which is set forth in O.C.G.A. Sec. 16-1-1 et seq., in the presence of any child enrolled in the center.
behaviors can be ignored while at the same time the adult is able to redirect the children to another activity. If the behavior cannot be ignored, the adult should prompt the child to use a more appropriate behavior and provide positive feedback when the child engages in the behavior;

l) Individualizing discipline based on the individual needs of children. For example, if a child has a hard time transitioning, the caregiver/teacher can identify strategies to help the child with the transition (individualized warning, job during transition, individual schedule, peer buddy to help, etc.) If a child has a difficult time during a large group activity, the child might be taught to ask for a break;

m) Using time-out for behaviors that are persistent and unacceptable. Time-out should only be used in combination with instructional approaches that teach children what to do in place of the behavior problem. (See guidance for time-outs below.)

Expectations for children’s behavior and the facility’s policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children’s appropriate behaviors before it becomes a problem.

**STANDARD 2.2.0.8: Preventing Expulsions, Suspensions, and Other Limitations in Services**

Child care programs should not expel, suspend, or otherwise limit the amount of services (including denying outdoor time, withholding food, or using food as a reward/punishment) provided to a child or family on the basis of challenging behaviors or a health/safety condition or situation unless the condition or situation meets one of the two exceptions listed in this standard.

Expulsion refers to terminating the enrollment of a child or family in the regular group setting because of a challenging behavior or a health condition. Suspension and other limitations in services include all other reductions in the amount of time a child may be in attendance of the regular group setting, either by requiring the child to cease attendance for a particular period of time or reducing the

| Not addressed. |  | DECAL may want to address this specific standard and add it to their rules. |
number of days or amount of time that a child may attend. Requiring a child to attend the program in a special place away from the other children in the regular group setting is included in this definition.

Child care programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program’s protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises.

Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children’s health conditions in collaboration with parents/guardians and the child’s primary care provider. Programs should attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children’s mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. Mental health consultation may be obtained from a variety of sources, as described in Standard 1.6.0.3.

When children exhibit or engage in challenging behaviors that cannot be resolved easily, as above, staff should:

a) Assess the health of the child and the adequacy of the curriculum in meeting the developmental and educational needs of the child;

b) Immediately engage the parents/guardians/family in a spirit of collaboration regarding how the child’s behaviors may be best handled, including appropriate solutions that have worked at home or in other settings;

c) Access an early childhood mental health consultant to assist in developing an effective plan to address the child’s challenging behaviors and to
assist the child in developing age-appropriate, pro-social skills;
d) Facilitate, with the family’s assistance, a referral for an evaluation for either Part C (early intervention) or Part B (preschool special education), as well as any other appropriate community-based services (e.g., child mental health clinic);
e) Facilitate with the family communication with the child’s primary care provider (e.g., pediatrician, family medicine provider, etc.), so that the primary care provider can assess for any related health concerns and help facilitate appropriate referrals.

The only possible reasons for considering expelling, suspending or otherwise limiting services to a child on the basis of challenging behaviors are:

a) Continued placement in the class and/or program clearly jeopardizes the physical safety of the child and/or his/her classmates as assessed by a qualified early childhood mental health consultant AND all possible interventions and supports recommended by a qualified early childhood mental health consultant aimed at providing a physically safe environment have been exhausted; or
b) The family is unwilling to participate in mental health consultation that has been provided through the child care program or independently obtain and participate in child mental health assistance available in the community; or
c) Continued placement in this class and/or program clearly fails to meet the mental health and/or social-emotional needs of the child as agreed by both the staff and the family AND a different program that is better able to meet these needs has been identified and can immediately provide services to the child.

In either of the above three cases, a qualified early childhood mental health consultant, qualified special education staff, and/or qualified community-based mental health care provider should be consulted, referrals for special education services and other community-based services should be facilitated, and a detailed transition plan from this program to a more appropriate setting should be developed with the family and followed. This transition could include a different private or public-funded child care
or early education program in the community that is better equipped to address the behavioral concerns (e.g., therapeutic preschool programs, Head Start or Early Head Start, prekindergarten programs in the public schools that have access to additional support staff, etc.), or public-funded special education services for infants and toddlers (i.e., Part C early intervention) or preschoolers (i.e., Part B preschool special education).

To the degree that safety can be maintained, the child should be transitioned directly to the receiving program. The program should assist parents/guardians in securing the more appropriate placement, perhaps using the services of a local child care resource and referral agency. With parent/guardian permission, the child’s primary care provider should be consulted and a referral for a comprehensive assessment by qualified mental health provider and the appropriate special education system should be initiated. If abuse or neglect is suspected, then appropriate child protection services should be informed. Finally, no child should ever be expelled or suspended from care without first conducting an assessment of the safety of alternative arrangements (e.g., Who will care for the child? Will the child be adequately and safely supervised at all times?)

<table>
<thead>
<tr>
<th>STANDARD 2.2.0.9: Prohibited Caregiver/Teacher Behaviors</th>
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<tbody>
<tr>
<td>The following behaviors should be prohibited in all child care settings and by all caregivers/teachers:</td>
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<tr>
<td>a) The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to:</td>
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<tr>
<td>1) Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting;</td>
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<tr>
<td>2) Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;</td>
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<tr>
<td>3) Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;</td>
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<tr>
<td>591-1.1.11 Discipline.</td>
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<tr>
<td>(1) Disciplinary actions used to correct a child’s behavior, guidance techniques and any activities in which the children participate or observe at the center shall not be detrimental to the physical or mental health of any child.</td>
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<tr>
<td>(2) Personnel shall not:</td>
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<tr>
<td>(a) Physically or sexually abuse a child or engage or permit others to engage in sexually overt conduct in the presence of any child enrolled in the center;</td>
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<tr>
<td>(b) Inflict corporal/physical punishment upon a child;</td>
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<tr>
<td>(c) Shake, jerk, pinch or handle a child roughly;</td>
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<tr>
<td>(d) Verbally abuse or humiliate a child which includes, but is not limited to, the use of threats, profanity or belittling</td>
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<tr>
<td>Meets to Exceeds.</td>
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<tr>
<td>This rule contains either directly or indirectly the actual wording or meaning of the Stepping Stones standard.</td>
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<tr>
<td>DECAL should focus on the other rules that need attention. This rule is in good shape as is.</td>
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RESEARCH INSTITUTE FOR KEY INDICATORS (RIKI)
4) 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 or tying to restrict movement, such as in a car seat (except when travelling) or taping the mouth;
   d) Using or withholding food as a punishment or reward;
   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, either as an incident of discipline or otherwise. Any child care program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child’s family;
   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;
   j) Physical activity/outdoor time should not be taken away as punishment.

(e) Isolate a child in a dark room, closet or unsupervised area;
(f) Use mechanical or physical restraints or devices to discipline children;
(g) Use medication to discipline or control children’s behavior without written medical authorization issued by a licensed professional and given with the parent’s written consent;
(h) Restrict unreasonably a child from going to the bathroom;
(i) Punish toileting accidents;
(j) Force-feed a child or withhold feeding a child regularly scheduled meals and/or snacks;
(k) Force or withhold naps;
(l) Allow children to discipline or humiliate other children;
(m) Confine a child for disciplinary purposes to a swing, highchair, infant carrier, walker or jumpseat;
(n) Commit any criminal act, as defined under Georgia law which is set forth in O.C.G.A. Sec. 16-1-1 et seq., in the presence of any child enrolled in the center.

**STANDARD 2.3.3.1: Parents'/Guardians’ Provision of Information on Their Child’s Health and Behavior**

The facility should ask parents/guardians for information regarding the child’s health, nutrition, level of physical activity, and behavioral status upon registration or when there has been an extended gap in the child’s attendance at the facility. The child’s health record should be updated if s/he have had any changes in their health or immunization status. Parents/guardians should be encouraged to sign a release of information/agreement so that child care workers can communicate directly with the child’s medical home/primary care provider.

**591-1-1-.20 Medications.**

(1) Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child’s physician or parent. Such authorization will include when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

**591-1-1-.23 Parental Authorizations.**

Meets to Exceeds. The rule contains the details of the information being requested in the Stepping Stones standard.

No action needed.
A center must obtain the following parental authorizations when a child is enrolled.

(a) Authorization for the center to obtain emergency medical care for the child when the parent is not available;
(b) Authorization for the center to dispense medication (see rule .20 for details about dispensing medication);
(c) Authorization for the child to participate in field trips and special activities away from the center (see rule .13 for details about field trips);
(d) Authorization for the child to participate in water-related activities occurring in water that is more than two (2) feet deep if the center participates in such activities (see rule .35 for details about water-related activities);
(e) Authorization for the center to provide routine transportation for the child to or from school, home or center (see rule .36 for details about transportation);
(f) Authorization for persons other than parents to pick up or drop off their child, including the names of such persons.

(5) Emergency Medical Information. Emergency medical information on each child to include allergies; special medical needs and conditions; current prescribed medications that the child is required to take on a daily basis for a chronic condition; the name and phone number of the child's doctor; the local medical facility that the center uses in the area where the center is located; and the telephone numbers where the parents can be reached shall be left at the center as well as be taken on the trip in the possession of the adult in charge of the trip.
**STANDARD 3.1.2.1: Routine Health Supervision and Growth Monitoring**

The facility should require that each child has routine health supervision by the child’s primary care provider, according to the standards of the American Academy of Pediatrics (AAP). For all children, health supervision includes routine screening tests, immunizations, and chronic or acute illness monitoring. For children younger than twenty-four months of age, health supervision includes documentation and plotting of sex-specific charts on child growth standards from the World Health Organization (WHO), available at http://www.who.int/childgrowth/standards/en/, and assessing diet and activity. For children twenty-four months of age and older, sex-specific height and weight graphs should be plotted by the primary care provider in addition to body mass index (BMI), according to the Centers for Disease Control and Prevention (CDC). BMI is classified as underweight (BMI less than 5%), healthy weight (BMI 5%-84%), overweight (BMI 85%-94%), and obese (BMI equal to or greater than 95%).

Follow-up visits with the child’s primary care provider that include a full assessment and laboratory evaluations should be scheduled for children with weight for length greater than 95% and BMI greater than 85%.

School health services can meet this standard for school-age children in care if they meet the AAP’s standards for school-age children and if the results of each child’s examinations are shared with the caregiver/teacher as well as with the school health system. With parental/guardian consent, pertinent health information should be exchanged among the child’s routine source of health care and all participants in the child’s care, including any school health program involved in the care of the child.

<table>
<thead>
<tr>
<th>591-1-1-07 Children’s Health.</th>
<th>Does not meet.</th>
<th>The Children’s Health rule provides what a provider must do related to the exclusion of sick children, notifying parents, and medical emergencies; but it does not address routine health supervision.</th>
<th>DECAL should see about adopting the language within the Stepping Stones standard. This will probably require a new rule rather than incorporating the language within this rule.</th>
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<tr>
<td>(1) Exclusion of Sick Children. A child shall not be accepted nor allowed to remain at the center if the child has the equivalent of a one hundred one (101) degrees Fahrenheit or higher oral temperature and another contagious symptom, such as but not limited to, a rash, diarrhea or a sore throat. When a child shows symptoms of illness during the day, the child shall be moved to a quiet area away from other children where the child shall be supervised and provided the necessary attention until such time as the child leaves the center or is able to return to the child’s group.</td>
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<td>(2) Parental Notification. Parents must be notified of a child’s illness or injury as follows: Immediately notify parents and obtain specific instructions until child can be picked up or returned to group. When professional medical attention is required, or when child experiences symptoms of moderate discomfort such as elevated temperature, vomiting or diarrhea. Notify parents by the end of the day. When professional medical attention is not required, or when child experiences symptoms of less than moderate discomfort, or when child experiences an adverse reaction to prescribed medication which does not constitute moderate discomfort.</td>
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<td>(3) Communicable Diseases. The Department’s current communicable disease chart of recommendations for exclusion of sick children from the center and their readmission shall be followed. Parents of all children enrolled shall be notified in writing of the occurrence of any of the illnesses on the communicable disease chart, as provided by the</td>
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<tr>
<td>STANDARD 3.1.3.1: Active Opportunities for Physical Activity</td>
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<td>The facility should promote children’s active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. All children, birth to six years, should participate daily in:</td>
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<td>a) Two to three occasions of active play outdoors, weather permitting (see Standard 3.1.3.2: Playing Outdoors for appropriate weather conditions);</td>
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<td>b) Two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day—indoor or outdoor;</td>
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<td>c) Continuous opportunities to develop and practice age-appropriate gross motor and movement skills.</td>
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<td>The total time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions.</td>
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<td>a) Outdoor play:</td>
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<td>1) Infants (birth to twelve months of age) should be taken outside two to three times per day, as tolerated. There is no recommended</td>
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<td>591-1-1-.03 Activities.</td>
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<td>(1) The center shall provide a daily planned program of varied and developmentally appropriate activities that promote the social, emotional, physical, cognitive, language and literacy development of each child. Center staff shall use a variety of teaching methods to accommodate the needs of the children's different learning styles.</td>
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<td>(2) Current lesson plans shall be kept on site and reflect appropriate instruction practices and activities to support children's development. The center shall have sufficient and varied play and learning equipment and materials to support the above program of activities in all developmental areas.</td>
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<td>(3) Opportunities for each child to make choices in a variety of activities shall be offered. Children with special needs shall be integrated into the activities provided by the center unless contraindicated medically or by written parental</td>
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<td>Partially Meets.</td>
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<td>This rule has the basic elements contained in the Stepping Stones standard but not the details (number of occasions, etc.) and in some cases time frames are not adequate, such as: infants should not be seated for more than fifteen minutes at a time where the rule states 30 minutes.</td>
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<tr>
<td>DECAL should review the specific language of the Stepping Stones standard in revising this rule.</td>
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duration of infants’ outdoor play;
2) Toddlers (twelve months to three years) and preschoolers (three to six years) should be allowed sixty to ninety total minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise should remain the same;
b) Total time allotted for moderate to vigorous activities:
   1) Toddlers should be allowed sixty to ninety minutes per eight-hour day for moderate to vigorous physical activity, including running;
   2) Preschoolers should be allowed ninety to one hundred and twenty minutes per eight-hour day.

Infants should have supervised tummy time every day when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity.

Time spent outdoors has been found to be a strong, consistent predictor of children’s physical activity. Children can accumulate opportunities for activity over the course of several shorter segments of at least ten minutes each. Because structured activities have been shown to produce higher levels of physical activity in young children, it is recommended that caregivers/teachers incorporate two or more short structured activities (five to ten minutes) or games daily that promote physical activity.

Opportunities to be actively enjoying physical activity should be incorporated into part-time programs by prorating these recommendations accordingly, i.e., twenty minutes of outdoor play for every three hours in the facility.

Active play should never be withheld from children who misbehave (e.g., child is kept indoors to help another caregiver/teacher while the rest of the children go outside). However, children with out-of-control behavior may need five minutes or less to calm themselves or settle down before resuming cooperative play or activities.
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Infants should not be seated for more than fifteen minutes at a time, except during meals or naps. Infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. if used should only be used for short periods of time. A least restrictive environment should be encouraged at all times.

Children should have adequate space for both inside and outside play.

(c) Outdoor Activities. Outdoor activities shall be provided daily, weather permitting, in accordance with the following:
1. Centers operating five (5) hours or more per day shall provide each child who is not an infant at least one and one-half (1 1/2) hours of outdoor activity per day.
2. Infants shall spend at least one (1) hour daily out of doors.
3. Centers operating less than five (5) hours per day shall provide a brief outdoor period for the children daily.

STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.

All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/ subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.

All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):
   a) Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant’s primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;
   b) Infants should be placed for sleep in safe sleep

591-1-1-.45 Infant-Sleeping Safety Requirements.
In order to reduce the risk of Sudden Infant Death Syndrome (SIDS), staff shall put an infant to sleep on the infant’s back unless the center has been provided a physician’s written statement authorizing another sleep position for that particular infant. The infant shall be placed for sleeping on a firm, tight-fitting mattress in a sturdy and safe crib. If the crib has side bars, the bars will be no more than two and three-eighths inches (2 3/8”) apart. Any crib used for sleeping shall have a tight-fitting bottom crib sheet with no pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items in the crib. If a blanket is required for the comfort of the infant, the infant’s feet shall be placed at the foot of the crib and the infant shall be covered with the blanket only to chest level with the blanket tucked firmly under the crib mattress. The infant’s sleeping area shall be maintained within a temperature range of sixty-five (65) to eighty-five (85) degrees depending upon the season. When an infant can easily turn over onto his or her stomach, staff shall continue to put the infant to sleep initially Partially meets.

This rule contains the basic elements of the Stepping Stones standard but more specific citations to the US Consumer Product Safety Commission (CPSC) and ASTM standards and guidelines are not present.

DECAL should add the specific wording regarding cribs meeting the standards and guidelines reviewed/approved by the CPSC and ASTM.
environments, which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child’s primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;

| c) | Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards) (4); |
| d) | If an infant arrivers at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant’s assigned crib); |
| e) | If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib; |
| f) | Only one infant should be placed in each crib (stackable cribs are not recommended); |
| g) | Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used (see Standard 3.1.4.2 for more detail information on swaddling); |
| h) | Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments; |
| i) | When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a

| on the infant’s back but allow the infant to roll over onto his or her stomach as the infant prefers. Positioning devices that restrict an infant’s movement in the crib shall not be used unless a physician’s written statement authorizing its use is provided for that particular infant. |
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<tr>
<th>Lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);</th>
<th>j) Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;</th>
<th>k) Bedding should be changed between children, and if mats are used, they should be cleaned between uses.</th>
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<tr>
<td>The lighting in the room must allow the caregiver/teacher to see each infant’s face, to view the color of the infant’s skin, and to check on the infant’s breathing and placement of the pacifier (if used). A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant’s head remains uncovered and re-adjust clothing as needed. The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms. Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.</td>
<td>591-1-10 Diapering Areas and Practices.</td>
<td>Does not meet.</td>
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<tr>
<td>STANDARD 3.2.1.4: Diaper Changing Procedure The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be 591-1-1.10 Diapering Areas and Practices. (1) Ventilation. For centers first licensed after March 1, 1991, and for centers that are renovated after March 1, 1991, the</td>
<td>This rule has the basic, overall elements to consider but does not have the specific diaper changing procedure as stated in Stepping Stones.</td>
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<tr>
<td>DECAL should adopt the diaper changing procedures as delineated in Stepping Stones.</td>
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simple and should be in multiple languages if caregivers/teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them.

An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

Step 1: Get organized. Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area:

a) Non-absorbent paper liner large enough to cover the changing surface from the child’s shoulders to beyond the child’s feet;  
b) Unused diaper, clean clothes (if you need them);  
c) Wipes for cleaning the child’s genitalia and buttocks removed from the container or dispensed so the container will not be touched during diaper changing;  
d) A wet cloth or paper towel;  
e) A plastic bag for any soiled clothes or cloth diapers;  
f) Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing;  
g) A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue.

Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change.  
a) Always keep a hand on the child;  
b) If the child’s feet cannot be kept out of the diaper changing areas shall be ventilated by functioning exhaust fans and a duct system or by the required operable windows.

(2) Lavatory. In centers first licensed after March 1, 1991, and centers that renovate existing plumbing facilities, a hand washing lavatory with running heated water shall be located adjacent to the diapering area. Flush sinks shall not be used for hand washing.

Cleansing procedures in other facilities shall be approved by the Department.

(3) Changing Diapers. Diapers shall be changed in the child’s own crib or on a diaper changing surface that is used for no purposes other than changing clothes in each room where infants or any other children wearing diapers are served.

(a) If diapers are changed on a diaper changing surface, the surface shall be smooth, nonporous, and equipped with a guard or rails to prevent falls. Between each diaper change, the diaper change surface shall be cleaned with a disinfectant and dried with a single-use disposable towel.  
(b) Infants and children shall not be left unattended while being diapered or having their clothes changed on the diaper changing surface.  
(c) Any items which might harm a child must be kept out of a child's reach.  

(4) Supplies. The following items shall also be provided at the diapering area: liquid soap, individually dispensed, single-use hand towels, single-use wash cloths, and covered...
or from contact with soiled skin during the changing process, remove the child’s shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing.

Step 3: Clean the child’s diaper area.
   a) Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child;
   b) If safety pins are used, close each pin immediately once it is removed and keep pins out of the child’s reach (never hold pins in your mouth);
   c) Lift the child’s legs as needed to use disposable wipes to clean the skin on the child’s genitalia and buttocks and prevent recontamination from a soiled diaper. If there is a need to clean between the labia of an infant girl, use only a wet cloth or paper towel. Remove stool and urine from front to back and use a fresh wipe each time you swipe. Put the soiled wipes into the soiled diaper or directly into a plastic-lined, hands-free covered can.

Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.
   a) Fold the soiled surface of the diaper inward;
   b) Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service;
   c) Put soiled clothes in a plastic-lined, hands-free plastic bag;
   d) If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can;
   e) Whether or not gloves were used, use a disposable antibacterial wipe or alcohol-based hand sanitizer to clean the surfaces of the caregiver/teacher’s hands and an application to clean the child’s hands, and put the wipes, if used, into the plastic-lined, hands-free covered can. Allow sanitized hands to dry completely before storage container for soiled items.

(5) Hygiene. Staff shall wash their hands with liquid soap and warm running water immediately before and after each diaper change they perform. Staff with diaper changing responsibilities shall not be simultaneously assigned to kitchen food preparation duties.

(6) Location of Diapering Area. The area used for diapering shall not be used for food preparation. It must be clear of formulas, food, food utensils and food preparation items.

(7) School-age Center. Except for children with special needs who are school-age but require diapering, the above rules do not apply to school-age centers
Validating the Georgia Child Care Center Regulations

Step 5: Put on a clean diaper and dress the child.
   a) Slide a fresh diaper under the child;
   b) Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can;
   c) Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
   d) Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin.

Step 6: Wash the child’s hands and return the child to a supervised area.
   a) Use soap and warm water, between 60°F and 120°F, at a sink to wash the child’s hands, if you can.

Step 7: Clean and disinfect the diaper-changing surface.
   a) Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-free covered can;
   b) If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;
   c) Remove any visible soil from the changing surface with a water saturated disposable paper towel or wipe;
   d) Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer’s instructions for use;
   e) Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

Step 8: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child’s daily log.
   a) In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary.
STANDARD 3.2.2.1: Situations that Require Hand Hygiene

All staff, volunteers, and children should follow the procedure in Standard 3.2.2.2 for hand hygiene at the following times:

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

b) Before and after:
   1) Preparing food or beverages;
   2) Eating, handling food, or feeding a child;
   3) 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;
   4) Playing in water (including swimming) that is used by more than one person;
   5) Diapering;

c) After:
   1) Using the toilet or helping a child use a toilet;
   2) Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;
   3) Handling animals or cleaning up animal waste;
   4) Playing in sand, on wooden play sets, and outdoors;
   5) Cleaning or handling the garbage.

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

591-1-17.17 Hygiene

(7) Handwashing, Children. Children's hands shall be washed with liquid soap and warm running water:
   a) Immediately upon arrival for care, when moving from one child care group to another, and upon re-entering the child care area after outside play;
   b) Before and after eating meals and snacks, handling or touching food, or playing in water;
   c) After toileting and diapering, playing in sand, touching animals or pets, and contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood;
   d) After contamination by any other means; and
   e) Washcloth handwashing is permitted for infants when the infant is too heavy to hold for handwashing or cannot stand safely to wash hands at a sink and for children with special needs who are not capable of washing their own hands. An individual washcloth shall be used only once for each child before laundering.

(8) Handwashing, Staff. Personnel shall wash their hands with liquid soap and warm running water:
   a) Immediately upon arrival for the day, when moving from one child care group to another, and upon re-entering the child care area after outside play;
   b) Before and after diapering each child, dispensing medication, applying topical medications, ointments, creams or lotions, handling and preparing food, eating, drinking, preparing bottles, feeding each child, and assisting children with eating and drinking; and
   c) After toileting or assisting children with toileting, using tobacco products, handling...
garbage and organic waste, touching animals or pets, and handling bodily fluids, such as, but not limited to, mucus, saliva, vomit or blood; and 
(d) After contamination by any other means.
(9) Laundry. If laundry is done on center premises, the laundry area shall be located outside the children's activity rooms or areas and not used as a passageway by children to travel from one area to another whenever any soiled or clean laundry is exposed.
(10) Potty Chairs. If used, toilet potty chairs shall after each use be emptied by disposal in a flush toilet, cleaned with a disinfectant, and stored in the bathroom. If a sink is used, the sink shall also be disinfected.
(11) Soiled Containers and Items. Separate containers shall be used for storing soiled disposable items, such as disposable diapers, disposable washcloths and soiled nondisposable items such as cloth diapers, washcloths and bed linens. Such containers shall be waterproof or equipped with a leakproof disposable liner, covered, easily cleaned and maintained in such a manner so as the contents of the container are never accessible to the children.
(12) Wet Clothing. Children's wet or soiled clothing shall be stored in individual plastic bags immediately after being removed from the child.

<table>
<thead>
<tr>
<th>STANDARD 3.2.2.2: Handwashing Procedure</th>
<th>591-1-1.17 Hygiene.</th>
<th>Does not meet.</th>
<th>This rule does not address a handwashing procedure other than stating “personnel shall wash their hands with liquid soap and warm water…”</th>
<th>DECAL should adopt the handwashing procedure as stated in Stepping Stones.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and staff members should wash their hands using the following method:</td>
<td>(8) Handwashing, Staff. Personnel shall wash their hands with liquid soap and warm running water:</td>
<td></td>
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<tr>
<td>a) Check to be sure a clean, disposable paper (or single-use cloth) towel is available; b) Turn on warm water, between 60°F and 120°F,</td>
<td>(a) Immediately upon arrival for the day, when moving from one child care group to another, and upon re-entering the child</td>
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</table>
Validating the Georgia Child Care Center Regulations

- To a comfortable temperature;
- Moisten hands with water and apply soap (not antibacterial) to hands;
- Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice) (2);
- Rub areas between fingers, around nailbeds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not be worn (3);
- Rinse hands under running water, between 60°F and 120°F, until they are free of soap and dirt. Leave the water running while drying hands;
- Dry hands with the clean, disposable paper or single use cloth towel;
- If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel;
- Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.

The use of alcohol based hand sanitizers is an alternative to traditional handwashing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces and hands should be permitted to air dry. Situations/times that children and staff should wash their hands should be posted in all handwashing areas.

Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps.

Children and staff who need to open a door to leave a bathroom or diaper changing area should open the door with a disposable towel to avoid possibly re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.
<table>
<thead>
<tr>
<th>STANDARD 3.2.2.3: Assisting Children with Hand Hygiene</th>
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<tbody>
<tr>
<td>Caregivers/teachers should provide assistance with handwashing at a sink for infants who can be safely cradled in one arm and for children who can stand but not wash their hands independently. A child who can stand should either use a child-height sink or stand on a safety step at a height at which the child’s hands can hang freely under the running water. After assisting the child with handwashing, the staff member should wash his or her own hands. Hand hygiene with an alcohol-based sanitizer is an alternative to handwashing with soap and water by children over twenty-four months of age and adults when there is no visible soiling of hands.</td>
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<td>(7) Handwashing, Children. Children's hands shall be washed with liquid soap and warm running water:</td>
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<td>(a) Immediately upon arrival for care, when moving from one child care group to another, and upon re-entering the child care area after outside play;</td>
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<tr>
<td>(b) Before and after eating meals and snacks, handling or touching food, or playing in water;</td>
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<td>(c) After toileting and diapering, playing in sand, touching animals or pets, and contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood;</td>
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<td>(d) After contamination by any other means; and</td>
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<td>(e) Washcloth handwashing is permitted for infants when the infant is too heavy to hold for handwashing or cannot stand safely to wash hands at a sink and for children with special needs who are not capable of washing their own hands. An individual washcloth shall be used only once for each child before laundering.</td>
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<tr>
<th>Partially meets.</th>
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<tr>
<td>There appears to be a discrepancy in that the rule suggests using a washcloth and does not address the use of an alcohol-based sanitizer as an alternative to handwashing with soap and water.</td>
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<thead>
<tr>
<th>STANDARD 3.2.3.4: Prevention of Exposure to Blood and Body Fluids</th>
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<tbody>
<tr>
<td>Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention (CDC). Standard Precautions should be used to handle potential exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids.</td>
</tr>
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<tr>
<th>Not addressed.</th>
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<tbody>
<tr>
<td>In child care settings:</td>
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<tr>
<td>a) Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering;</td>
</tr>
<tr>
<td>b) Gowns and masks are not required;</td>
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<tr>
<th>May want to consider the use of an alcohol-based sanitizer as an alternative to handwashing with soap and water.</th>
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<tbody>
<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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</tbody>
</table>
c) Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection. Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of bloodborne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration (OSHA).

Procedures for Standard Precautions should include:

a) Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required.

b) The staff should use barriers and techniques that:
   1) Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and tissue discharges; and
   2) Reduce the spread of infectious material within the child care facility. Such techniques include avoiding touching surfaces with potentially contaminated materials unless those surfaces are disinfected before further contact occurs with them by other objects or individuals.

c) When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges occur, these spills should be cleaned up immediately, and further managed as follows:
   1) For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7;
   2) For spills of blood or other potentially infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucus membrane (eyes, nose, mouth);
3) Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie;
4) Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting.

Prior to using a disinfectant, clean the surface with a detergent and rinse well with water. Facilities should follow the manufacturer’s instruction for preparation and use of disinfectant (3,4). For guidance on disinfectants, refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to bloodborne pathogens.

STANDARD 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs

Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises during the child care program’s paid time including break time.

591-1-1.28 Prohibited Substances. (1) Alcohol and Illegal Drugs. Staff, chaperons and students in training shall not be under the influence of or consume alcohol, marijuana or other controlled substances on the center premises during the hours of operation or at any other time or place where there are children present for whom the center staff is responsible.

Meets.  

No changes.
(2) No Smoking. Smoking is prohibited on the premises of a center during the hours of operation and no smoking signs must be posted. Smoking is also prohibited in any vehicle used to transport children during the hours that the center is in operation.

STANDARD 3.4.3.1: Emergency Procedures
When an immediate emergency medical response is required, the following emergency procedures should be utilized:

a) First aid should be employed and an emergency medical response team should be called such as 9-1-1 and/or the poison center if a poison emergency (1-800-222-1222);

b) The program should implement a plan for emergency transportation to a local emergency medical facility;

c) The parent/guardian or parent/guardian’s emergency contact person should be called as soon as practical;

d) A staff member should accompany the child to the hospital and will stay with the child until the parent/ guardian or emergency contact person arrives. Child to staff ratio must be maintained, so staff 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 or feasible to follow standard or previously agreed upon emergency procedures (see also Standard 9.2.4.3, Disaster Planning, Training, and Communication). Children with known medical conditions that might involve emergent care require a Care Plan created by the child’s primary care provider. All staff need to be trained to manage an emergency until emergency medical care becomes available.

591-1-1-.07 Children's Health.

4) Medical Emergencies. A center shall have a written plan which outlines how emergency medical services will be obtained, including place(s) the child will be taken for emergency care. When a medical emergency arises involving a child, the center staff shall seek prompt emergency medical treatment and provide any certified or licensed emergency medical persons with immediate access to the child.

Partially meets.

The rule specifies a written plan for emergency medical services but does not specify the procedures.

DECAL should adopt the emergency procedures for an emergency medical response as outlined in Stepping Stones.

STANDARD 3.4.4.1: Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
Each facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect. The facility should report to the child abuse reporting hotline, department of health.

591-1-1-.29 Required Reporting.

1) The director or designated person-in-charge shall report or cause to be reported the following:

a) Child Abuse, Neglect or Deprivation. Suspected incidents of child abuse, neglect or deprivation shall be reported to the local

Partially meets.

The rule covers staff training but does not have a requirement for a written policy or an instruction sheet about child abuse reporting.

DECAL may want to add the wording from the Stepping Stones standard.
social services, child protective services, or police as required by state and local laws, in any instance where there is reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. Phone numbers and reporting system as required by state or local agencies should be clearly posted by every phone.

Caregivers/teachers should receive initial and ongoing training to assist them in preventing child abuse and neglect and in recognizing signs of child abuse and neglect. Programs are encouraged to partner with primary care providers, child care health consultants and/or child protection advocates to provide training and to be available for consultation.

Employees and volunteers in centers and large family child care homes should receive an instruction sheet about child abuse and neglect reporting that contains a summary of the state child abuse reporting statute and a statement that they will not be discharged/disciplined solely because they have made a child abuse and neglect report. Some states have specific forms that are required to be completed when abuse and neglect is reported. Some states have forms that are not required but assist mandated reporters in documenting accurate and thorough reports. In those states, facilities should have such forms on hand and all staff should be trained in the appropriate use of those forms. Parents/guardians should be notified upon enrollment of the facility’s child abuse and neglect reporting requirement and procedures.

<table>
<thead>
<tr>
<th>STANDARD 3.4.4.3: Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma</th>
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<tbody>
<tr>
<td>All child care facilities should have a policy and procedure to identify and prevent shaken baby syndrome/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/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/abusive head trauma, strategies for coping with a crying, fussing or distraught child, and the development and vulnerabilities of the brain in infancy and youth.</td>
</tr>
</tbody>
</table>

| County Department of Family and Children Services in accordance with state law. |

<table>
<thead>
<tr>
<th>591-1-1-.33 Staff Training</th>
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</thead>
<tbody>
<tr>
<td>(b) Two (2) clock hours of training in identifying, reporting and meeting the needs of abused, neglected or deprived children.</td>
</tr>
</tbody>
</table>

| Not address. |

DECAL may want to address this specific standard and add it to their rules.
<table>
<thead>
<tr>
<th>STANDARD 3.4.4.4: Care for Children Who Have Been Abused/Neglected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers/teachers should have access to specialized training and expert advice for children with behavioral abnormalities related to abuse or neglect are enrolled.</td>
</tr>
</tbody>
</table>

**591-1-1-.33 Staff Training.**

1. **Orientation.** Prior to assignment to children or task, all employees must receive initial orientation on the following subjects:
   - (a) The center's policies and procedures;
   - (b) The portions of these rules dealing with the care, health and safety of children;
   - (c) The employee's assigned duties and responsibilities;
   - (d) Reporting requirements for suspected cases of child abuse, neglect or deprivation; communicable diseases and serious injuries;
   - (e) Emergency weather plans;
   - (f) Childhood injury control;
   - (g) The administration of medicine;
   - (h) Reducing the risk of Sudden Infant Death Syndrome (SIDS);
   - (i) Hand washing;
   - (j) Fire Safety;
   - (k) Water Safety;
   - (l) Prevention of HIV/AIDS and blood borne pathogens.

2. **First Year Training - Direct Care Staff.**

Within the first year of employment, all staff who provide any direct care to children shall obtain ten (10) clock hours of training or instruction in child care issues from an accredited school or Department-approved source. At least six (6) of the clock hours must be divided as follows:

(a) Four (4) clock hours of training in any of the following topics: disease control, cleanliness, basic hygiene, illness detection, illness disposition and childhood injury control.

**Partially meets.**

Rule addresses training but not expert advice.

**DECAL may want to add the additional working related to expert advice.**
(b) Two (2) clock hours of training in identifying, reporting and meeting the needs of abused, neglected or deprived children.

(3) First Year Training - Food Preparation. Within the first year of employment, the director and the person primarily responsible for food preparation hired after the effective date of these rules shall receive four (4) clock hours of training in food nutrition planning, preparation, serving, proper dish washing and food storage.

(4) Ongoing Training. On an annual basis, all supervisory and caregiver personnel shall attend ten (10) clock hours of training which is task-focused in early childhood education or child development or subjects relating to job assignment and is offered by an accredited college, university or vocational program or other Department-approved source.

(5) Documentation of Training. Evidence of orientation and training shall be documented in the personnel file of each staff member which shall be available to the Department for inspection.

(6) Exemptions from Training. Custodial, maintenance personnel or volunteers who provide no direct care to children are not required to obtain first year training or ongoing training.

| STANDARD 3.4.4.5: Facility Layout to Reduce Risk of Child Abuse and Neglect |
|---|---|---|
| The physical layout of facilities should be arranged so that there is a high level of visibility in the inside and outside areas as well as diaper changing areas and toileting areas | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
used by children. All areas should be viewed by at least one other adult in addition to the caregiver/teacher at all times when children are in care. For center-based programs, rooms should be designed so that there are windows to the hallways to keep classroom activities from being too private. Ideally each area of the facility should have two adults at all times. Such an arrangement reduces the risk of child abuse and neglect and the likelihood of extended periods of time in isolation for individual caregivers/teachers with children, especially in areas where children may be partially undressed or in the nude.

<table>
<thead>
<tr>
<th>STANDARD 3.5.0.1: Care Plan for Children with Special Health Care Needs</th>
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</thead>
<tbody>
<tr>
<td>Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. In addition to the information specified in Standard 9.4.2.4 for the Health Report, there should be:</td>
</tr>
<tr>
<td>a) A list of the child’s diagnosis/diagnoses;</td>
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<tr>
<td>b) Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.);</td>
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<tr>
<td>c) Medications to be administered on a scheduled basis;</td>
</tr>
<tr>
<td>d) Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language;</td>
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<tr>
<td>e) Procedures to be performed;</td>
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<tr>
<td>f) Allergies;</td>
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<tr>
<td>g) Dietary modifications required for the health of the child;</td>
</tr>
<tr>
<td>h) Activity modifications;</td>
</tr>
<tr>
<td>i) Environmental modifications;</td>
</tr>
<tr>
<td>j) Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid;</td>
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<tr>
<td>k) Symptoms for caregiver/teachers to observe;</td>
</tr>
<tr>
<td>l) Behavioral modifications;</td>
</tr>
<tr>
<td>m) Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire;</td>
</tr>
<tr>
<td>n) Suggested special skills training and education</td>
</tr>
</tbody>
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|  | Not addressed. |  | DECAL may want to address this specific standard and add it to their rules. |
The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.

### STANDARD 3.5.0.2: Caring for Children Who Require Medical Procedures

A facility that enrolls children who require the following medical procedures: tube feedings, endotracheal suctioning, supplemental oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own), checking blood sugars or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, should receive a written plan of care from the primary care provider who prescribed the special treatment (such as a urologist for catheterization). Often, the child’s primary care provider may be able to provide this information. This plan of care should address any special preparation to perform routine and/or urgent procedures (other than those that might be required in an emergency for any typical child, such as cardiopulmonary resuscitation [CPR]). This plan of care should include instructions for how to receive training in performing the procedure, performing the procedure, a description of common and uncommon complications of the procedure, and what to do and who to notify if complications occur. Specific/relevant training for the child care staff should be provided by a qualified health care professional in accordance with state practice acts. Facilities should follow state laws where such laws require RN’s or LPN’s under RN supervision to perform certain medical procedures. Updated, written medical orders are required for nursing procedures.

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
### STANDARD 3.6.1.1: Inclusion/Exclusion/ Dismissal of Children

**Preparation for managing illness:**

Caregivers/teachers should:

- a) Encourage all families to have a backup plan for child care in the event of short or long term exclusion;
- b) Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program’s inclusion/exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program;
- c) Develop, with a child care health consultant, protocols and procedures for handling children’s illnesses, including care plans and an inclusion/exclusion policy;
- d) Request the primary care provider’s note to readmit a child if the primary care provider’s advice is needed to determine whether the child is a health risk to others, or if the primary care provider’s guidance is needed about any special care the child requires (1);
- e) Rely on the family’s description of the child’s behavior to determine whether the child is well enough to return, unless the child’s status is unclear from the family’s report.

Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent/guardian when a child develops 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 the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not

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**591-1-.07 Children's Health.**

(1) Exclusion of Sick Children. A child shall not be accepted nor allowed to remain at the center if the child has the equivalent of a one hundred one (101) degrees Fahrenheit or higher oral temperature and another contagious symptom, such as but not limited to, a rash, diarrhea or a sore throat. When a child shows symptoms of illness during the day, the child shall be moved to a quiet area away from other children where the child shall be supervised and provided the necessary attention until such time as the child leaves the center or is able to return to the child's group.

**Partially meets.**

**Other than having 101 degree, rash, sore throat, and diarrhea as exclusion of children, the detail present in the Stepping Stones standard is not present in this rule.**

**DECAL should add the Stepping Stones standard detail wording.**
Validating the Georgia Child Care Center Regulations

Conditions/symptoms that do not require exclusion:

a) Common colds, runny noses (regardless of color or consistency of nasal discharge);

b) A cough not associated with an infectious disease (such as pertussis) or a fever;

c) Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;

d) Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);

e) Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/guardians should discuss care of this condition with their child's primary care provider, and follow the primary care provider’s advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted;

f) Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body’s response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102°F per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone;

g) Rash without fever and behavioral changes;

h) Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the
day);
i) Ringworm (exclusion for treatment may be
delayed until the end of the day);
j) Molluscum contagiosum (do not require exclusion
or covering of lesions);
k) Thrush (i.e., white spots or patches in the mouth
or on the cheeks or gums);
l) Fifth disease (slapped cheek disease, parvovirus
B19) once the rash has appeared;
m) Methicillin-resistant Staphylococcus aureus, or
MRSA, without an infection or illness that would
otherwise require exclusion. Known MRSA
carriers or colonized individuals should not be
excluded;
n) Cytomegalovirus infection;
o) Chronic hepatitis B infection;
p) Human immunodeficiency virus (HIV) infection;
q) Asymptomatic children who have been
previously evaluated and found to be shedding
potentially infectious organisms in the stool.
Children who are continent of stool or who are
diapered with formed stools that can be contained
in the diaper may return to care. For some
infectious organisms, exclusion is required until
certain guidelines have been met. Note: These
agents are not common and caregivers/ teachers
will usually not know the cause of most cases of
diarrhea;
r) Children with chronic infectious conditions that
can be accommodated in the program according to
the legal requirement of federal law in the
Americans with Disabilities Act. The act requires
that child care programs make reasonable
accommodations for children with disabilities
and/or chronic illnesses, considering each child
individually.

Key criteria for exclusion of children who are ill:

When a child becomes ill but does not require immediate
medical help, a determination must be made regarding
whether the child should be sent home (i.e., should be tem-
porarily “excluded” from child care). Most illnesses do not
require exclusion. 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.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected.

Temporary exclusion is recommended when the child has any of the following conditions:

a) The illness prevents the child from participating comfortably in activities;
b) The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
c) An acute change in behavior - this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;
d) Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures;

e) Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded.

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if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2):

1) Toxin-producing *E. coli* or *Shigella* infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms;

2) *Salmonella* serotype Typhi infection, until diarrhea resolves. In children younger than five years with *Salmonella* serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool.

Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;

f) Blood or mucus in the stools not explained by dietary change, medication, or hard stools;

g) Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;

h) Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;

i) Mouth sores with drooling unless the child’s primary care provider or local health department authority states that the child is noninfectious;

j) Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease;

k) Active tuberculosis, until the child’s primary care provider or local health department states child is on appropriate treatment and can return;

l) Impetigo, until treatment has been started;

m) Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started;
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| n) Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day); o) Scabies, until after treatment has been given; p) Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash); q) Rubella, until six days after the rash appears; r) Pertussis, until five days of appropriate antibiotic treatment; s) Mumps, until five days after onset of parotid gland swelling; t) Measles, until four days after onset of rash; u) Hepatitis A virus infection, until one week after onset of illness or jaundice if the child’s symptoms are mild or as directed by the health department. (Note: immunization status of child care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care provider for dosage and recommendations; v) Any child determined by the local health department to be contributing to the transmission of illness during an outbreak. |
|---|---|---|---|---|

**STANDARD 3.6.1.2: Staff Exclusion for Illness**

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member.

A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists. The staff member should be excluded as follows:

- a) Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;
- b) Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;
- c) Rash with fever or joint pain, until diagnosed not

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| 591-1-1.17 Hygiene. (4) Contagious Diseases. Staff, or any other persons being supervised by the staff, shall not be allowed in the center who knowingly have or present symptoms of a fever or diarrhea. | Partially meets. | This rule covers only diarrheal illness but none of the other specific illnesses that should lead to exclusion. | DECAL should add the specific exclusionary criteria listed in the Stepping Stones standard. |
to be measles or rubella;
d) Measles, until four days after onset of the rash (if the staff member or substitute is immunocompetent);
e) Rubella, until six days after onset of rash;
f) Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if E. coli 0157:H7 or Shigella is isolated, until diarrhea resolves and two stool cultures are negative, for Salmonella serotype Typhi, three stool cultures collected at twenty-four hour intervals and resolution of diarrhea is required;
g) Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions;
h) Hepatitis A virus, until one week after symptom onset or as directed by the health department;
i) Pertussis, until after five days of appropriate antibiotic therapy;
j) Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;
k) Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider;
l) Strep throat or other streptococcal infection, until twenty-four hours after initial antibiotic treatment and end of fever;
m) Head lice, from the end of the day of discovery until after the first treatment;
n) Scabies, until after treatment has been completed;
o) Haemophilus influenzae type b (Hib), prophylaxis, until antibiotic treatment has been initiated;
p) Meningococcal infection, until appropriate therapy has been administered for twenty-four hours;
q) Respiratory illness, if the illness limits the staff member’s ability to provide an acceptable level of child care and compromises the health and safety of the children.

Caregivers/teachers who have herpes cold sores should not be excluded from the child care facility, but should:
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<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Partial</th>
<th>Not addressed</th>
<th>DECAL may want to include the wording from the Stepping Stones standard.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
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<tbody>
<tr>
<td>STANDARD 3.6.1.4: Infectious Disease Outbreak Control</td>
<td>During the course of an identified outbreak of any reportable illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is contributing to transmission of the illness at the facility, 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 care provider who made the initial determination decides that the risk of transmission is no longer present.</td>
<td>Partially meets.</td>
<td>The rule addresses reporting the case but says nothing about excluding the staff or child who may be contributing to the outbreak.</td>
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</tr>
<tr>
<td>STANDARD 3.6.2.10: Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill</td>
<td>Facilities that care for children who are ill who have conditions that require additional attention from the caregiver/teacher, should arrange for or ask the child care health consultant to arrange for a clinical health evaluation, by a licensed primary care provider, for each child who is admitted to the facility. These facilities should include children with conditions listed in Standard 3.6.1.1 if their policies and plans address the management of these conditions, except for the following conditions which require exclusion from all types of child care facilities that are not medical care institutions (such as hospitals or skilled nursing facilities): a) Fever (see COMMENTS section for definition of fever) and a stiff neck, lethargy, irritability, or persistent crying; b) Diarrhea (loose stools, not contained in the diaper, that are two or more greater than normal frequency) and one or more of the following: 1) Signs of dehydration, such as dry mouth, no tears, lethargy, sunken fontanelle (soft spot on the head);</td>
<td>Not addressed.</td>
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**591-1-1.29 Required Reporting.**
(1) The director or designated person-in-charge shall report or cause to be reported the following:
(b) Communicable Diseases. Any cases or suspected cases of notifiable communicable diseases shall be reported to the local County Health Department as required by the rules of the Department of Human Resources regarding Notification of Disease, Chapter 290-5-3.
2) Blood or mucus in the stool until it is evaluated for organisms that can cause dysentery;
3) Diarrhea caused by *Salmonella*, *Campylobacter*, *Giardia*, *Shigella*, or *E. coli* 0157:H7 until specific criteria for treatment and return to care are met.
c) Vomiting with signs of dehydration and inability to maintain hydration with oral intake;
d) Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness;
e) Untreated infestation of scabies or head lice;
f) Untreated infectious tuberculosis;
g) Undiagnosed rash with fever or behavior change;
h) Abdominal pain that is intermittent or persistent and is accompanied by fever, diarrhea, or vomiting;
i) Difficulty in breathing;
j) An acute change in behavior;
k) Undiagnosed jaundice (yellow skin and whites of eyes);
l) Other conditions as may be determined by the director or child care health consultant;
m) Upper or lower respiratory infection in which signs or symptoms require a higher level of care than can be appropriately provided.

**STANDARD 3.6.2.2: Space Requirements for Care of Children Who Are Ill**

Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group should meet all requirements for well children and include the following additional requirements:

a) If the program for children who are ill is in the same facility as the well-child program, well children should not use or share furniture, fixtures, equipment, or supplies designated for use with children who are ill unless it has been cleaned and sanitized before use by well children;
b) Indoor space that the facility uses for children

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who are ill, including hallways, bathrooms, and kitchens, should be separate from indoor space used with well children; this reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal;

c) Children whose symptoms indicate infections of the gastrointestinal tract (often with diarrhea) who receive care in special facilities for children who are ill should receive this care in a space separate from other children with other illnesses to reduce the likelihood of disease being transmitted between children by limiting child-to-child interaction, separating staff responsibilities, and not mixing supplies, toys, and equipment;

d) If the facility cares for children with chickenpox, these children require a room with separate ventilation with exhaust to, and air exchange with, the outside (3);

e) Each child care room should have a handwashing sink that can provide a steady stream of water, between 60°F and 120°F, at least for ten seconds. Soap and disposable paper towels should be available at the handwashing sink at all times. A hand sanitizing dispenser is an alternative to traditional handwashing;

f) Each room where children who wear diapers receive care should have its own diaper changing area adjacent to a handwashing sink and/or hand sanitizer dispenser.

| STANDARDS 3.6.2.5: Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill |
|---|---|---|
| Each caregiver/teacher in a facility that cares for children who are ill should have at least two years of successful work experience as a caregiver/teacher in a regular well-child facility prior to employment in the special facility. In addition, facilities should document, for each caregiver/teacher, twenty hours of pre-service orientation training on care of children who are ill beyond the | Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
orientation training specified in Standards 1.4.2.1 through Standard 1.4.2.3. This training should include the following subjects:

a) Pediatric first aid and CPR, and first aid for choking;

b) General infection-control procedures, including:
   1) Hand hygiene;
   2) Handling of contaminated items;
   3) Use of sanitizing chemicals;
   4) Food handling;
   5) Washing and sanitizing of toys;
   6) Education about methods of disease transmission.

c) Care of children with common mild childhood illnesses, including:
   1) Recognition and documentation of signs and symptoms of illness including body temperature;
   2) Administration and recording of medications;
   3) Nutrition of children who are ill;
   4) Communication with parents/guardians of children who are ill;
   5) Knowledge of immunization requirements;
   6) Recognition of need for medical assistance and how to access;
   7) Knowledge of reporting requirements for infectious diseases;
   8) Emergency procedures.

d) Child development activities for children who are ill;

e) Orientation to the facility and its policies.

This training should be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these evaluations, the training on care of children who are ill should be updated with a minimum of six hours of annual training for individuals who continue to provide care to children who are ill.

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<thead>
<tr>
<th>STANDARD 3.6.3.1: Medication Administration</th>
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<td>The administration of medicines at the facility should be limited to:</td>
</tr>
<tr>
<td>a) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the</td>
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<th>591-1-1-20 Medications.</th>
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<td>(1) Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the</td>
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<tr>
<th>Child’s physician or parent. Such authorization will include when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.</th>
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<tr>
<td>(2) Dispensing Medication. Written authorization to dispense medications shall be limited to two (2) weeks unless otherwise prescribed by a physician. Medication shall only be dispensed out of its original container which must be labeled with the child’s name.</td>
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<tr>
<td>(3) Dispensing Records. The center shall maintain a record of all medications dispensed to children by personnel to include the date, time and amount of medication that was administered; any noticeable adverse reactions to the medication; and the signature or initials of the person administering the medication.</td>
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<td>(4) Storage. Medications shall be kept in a locked storage cabinet or container which is not accessible to the children and stored separate from cleaning chemicals, supplies or poisons. Medications requiring refrigeration shall be placed in a leakproof container in a refrigerator that is not accessible to the children.</td>
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<tr>
<td>(5) Unused Medication. Medicines which are no longer to be dispensed shall be returned to the child’s parents immediately.</td>
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<tr>
<td>(6) Non-Emergency Injections. Non-emergency injections shall only be administered by appropriately licensed persons unless the parent and physician of the child sign a written authorization for the child to self-administer the injection.</td>
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<th>Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family.</th>
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<tr>
<td>No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child’s prescribing health professional.</td>
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<td>Documentation that the medicine/agent is administered to the child as prescribed is required.</td>
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<td>“Standing orders” guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child’s primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child’s parents/guardians must be obtained on the special care plan. Care plans should be updated as needed, but at least yearly.</td>
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<th>b) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings).</th>
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STANDARD 3.6.3.2: Labeling, Storage, and Disposal of Medications

Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:

- The child’s first and last names;
- The date the prescription was filled;
- The name of the prescribing health professional who wrote the prescription, the medication’s expiration date;
- The manufacturer’s instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- The name and strength of the medication.

Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child’s name and specific instructions given by the child’s prescribing health professional for administration.

All medications, refrigerated or unrefrigerated, should:

- Have child-resistant caps;
- Be kept in an organized fashion;
- Be stored away from food;
- Be stored at the proper temperature;
- Be completely inaccessible to children.

Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:

a) If a medication lists any specific instructions on how to dispose of it, follow those directions.

(1) Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child’s physician or parent. Such authorization will include when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

(2) Dispensing Medication. Written authorization to dispense medications shall be limited to two (2) weeks unless otherwise prescribed by a physician. Medication shall only be dispensed out of its original container which must be labeled with the child’s name.

(3) Dispensing Records. The center shall maintain a record of all medications dispensed to children by personnel to include the date, time and amount of medication that was administered; any noticeable adverse reactions to the medication; and the signature or initials of the person administering the medication.

(4) Storage. Medications shall be kept in a locked storage cabinet or container which is not accessible to the children and stored separate from cleaning chemicals, supplies or poisons. Medications requiring refrigeration shall be placed in a leakproof container in a refrigerator that is not accessible to the children.

(5) Unused Medication. Medicines which are no longer to be dispensed shall be returned to the child’s parents immediately.

(6) Non-Emergency Injections. Non-emergency injections shall only be
### STANDARD 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 trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to:

- a) Check that the name of the child on the medication and the child receiving the medication are the same;
- b) Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child’s name;
- c) Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the medication;
- d) Observe and report any side effects from medications;
- e) Document the administration of each dose by the time and the amount given;
- f) Document the person giving the administration and any side effects noted;
- g) Handle and store all medications according to label instructions and regulations.

The trainer in medication administration should be a licensed health professional.

<table>
<thead>
<tr>
<th>591-1-1-.33 Staff Training.</th>
<th>Does not meet.</th>
<th>The rule has staff training as part of orientation but does not have any specifics as outline in the Stepping Stones standard.</th>
<th>DECAL should adopt the language in the standard regarding what staff need to be trained on related to medication administration.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Orientation. Prior to assignment to children or task, all employees must receive initial orientation on the following subjects:</td>
<td></td>
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<tr>
<td>(g) The administration of medicine;</td>
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administered by appropriately licensed persons unless the parent and physician of the child sign a written authorization for the child to self-administer the injection.
STANDARD 4.2.0.10: Care for Children with Food Allergies

When children with food allergies attend the early care and education facility, the following should occur:

a) Each child with a food allergy should have a care plan prepared for the facility by the child’s primary care provider, to include:
   1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;
   2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include specific symptoms that would indicate the need to administer one or more medications;

b) Based on the child’s care plan, the child’s caregivers/teachers should receive training, demonstrate competence in, and implement measures for:
   1) Preventing exposure to the specific food(s) to which the child is allergic;
   2) Recognizing the symptoms of an allergic reaction;
   3) Treating allergic reactions;

c) Parents/guardians and staff should arrange for the facility to have necessary medications, proper storage of such medications, and the equipment and training to manage the child’s food allergy while the child is at the early care and education facility;

d) Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;

e) The facility should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;

Not addressed.
j) The facility should recommend to the family that the child’s primary care provider be notified if the child has required treatment by the facility for a food allergic reaction;
g) The facility should contact the emergency medical services system immediately whenever epinephrine has been administered;
h) Parents/guardians of all children in the child’s class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting;
i) Individual child’s food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served;
j) 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.

<table>
<thead>
<tr>
<th>STANDARD 4.2.0.6: Availability of Drinking Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. Water should not be a substitute for milk at meals or snacks where milk is a required food component unless it is recommended by the child’s primary care provider. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle. Toddlers and older children will need additional water as physical activity and/or hot temperatures cause their needs to increase. Children should learn to drink water from a cup or drinking fountain without mouthing the fixture. They should not be allowed to have water continuously in hand in a “sippy cup” or bottle. Permitting toddlers to suck continuously on a bottle or sippy cup filled with water, in order to soothe themselves, may cause nutritional or in rare instances, electrolyte imbalances. When tooth brushing is not done after a feeding, children should be offered water to drink to rinse food from their teeth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>591-1-1.15 Food Service and Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking water shall be offered at least once between meals and snacks to children less than three (3) years of age</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Partially meets</th>
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<tbody>
<tr>
<td>This rule does not address what to do on very hot days for infants, toddlers and preschoolers.</td>
</tr>
<tr>
<td>DECAL may want to adopt the language in the standard regarding the availability of drinking water on hot days.</td>
</tr>
</tbody>
</table>
STANDARD 4.2.0.8: Feeding Plans and Dietary Modifications

Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child, including use of human milk or any special feeding utensils. The staff should review this history with the child’s parents/guardians, clarifying and discussing how parental/guardian home feeding routines may differ from the facility’s planned routine. The child’s primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the early care and education program and these plans should be shared with the child’s parents/guardians upon request.

If dietary modifications are indicated, based on a child’s medical or special dietary needs, the caregiver/teacher should modify or supplement the child’s diet to meet the individual child’s specific needs. Dietary modifications should be made in consultation with the parents/guardians and the child’s primary care provider. Caregivers/teachers can consult with a nutritionist/registered dietitian.

Reasons for modification of a child’s diet may be related to food sensitivity. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life threatening. Modification of a child’s diet may be related to a food allergy, inability to digest or to tolerate certain foods, need for extra calories, need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues. Examples include celiac disease, phenylketonuria, diabetes, severe food allergy (anaphylaxis), and others. In some cases, a child may become ill if the child is unable to eat, so missing a meal could have a negative consequence, especially for diabetics.

For a child identified with special health care needs for dietary modification or special feeding techniques, written instructions from the child’s parent/guardian and the child’s primary care provider should be provided in the child’s record and carried out accordingly. Dietary modifications should be recorded. These written instructions must identify:

a) The child’s full name and date of instructions;

591-1-1-.15 Food Service and Nutrition.
Partial meets.

(1) Compliance with USDA Nutritional Guidelines. Meals and snacks with serving sizes dependent upon the age of the child shall meet nutritional guidelines as established by the United States Department of Agriculture Child Care Food Program. Meals and snacks shall be varied daily, and additional servings of nutritious food shall be offered to children over and above the required daily minimum, if not contraindicated by special diets.

(2) Feeding of Children. A signed written feeding plan for children less than one (1) year of age shall be obtained from parents. Instructions from the parent shall be updated regularly as new foods are added or other dietary changes are made. The feeding plan shall be posted in the child’s assigned room and must include the child’s feeding schedule, the amount of formula or breast milk to be given, instructions for the introduction of solid foods, the amount of food to be given and notation of any type(s) of commercially premixed formula which may not be used in an emergency because of food allergies.

(a) Center personnel shall hold and feed infants less than six (6) months of age and older children who cannot hold their own bottles or sit alone. Baby bottles shall never be propped; the infant’s head shall be elevated while feeding.

(b) Honey shall not be served to children less than one (1) year of age.

(c) As soon as the feeding plan indicates that a child is ready for solid foods, the child shall be fed from individual spoons and individual containers or dishes. A child shall not be fed directly from the original baby food container if the contents are to be fed to the

Partial meets. The rule addresses the need for a written feeding plan but the rule does not deal with the specific written instructions for a child identified with special health care needs other than that a written statement from a medical authority shall be on file.

DECAL should adopt the specific language from the standard regarding the written instructions for a child identified with special health care needs.
b) The child’s special needs;
c) Any dietary restrictions based on the special needs;
d) Any special feeding or eating utensils;
e) Any foods to be omitted from the diet and any foods to be substituted;
f) Limitations of life activities;
g) Any other pertinent special needs information;
h) What, if anything, needs to be done if the child is exposed to restricted foods.

The written history of special nutrition or feeding needs should be used to develop individual feeding plans and, collectively, to develop facility menus. Disciplines related to special nutrition needs, including nutrition, nursing, speech, occupational therapy, and physical therapy, should participate when needed and/or when they are available to the facility. The nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications.

The feeding plan should include steps to take when a situation arises that requires rapid response by the staff, such as a child’s choking during mealtime or a child with a known history of food allergies demonstrating signs and symptoms of anaphylaxis (severe allergic reaction, e.g., difficulty breathing or severe redness and swelling of the face or mouth). The completed plan should be on file and accessible to the staff and available to parents/guardians upon request.
school-age centers where the food may be provided by the parents by agreement between the school-age center and the parents. The menus shall be dated and posted near the front entrance of the center in a location conspicuous to parents. Substitutions shall be recorded on the posted menu. Menus shall be retained at the center for six (6) months.

(6) Meal Service.
(a) Children shall be served all meals and snacks scheduled for the period during which they are present. In those centers where the parents of children enrolled provide the meals and snacks, the center shall ensure that no child remains at the center without receiving the scheduled nutritious meals and snacks. There shall be a period of at least two (2) hours between each required meal or snack. Drinking water shall be offered at least once between meals and snacks to children less than three (3) years of age. The following meals and snacks shall be scheduled and served by the center when appropriate:
1. Breakfast or a morning snack;
2. Lunch;
3. An afternoon snack;
4. Supper if a center operates evening care;
5. An evening snack prior to bedtime if a center operates night-time care.
(b) Food and beverages shall be served in individual plates or bowls and with individual glasses or cups.
(c) Children shall be encouraged but not forced to eat.
(d) Caregivers shall not use food to punish or reward children.
(e) Children shall be given necessary assistance in feeding and encouraged to develop good nutritional habits.
(f) Hot food shall not be served at a temperature which would cause the
(g) Drinking water shall be available to all children.

(7) Restrictions. Peanuts, hot dogs, raw carrots, popcorn, fish with bones and grapes shall not be served to the children less than three (3) years of age. Children older than three (3) years of age may be served these foods provided that the foods are cut in such a way as to minimize choking. Foods and drinks with little or no nutritional value, i.e., sweets, soft drinks, etc. shall be served only on special occasions and only in addition to the required nutritious meals and snacks. Powdered nonfat dry milk shall only be used for cooking purposes.

(8) Modified Diets. When a child requires a modified diet for medical reasons, a written statement from a medical authority shall be on file. When a child requires a modified diet for religious reasons, a written statement to that effect from the child's parents shall be on file. All caregiver personnel shall be informed of the diet restriction for the child and only food that complies with the prescribed dietary regimen but still meets the food and nutrition requirements shall be served to the child.

(9) Unconsumed Food. Any portions of food or drink which are served to children or placed on the table for service and are not consumed at that meal or snack by the children to whom the portions are served shall be thrown away. Any formula or breast milk remaining one hour from the beginning of the feeding shall be discarded or returned to parents.

(10) Catered Food. Food purchased from a caterer shall be prepared in a facility with
### STANDARD 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants

A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child’s parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child’s nutritional and developmental needs.

For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement the human milk. Modification of basic food patterns should be provided in writing by the child’s primary care provider.

Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two- to seven-day intervals (1).

### 591-1-.15 Food Service and Nutrition

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Partially meets.</th>
<th>Rule does not address the age of the infant when introducing age-appropriate solid foods.</th>
<th>DECAL should add the age of the infant to this rule.</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) As soon as the feeding plan indicates that a child is ready for solid foods, the child shall be fed from individual spoons and individual containers or dishes. A child shall not be fed directly from the original baby food container if the contents are to be fed to the child at more than one (1) meal or to more than one (1) child.</td>
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</tbody>
</table>

### STANDARD 4.3.1.3: Preparing, Feeding, and Storing Human Milk

Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and current food service permit and shall be maintained at a safe temperature [forty-five (45) degrees Fahrenheit or below for foods requiring refrigeration or one hundred forty (140) degrees Fahrenheit for foods which must be heated prior to serving] until served.

(11) Vending Machines. Soft drink vending machines and other food dispensers shall not be maintained on center premises for children's use. Vending machines and dispensers for staff shall be outside of the children's areas.

### 591-1-.15 Food Service and Nutrition

(3) Baby Bottles and Formula. All baby bottles shall be clearly labeled with the individual child's name. Formula or breast milk shall be supplied by the parent daily in bottles. Only the current day's formula or breast milk shall be served. Bottles shall be refrigerated at a temperature of forty-five (45) degrees Fahrenheit or below for foods requiring refrigeration or one hundred forty (140) degrees Fahrenheit for foods which must be heated prior to serving. This rule contains all the basic elements regarding the preparing, feeding, and storing of human milk. However, it lacks the specificity contained in the Stepping Stones standard regarding human milk storage guidelines. DECAL should add the guidelines for human milk storage as proposed by the Academy of Breastfeeding Medicine.
nipples should be used in feeding. The bottle or container should be properly labeled with the infant’s full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival.

The mother’s own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother’s written permission.

Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.

Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child’s full name. The filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.

Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother’s milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant’s full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.

Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the Academy of Breastfeeding
Medicine as shown later in this standard, should be returned to the mother. Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child’s fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.

Human milk can be stored using the following guidelines from the Academy of Breastfeeding Medicine:

<table>
<thead>
<tr>
<th>Location</th>
<th>Temperature</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countertop, table</td>
<td>Room temperature (up to 77°F or 25°C)</td>
<td>6-8 hours</td>
<td>Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler.</td>
</tr>
<tr>
<td>Insulated cooler bag</td>
<td>5°F – 39°F or -15°C – 4°C</td>
<td>24 hours</td>
<td>Keep ice packs in contact with milk containers at all times, limit opening cooler bag.</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>39°F or 4°C</td>
<td>5 days</td>
<td>Store milk in the back of the main body of the refrigerator.</td>
</tr>
<tr>
<td>Freezer compartment of a refrigerator</td>
<td>5°F or -15°C</td>
<td>2 weeks</td>
<td>Store milk toward the back of the freezer, where the temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality.</td>
</tr>
<tr>
<td>Freezer compartment of refrigerator with separate doors</td>
<td>0°F or -18°C</td>
<td>3-6 months</td>
<td></td>
</tr>
<tr>
<td>Chest or upright deep freezer</td>
<td>-4°F or -20°C</td>
<td>6-12 months</td>
<td></td>
</tr>
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</table>

STANDARD 4.3.1.5: Preparing, Feeding, and Storing Infant Formula

591-1.1-.15 Food Service and Nutrition
(3) Baby Bottles and Formula. All baby bottles shall be clearly labeled with the
Partially meets.

Rule does not address iron fortified formula.

DECAL should add language from the Stepping Stones standard regarding iron fortified formula.
Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer’s instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer’s directions. 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 at [http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html](http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html) (8). The local WIC program can also provide instructions.

Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child’s primary care provider provides written documentation that the child has a medical reason for this type of feeding.

Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.

Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child’s full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child’s full name, and may be stored in the refrigerator for up to twenty-four hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child’s full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer’s instructions for mixing and storing of any formula preparation.

Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be
For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant’s care plan, on how to prepare the formula.

### STANDARD 4.5.0.10: Foods that Are Choking Hazards

Caregivers/teachers should not offer to children under four years of age foods that are associated with young children’s choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).

### 591-1-1.15 Food Service and Nutrition.

**Does not meet.**

**Rule specifies three years of age while the Stepping Stones standard specifies 4 years of age as the cut off age for foods that are choking hazards.**

**DECAL needs to have the age requirement match with the Stepping Stones standard.**

### STANDARD 4.5.0.6: Adult Supervision of Children Who Are Learning to Feed Themselves

Children in mid-infancy who are learning to feed themselves should be supervised by an adult seated within arm’s reach of them at all times while they are being fed. Children over twelve months of age who can feed themselves should be supervised by an adult who is seated at the same table or within arm’s reach of the child’s highchair or feeding table. When eating, children should be within sight of an adult at all times.

### 591-1-1.15 Food Service and Nutrition.

**Partially meets.**

**Although it is implied that there is adult supervision given the terminology “assisted and encouraged” there is no direct statement regarding adult supervision.**

**DECAL may want to add this wording from the Stepping Stones standard.**

### STANDARD 4.5.0.9: Hot Liquids and Foods

Adults should not consume hot liquids above 120°F in child care areas (3). Hot liquids and hot foods should be kept out of the reach of infants, toddlers, and preschoolers.

### 591-1-1.15 Food Service and Nutrition.

**Not addressed.**
Hot liquids and foods should not be placed on a surface at a child's level, at the edge of a table or counter, or on a tablecloth that could be yanked down. Appliances containing hot liquids, such as coffee pots and crock pots, should be kept out of the reach of children. Electrical cords from any appliance, including coffee pots, should not be allowed to hang within the reach of children. Food preparers should position pot handles toward the back of the stove and use only back burners when possible.

**STANDARD 4.8.0.1: Food Preparation Area**

The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. The food preparation area should not be used as a passageway while food is being prepared. Food preparation areas should be separated by a door, gate, counter, or room divider from areas the children use for activities unrelated to food, except in small family child care homes when separation may limit supervision of children.

Infants and toddlers should not have access to the kitchen in child care centers. Access by older children to the kitchen of centers should be permitted only when supervised by staff members who have been certified by the nutritionist/registered dietitian or the center director as qualified to follow the facility’s sanitation and safety procedures.

In all types of child care facilities, children should never be in the kitchen unless they are directly supervised by a caregiver/teacher. Children of preschool-age and older should be restricted from access to areas where hot food is being prepared. School-age children may engage in food preparation activities with adult supervision in the kitchen or the classroom. Parents/guardians and other adults should be permitted to use the kitchen only if they know and follow the food safety rules of the facility. The facility should check with local health authorities about any additional regulations that apply.

**591-1-.18 Kitchen Operations.**

(2) Food Preparation Areas. Each center shall have a designated space for food preparation separate from rooms used by children and in an area not used for diaperchanging.

(8) Exclusion of Children. Children shall not be permitted in the kitchen except as part of a planned, supervised learning experience.

| STANDARD 4.8.0.3: Maintenance of Food Service Surfaces and Equipment | | | |
|---|---|---|
| All surfaces that come into contact with food, including food preparation surface areas shall be nonporous with no unsealed cracks or seams. | Meets. | |
Validating the Georgia Child Care Center Regulations

2013

<table>
<thead>
<tr>
<th>Tables and countertops, as well as floors and shelving in the food preparation area should be in good repair, free of cracks or crevices, and should be made of smooth, non-porous material that is kept clean and sanitized. All kitchen equipment should be clean and should be maintained in operable condition according to the manufacturer’s guidelines for maintenance and operation. The facility should maintain an inventory of food service equipment that includes the date of purchase, the warranty date, and a history of repairs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STANDARD 4.9.0.2: Staff Restricted from Food Preparation and Handling</td>
</tr>
<tr>
<td>Anyone who has signs or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannot be covered, or who potentially or actually is infected with bacteria, viruses or parasites that can be carried in food, should be excluded from food preparation and handling. Staff members may not contact exposed, ready-to-eat food with their bare hands and should use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. No one with open or infected skin eruptions should work in the food preparation area unless the injuries are covered with nonporous (such as latex or vinyl), single use gloves. In centers and large family child care homes, staff members who are involved in the process of preparing or handling food should not change diapers. Staff members who work with diapered children should not prepare or serve food for older groups of children. When staff members who are caring for infants and toddlers are responsible for changing diapers, they should handle food only for the infants and toddlers in their groups and only after thoroughly washing their hands. Caregivers/teachers who prepare food should wash their hands carefully before handling any food, regardless of whether they change diapers. When caregivers/teachers must handle food, staffing assignments should be made to foster completion of the food handling activities by caregivers/teachers of older children, or by caregivers/teachers of infants and toddlers before the caregiver/teacher assumes other caregiving duties for that day. Aprons worn in the food service area must be clean</td>
</tr>
<tr>
<td>Not addressed.</td>
</tr>
<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
</tbody>
</table>
and should be removed when diaper changing or when using the toilet.

<table>
<thead>
<tr>
<th>Standard 4.9.0.3: Precautions for a Safe Food Supply</th>
<th>Partially meets to exceeds.</th>
<th>Rule does not contain the specific detailed language as in the Stepping Stones standard but does exceed the Stepping Stones standard regarding hot food temperature of 140 degrees.</th>
<th>DECAL should consider adding the additional specific and detailed language contained in the Stepping Stones standard.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>591-1-1.18 Kitchen Operations.</strong> (1) Food. Food shall be in sound condition, free from spoilage and contamination and safe for human consumption. Eggs, pork, pork products, poultry and fish shall be thoroughly cooked. All raw fruits and vegetables shall be washed thoroughly before being cooked or served. Foods not subject to further washing or cooking before serving shall be stored in such a manner as to be protected against contamination. Meats, poultry, fish, dairy products and processed foods shall have been inspected under an official regulatory program. Hot foods shall be maintained at a temperature of one hundred forty (140) degrees Fahrenheit or above except during serving. Food and drinks shall be prepared as close to serving time as possible to protect children and personnel from foodborne illness.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
h) Frozen foods should be defrosted in one of four ways: In the refrigerator; under cold running water; as part of the cooking process, or by removing food from packaging and using the defrost setting of a microwave oven (5). Note: Frozen human milk should not be defrosted in the microwave;

i) Frozen foods should never be defrosted by leaving them at room temperature or standing in water that is not kept at refrigerator temperature (5);

j) All fruits and vegetables should be washed thoroughly with water prior to use (5);

k) Food should be served promptly after preparation or cooking or should be maintained at temperatures of not less than 135°F for hot foods and not more than 41°F for cold foods (12);

l) All opened moist foods that have not been served should be covered, dated, and maintained at a temperature of 41°F or lower in the refrigerator or frozen in the freezer, verified by a working thermometer kept in the refrigerator or freezer (12);

m) Fully cooked and ready-to-serve hot foods should be held for no longer than thirty minutes before being served, or promptly covered and refrigerated;

n) Pasteurized eggs or egg products should be substituted for raw eggs in the preparation of foods such as Caesar salad, mayonnaise, meringue, eggnog, and ice cream. Pasteurized eggs or egg products should be substituted for recipes in which more than one egg is broken and the eggs are combined, unless the eggs are cooked for an individual child at a single meal and served immediately, such as in omelets or scrambled eggs; or the raw eggs are combined as an ingredient immediately before baking and the eggs are fully cooked to a ready-to-eat form, such as a cake, muffin or bread;

o) Raw animal foods should be fully cooked to heat all parts of the food to a temperature and for a time of; 145°F or above for fifteen seconds for fish and meat; 160°F for fifteen seconds for chopped or ground fish, chopped or ground meat or raw eggs; or 165°F or above for fifteen
seconds for poultry or stuffed fish, stuffed meat, stuffed pasta, stuffed poultry or stuffing containing fish, meat or poultry.

**STANDARD 5.1.1.2: Inspection of Buildings**

Newly constructed, renovated, remodeled, or altered buildings should be inspected by a public inspector to assure compliance with applicable building and fire codes before the building can be made accessible to children.

<table>
<thead>
<tr>
<th>591-1-1-25 Physical Plant. (5) Construction and Renovation. A person planning the construction of a new center or planning any structural changes to an existing center shall obtain approval from the Department local zoning authorities, fire safety agencies and local building authorities. Construction and maintenance work shall take place only in areas that are not accessible to the children.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets.</td>
</tr>
</tbody>
</table>

**STANDARD 5.1.1.3: Compliance with Fire Prevention Code**

Every twelve months, the child care facility should obtain written documentation to submit to the regulatory licensing authority that the facility complies with a state-approved or nationally recognized Fire Prevention Code. If available, this documentation should be obtained from a fire prevention official with jurisdiction where the facility is located. Where fire safety inspections or a Fire Prevention Code applicable to child care centers is not available from local authorities, the facility should arrange for a fire safety inspection by an inspector who is qualified to conduct such inspections using the National Fire Protection Association’s NFPA 101: Life Safety Code.

<table>
<thead>
<tr>
<th>591-1-1-25 Physical Plant (10) Fire Safety. A center must be in compliance with applicable laws and regulations issued by the state fire marshal, the proper local fire marshal or state inspector, including a certificate of occupancy if required prior to receiving any children for care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially meets.</td>
</tr>
<tr>
<td>Rule does not specify every 12 months.</td>
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<tr>
<td>DECAL should add the timeframe of every 12 months.</td>
</tr>
</tbody>
</table>

**STANDARD 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 (1,3). The environmental audit should include assessments of:

- Potential air, soil, and water contamination on child care facility sites and outdoor play spaces;
- Potential toxic or hazardous materials in building

| Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
RESEARCH INSTITUTE FOR KEY INDICATORS (RIKI)

<table>
<thead>
<tr>
<th>STANDARD 5.1.6.6: Guardrails and Protective Barriers</th>
<th>2013</th>
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</thead>
<tbody>
<tr>
<td>Guardrails, a minimum of thirty-six inches in height, 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 thirty-inch vertical distance to fall. Spaces below the thirty-six inches height guardrail should be further divided with intermediate rails or balusters as detailed in the next paragraph. For preschoolers, bottom guardrails greater than nine inches but less or equal to twenty-three inches above the floor should be provided for all porches, landings, balconies, and similar structures. For school age children, bottom guardrails should be greater than nine inches but less or equal to twenty inches above the floor, as specified above. For infants and toddlers, protective barriers should be less than three and one-half inches above the floor, as specified above. All spaces in guardrails should be less than three and a half inches. All spaces in protective barriers should be less than three and one-half inches. If spaces do not meet the specifications as listed above, a protective material sufficient to prevent the passing of a three and one-half inch diameter sphere should be provided. Where practical or otherwise required by applicable codes, guardrails should be a minimum of forty-two inches in height to help prevent falls over the open side by staff and other adults in the child care facility.</td>
<td></td>
</tr>
<tr>
<td>Not addressed.</td>
<td></td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 5.2.1.10: Gas, Oil, or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unvented gas or oil heaters and portable open-flame kerosene space heaters should be prohibited. Gas cooking appliances, including portable gas stoves, should not be used for heating purposes. Charcoal grills should not be used for space heating or any other indoor purposes.</td>
<td></td>
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<tr>
<td>Meets.</td>
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<tr>
<th>591-1-1-.25 Physical Plant.</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>(12) Heating and Cooling Equipment. Heating and cooling equipment shall be protected to prevent children from touching it. Fans, space heaters, etc. shall be positioned or installed so as to be inaccessible to the children.</td>
<td>Meets.</td>
</tr>
</tbody>
</table>
Heat in units that involve flame should be vented properly to the outside and should be supplied with a source of combustion air that meets the manufacturer’s installation requirements.

**STANDARD 5.2.4.2: Safety Covers and Shock Protection Devices for Electrical Outlets**

All electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning should be a type called “tamper-resistant electrical outlets.” These types of outlets look like standard wall outlets but contain an internal shutter mechanism that prevents children from sticking objects like hairpins, keys, and paperclips into the receptacle (2). This spring-loaded shutter mechanism only opens when equal pressure is applied to both shutters such as when an electrical plug is inserted (2,3).

In existing child care facilities 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” should not be used since they can be removed from an electrical outlet by children (2,3).

All newly installed or replaced electrical outlets that are accessible to children should use “tamper-resistant electrical outlets.”

In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed (2). A GFCI is designed to trip before a deadly electrical shock can occur (1). To ensure that GFCIs are functioning correctly, they should be tested at least monthly (2). GFCIs are also available in a tamper-resistant design.

**591-1-1.25 Physical Plant**

(8) Electrical Outlets. Except in school-age centers, all unused electrical outlets within reach of children shall have protective caps specifically designed to prohibit children from placing anything in the receptacle. Electrical outlets in use which the children can reach shall be made inaccessible to the children.

Not addressed. Partially meets. Rule does not contain GFCI. DECAL should add the reference to GFCI.
<table>
<thead>
<tr>
<th>STANDARD 5.2.5.1: Smoke Detection Systems and Smoke Alarms</th>
</tr>
</thead>
</table>
| In centers with new installations, a smoke detection system (such as hard-wired system detectors with battery back-up system and control panel) or monitored wireless battery operated detectors that automatically signal an alarm through a central control panel when the battery is low or when the detector is triggered by a hazardous condition should be installed with placement of the smoke detectors in the following areas:  
  a) Each story in front of doors to the stairway;  
  b) Corridors of all floors;  
  c) Lounges and recreation areas;  
  d) Sleeping rooms.  
In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system or are of the wireless signal-monitored-alarm system type should be installed. Battery-operated smoke alarms should be permitted provided that the facility demonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve.  
Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages. |

<table>
<thead>
<tr>
<th>STANDARD 5.2.7.6: Storage and Disposal of Infectious and Toxic Wastes</th>
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<tbody>
<tr>
<td>Infectious and toxic wastes should be stored separately from other wastes, and should be disposed of in a manner approved by the regulatory health authority.</td>
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</table>

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<thead>
<tr>
<th>STANDARD 5.2.8.1: Integrated Pest Management</th>
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<tbody>
<tr>
<td>Facilities should adopt an integrated pest management program (IPM) 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. IPM is a simple, common-sense approach to pest management that</td>
</tr>
</tbody>
</table>

| Not addressed. |

| DECAL may want to address this specific standard and add it to their rules. |

| Not addressed. |

| DECAL may want to address this specific standard and add it to their rules. |
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eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment (2,4).

Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises (5).

Pest Monitoring: Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frass, rub marks).

Pesticide Use: If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator who has the licenses or certifications required by state and local laws.

Facility managers should follow all instructions on pesticide product labels and should not apply any pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility. Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to.

Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about pesticide usage at the facility.

Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which
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children may come in direct contact (3).

Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label.

Notification: Notification should be given to parents/guardians and staff before using pesticides, to determine if any child or staff member is sensitive to the product. A member of the child care staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact.

Registry: Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur.

Warning Signs: Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas.

Record Keeping: Child care facilities should keep records of pesticide use at the facility and make the records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years.

Pesticide Storage: Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.

STANDARD 5.2.9.1: Use and Storage of Toxic Substances

The following items should be used as recommended by the manufacturer and should be stored in the original labeled containers:

a) Cleaning materials;
   b) Detergents;
   c) Automatic dishwasher detergents;
   d) Aerosol cans;

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
| e) Pesticides;  
| f) Health and beauty aids;  
| g) Medications;  
| h) Lawn care chemicals;  
| i) Other toxic materials. |

Material Safety Data Sheets (MSDS) must be available on-site for each hazardous chemical that is on the premises. These substances should be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistant opening device, inaccessible to children, and separate from stored medications and food.

Chemicals used in lawn care treatments should be limited to those listed for use in areas that can be occupied by children.

Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely (see Standard 3.6.3.1) and disposed of properly (see Standard 3.6.3.2), and the telephone number for the poison center should be posted in a location where it is readily available in emergency situations (e.g., next to the telephone). Poison centers are open twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.

**STANDARD 5.2.9.13: Testing for Lead**

In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface. In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or non-toxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or

| Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
lead abatement activities. Any surface and the grounds around and under surfaces that children use at a child care facility, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/teachers should check the U.S. Consumer Product Safety Commission’s Website, http://www.cpsc.gov, for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only nontoxic paints should be used.

**STANDARD 5.2.9.2: Use of a Poison Center**
The poison center should be called for advice about any exposure to toxic substances, or any potential poisoning emergency. The national help line for the poison center is 1-800-222-1222, and specialists will link the caregiver/teacher with their local poison center. The advice should be followed and documented in the facility’s files. The caregiver/teacher should be prepared for the call by having the following information for the poison center specialist:

- a) The child’s age and sex;
- b) The substance involved;
- c) The estimated amount;
- d) The child’s condition;
- e) The time elapsed since ingestion or exposure.

The caregiver/teacher should not induce vomiting unless instructed by the poison center. Not addressed. DECAL may want to address this specific standard and add it to their rules.

**STANDARD 5.2.9.3: Informing Staff Regarding Presence of Toxic Substances**
Employers should provide staff with hazard information, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxic substances such as formaldehyde, cleaning and sanitizing supplies, insecticides, herbicides, and other hazardous chemicals in use in the facility. Staff should always read the label prior to use to determine safety in use. For example, toxic products regulated by the Environmental Protection Agency (EPA) will have an EPA signal word of Not addressed. DECAL may want to address this specific standard and add it to their rules.
CAUTION, WARNING, or DANGER. Where nontoxic substitutes are available, these nontoxic substitutes should be used instead of toxic chemicals. If a nontoxic product is not available, caregivers/teachers should use the least toxic product for the job. A CAUTION label is safer than a WARNING label, which is safer than a DANGER label.

**STANDARD 5.2.9.5: Carbon Monoxide Detectors**

Carbon monoxide detector(s) should be installed in child care settings if one of the following guidelines is met:

a) The child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage;

b) If detectors are required by state/local law or state licensing agency.

Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every five years.

**STANDARD 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:

a) On the premises of the child care facility;

b) In each vehicle used when transporting children;

c) On field trips.

Drivers, while transporting children should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or a part of traffic, with the exception of use of a navigational system or global positioning system device.

**STANDARD 5.4.5.2: Cribs**

Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards.

Recalled or “second-hand” cribs should not be used or

<table>
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<tr>
<th>591-1-1-.25 Physical Plant</th>
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<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(18) Telephone. An operable telephone shall be readily available in the center and the following emergency telephone numbers must be posted in a conspicuous place next to the telephone: physician or hospital; county health department; regional poison control center; all emergency numbers or numbers of local ambulance service, fire and police departments.</em></td>
<td>Partially meets and exceeds.</td>
<td>Within this rule it is met by requiring the phone and exceeds that standard by specifying numbers to be posted; but there is on mention about use and transportation.</td>
</tr>
<tr>
<td>591-1-1-.30 Sleeping and Resting Equipment.</td>
<td>Partially meets.</td>
<td>DECAL may want to add the additional sections regarding use and lack of use during transporting children.</td>
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When it is determined that a crib is no longer safe for use in the facility, it should be dismantled and disposed of appropriately.

Staff should only use cribs for sleep purposes and should ensure that each crib is a safe sleep environment. No child of any age should be placed in a crib for a time-out or for disciplinary reasons. When an infant becomes large enough or mobile enough to reach crib latches or potentially climb out of a crib, they should be transitioned to a different sleeping environment (such as a cot or sleeping mat).

Each crib should be identified by brand, type, and/or product number and relevant product information should be kept on file (with the same identification information) as long as the crib is used or stored in the facility.

Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used.

Safety standards document that cribs used in facilities should be made of wood, metal, or plastic. Crib slats should be spaced no more than two and three-eighths inches apart, with a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. The minimum height from the top of the mattress to the top of the crib rail should be twenty inches in the highest position. Cribs with drop sides should not be used.

The crib should be placed away from window blinds or draperies.

As soon as a child can climb out of a crib, playpens and cots or mats.

(2) Cribs. A crib with a mattress shall be available for each infant.

(a) Crib Construction. Cribs shall be of sturdy construction with bars no more than two and three-eighths inches (2 3/8") apart. Locks and latches on the dropside of the crib shall be safe and secure from accidental release. Stack cribs shall not be used.

(b) Crib Mattress. A mattress shall be at least two inches (2") thick and covered with waterproof, washable material. Before a change of occupant, each mattress shall be cleaned with a disinfectant.

(c) Crib Bedding. Each crib shall have individual crib-size bedding, including a sheet and a cover which is changed daily or more often as needed and prior to a change of occupant.

(d) Mobiles. If crib mobiles or other mobiles are used in the center, the mobiles shall be placed or installed in such a manner so as to be incapable of being touched by any infant or child.

(e) Crib Safety. Crib sides shall always be up and the fastening secured when a child is in the crib except when personnel are standing at the side of the crib giving the child personal attention. There shall be no restraining devices of any type used in the crib unless prescribed in writing by a physician. Staff shall be responsible for using the restraints safely and in accordance with the prescription. Loose plastic materials shall not be used in cribs.
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<table>
<thead>
<tr>
<th>Standard</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5.0.6: Inaccessibility to Matches, Candles, and Lighters</td>
<td>Matches, candles, and lighters should not be accessible to children.</td>
</tr>
<tr>
<td>5.5.0.7: Storage of Plastic Bags</td>
<td>Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children.</td>
</tr>
<tr>
<td>5.5.0.8: Firearms</td>
<td>Centers should not have any firearms, pellet or BB guns (loaded or unloaded), darts, bows and arrows, cap pistols, stun guns, paint ball guns, or objects manufactured for play as toy guns within the premises at any time.</td>
</tr>
<tr>
<td>6.1.0.3: Rooftops as Play Areas</td>
<td>A rooftop used as a play area should be enclosed with a fence from four to six feet high, in accordance with local ordinance, and the bottom edge should be less than three and one-half inches from the base (1).</td>
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</table>

Note: DECAL may want to address this specific standard and add it to their rules.
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<table>
<thead>
<tr>
<th>Section</th>
<th>Addressed</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>fire escape should lead from the roof to an open space at the ground level that meets the safety standards for outdoor play areas.</td>
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</tr>
<tr>
<td><strong>STANDARD 6.1.0.4: Elevated Play Areas</strong></td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
<tr>
<td>Elevated play areas that have been created using a retaining wall should have a guardrail, protective barrier, or fence running along the top of the retaining wall. If the exposed side of the retaining wall is higher than two feet, a fence not less than six feet high should be installed. The bottom edge of the fence should be less than three and one-half inches from the base and should be designed to prevent children from climbing it. Fences should be designed so all spaces are less than three and one-half inches (1). If the height of the exposed side of the retaining wall is two feet or lower, a guardrail should be installed if caring for preschool and school-age children. The space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-three inches. For school-age children, the space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-eight inches. If caring for infants or toddlers, a protective barrier should be installed. The space between the barrier and the ground should be less than three and one-half inches and should be from four to six feet in height.</td>
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<tr>
<td><strong>STANDARD 6.1.0.6: Location of Play Areas Near Bodies of Water</strong></td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
<tr>
<td>Outside play areas should be free from the following bodies of water: a) Unfenced swimming and wading pools; b) Ditches; c) Quarries; d) Canals; e) Excavations; f) Fish ponds; g) Water retention or detention basins; h) Other bodies of water.</td>
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</table>
## STANDARD 6.1.0.8: Enclosures for Outdoor Play Areas

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. 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. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed.

Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.

### 591-1.1-26 Playgrounds

- **(4) Fence or Approved Barriers.** Playgrounds shall be protected from traffic or other hazards by a four (4) foot or higher secure fence or other barrier approved by this Department. Fencing material shall not present a hazard to children and shall be maintained so as to prevent children from leaving the playground area by any means other than through an approved access route. Fence gates shall be kept closed except when persons are entering or exiting the area.

- **(5) Enclosures for Outdoor Play Areas.** The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. These areas should have at least two exits, with at least one being remote from the buildings.

- **(6) Gates.** Gates should be equipped with self-closing and positive self-latching closure mechanisms. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed.

Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.

## STANDARD 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 such as asphalt, concrete, dirt, grass, or flooring covered by carpet or gym mats not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over and surrounded by a shock-absorbing surface. This material may be either the unitary or the loose-fill type, as defined by the U.S. Consumer Product Safety Commission (CPSC) guidelines and ASTM International (ASTM) standards, extending at least six feet beyond the perimeter of the stationary equipment. These shock-absorbing surfaces must conform to the standard stating that the impact of falling from the height of the structure will be less than or equal to peak deceleration of 200G and a Head Injury Criterion.

### 591-1.1-26 Playgrounds

- **(7) Anchoring of Certain Equipment and Fall Zones.** Climbing and swinging equipment shall be anchored and have a resilient surface beneath the equipment. The fall-zone from such equipment must be adequately maintained by the center to assure continuing resiliency.

### 591-1.2 Playgrounds

- **(8) Safety and Upkeep of Playground.** Playgrounds shall be kept clean, free from litter and free of hazards, such as but not limited to non-resilient surfaces under the fall-zone of play equipment, rocks, exposed tree roots and exposed sharp edges of concrete or equipment.

### Rule Compliance

- **Partially meets.**
- **Rule does not address the CPSA or ASTM standards.**
- **DECAL should add the references to the CPSC and ASTM standards.**
Validating the Georgia Child Care Center Regulations

(HIC) of 1000 and should be maintained at all times. Organic materials that support colonization of molds and bacteria should not be used. All loose fill materials must be raked to retain their proper distribution, shock-absorbing properties and to remove foreign material. This standard applies whether the equipment is installed outdoors or indoors.

**STANDARD 6.2.4.4: Trampolines**
Trampolines, both full and mini-size, should be prohibited from being used as part of the child care program activities both on-site and during field trips.

**STANDARD 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 the following:

- 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.

Observations should be documented and filed, and the problems corrected. Facilities should conduct a monthly inspection.

**591-1-.12 Equipment and Toys.**
(1) All indoor and outdoor furniture, activity materials, and equipment shall be used:
   a) In a safe and appropriate manner by each employee and child in attendance; and
   b) In accordance with the manufacturer’s instructions, recommendations, and intended use.

(2) Equipment. All equipment and furniture shall be used only by the age-appropriate group of children. Equipment and furniture shall be:
   a) Free from hazardous conditions such as, but not limited to, sharp rough edges or toxic paint;
   b) Kept clean;
   c) Placed so as to permit the children’s freedom of movement and to minimize danger of accident and collision;
   d) Secured if equipment and furniture is of a weight or mass that could cause injury from tipping, falling, or being pulled or pushed over. Potentially unstable equipment and furniture that might injure a child if not secured include, but are not

<table>
<thead>
<tr>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
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<tbody>
<tr>
<td>Partially meets.</td>
<td>No mention of when observations are made and it should be done monthly.</td>
</tr>
<tr>
<td>DECAL should consider adding this minor addition.</td>
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</table>
limited to, televisions, chests of drawers, bookcases, shelving, cabinets and fish tanks. Examples of items not required to be secured include, but are not limited to, child-sized tables and chairs, rocking chairs, and cribs.

**STANDARD 6.3.1.1: Enclosure of Bodies of Water**

All water hazards, such as pools, swimming pools, stationary wading pools, ditches, fish ponds, and water retention or detention basins should be enclosed with a fence that is four to six feet high or higher and comes within three and one-half inches of the ground. Openings in the fence should be no greater than three and one-half inches. The fence should be constructed to discourage climbing and kept in good repair.

If the fence is made of horizontal and vertical members (like a typical wooden fence) and the distance between the tops of the horizontal parts of the fence is less than forty-five inches, the horizontal parts should be on the swimming pool side of the fence. The spacing of the vertical members should not exceed one and three-quarters inches.

For a chain link fence, the mesh size should not exceed one and one-quarter square inches.

Exit and entrance points should have self-closing, positive latching gates with locking devices a minimum of fifty-five inches from the ground.

A wall of the child care facility should not constitute one side of the fence unless the wall has no openings capable of providing direct access to the pool (such as doors, windows, or other openings).

If the facility has a water play area, the following requirements should be met:

- a) Water play areas should conform to all state and local health regulations;
- b) Water play areas should not include hidden or enclosed spaces;
- c) Spray areas and water-collecting areas should have a non-slip surface, such as asphalt;
- d) Water play areas, particularly those that have standing water, should not have sudden changes in depth of water;
- e) Drains, streams, water spouts, and hydrants

Not Addressed.

DECAL may want to address this specific standard and add it to their rules.
should not create strong suction effects or water-jet forces;
f) All toys and other equipment used in and around the water play area should be made of sturdy plastic or metal (no glass should be permitted);
g) Water play areas in which standing water is maintained for more than twenty-four hours should be treated according to Standard 6.3.4.1, and inspected for glass, trash, animal excrement, and other foreign material.

STANDARD 6.3.1.2: Accessibility to Above-Ground Pools
Above-ground pools should have non-climbable sidewalls that are at least four feet high or should be enclosed with an approved fence. When the pool is not in use, steps should be removed from the pool or otherwise protected to ensure that they cannot be accessed.

591-1.1-35 Swimming Pools and Water-related Activities.
(2) Accessibility of Pools. All swimming and wading pools shall be inaccessible to children except during supervised activities.

Meets.
This rule addresses accessibility but does not contain the additional specificity regarding non-climbable sidewalls, fencing, or steps.

DECAL may want to add this specificity to the rule.

STANDARD 6.3.1.4: Safety Covers for Swimming Pools
When not in use, in-ground and above-ground swimming pools should be covered with a safety cover that meets or exceeds the ASTM International (ASTM) standard “F1346-03: Standard performance specification for safety covers and labeling requirements for all covers for swimming pools, spas, and hot tubs” (2).

Not addressed.

DECAL may want to address this specific standard and add it to their rules.

STANDARD 6.3.1.6: Pool Drain Covers
All covers for the main drain and other suction ports of swimming and wading pools should be listed by a nationally recognized testing laboratory in accordance with ASME/ANSI standard “A112.19.8: Standard for Suction Fittings for Use in Swimming Pools, Wading Pools, Spas and Hot Tubs,” and should be used under conditions that do not exceed the approved maximum flow rate, be securely anchored using manufacturer-supplied parts installed per manufacturer’s specifications, be in good repair, and be replaced at intervals specified by manufacturer. Facilities with one outlet per pump, or multiple outlets per pump with less than thirty-six inches center-to-center distance for two outlets, must be equipped with a Safety Vacuum Release System (SVRS) meeting the

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Compliance</th>
<th>DECAL Notes</th>
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<tbody>
<tr>
<td><strong>STANDARD 6.3.2.1: Lifesaving Equipment</strong>&lt;br&gt;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, should be kept in good repair, and should be stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment so that in emergencies, caregivers/teachers will use equipment appropriately. Children should be familiarized with the use of the equipment based on their developmental level.</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<tr>
<td><strong>STANDARD 6.3.5.1: Hot Tubs, Spas, and Saunas</strong>&lt;br&gt;Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children.</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
<td></td>
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<tr>
<td><strong>STANDARD 6.3.5.2: Water in Containers</strong>&lt;br&gt;Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
<td></td>
</tr>
<tr>
<td><strong>STANDARD 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age</strong>&lt;br&gt;Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects</td>
<td>Partially meets.</td>
<td>Rule does not address the specific examples as provided in the Stepping Stones standard.</td>
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</table>

591-1-1.12 Equipment and Toys.<br>(4) Toys for Children Under Three. Toys for children under three (3) years of age shall also be age-appropriate. Those toys shall be:<br>(a) Non-toxic and lead-free; | |

should not be accessible to children under three years of age:

- Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches;
- Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter;
- Toys with sharp points and edges;
- Plastic bags;
- Styrofoam objects;
- Coins;
- Rubber or latex balloons;
- Safety pins;
- Marbles;
- Magnets;
- Foam blocks, books, or objects;
- Other small objects;
- Latex gloves;
- Bulletin board tacks;
- Glitter.

(b) Too large to be swallowed by a child and not capable of causing asphyxiation or strangulation;
(c) Free of sharp pieces, edges or points of small parts which may be pried off by a child;
(d) Free of rust;
(e) Easily cleaned with a disinfectant daily.

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<tr>
<th>STANDARD 6.4.1.5: Balloons</th>
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<tbody>
<tr>
<td>Infants, toddlers, and preschool children should not be permitted to inflate balloons, suck on or put balloons in their mouths nor have access to uninflated or underinflated balloons. Children under eight should not have access to latex balloons or inflated latex objects that are treated as balloons and these objects should not be permitted in the child care facility.</td>
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<tr>
<th>591-1-1.12 Equipment and Toys.</th>
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<tr>
<td>(3) Toys. A variety of age-appropriate toys and play materials shall be available. They shall be stored on low, open shelves accessible to children in each room or assigned area. Toys that launch projectiles, such as dart guns, pop guns, slingshots, etc., shall not be allowed in the center, and balloons shall not be accessible to preschool children.</td>
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<th>Partially meets.</th>
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<tr>
<td>Rule does not address children under age eight.</td>
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<tr>
<td>DECAL may want to add this age range to this rule.</td>
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<tr>
<th>STANDARD 6.4.2.2: Helmets</th>
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<tbody>
<tr>
<td>All children one year of age and over should wear properly fitted and approved helmets while riding toys with wheels (tricycles, bicycles, etc.) or using any wheeled equipment (rollerblades, skateboards, etc.). Helmets should be removed as soon as children stop riding the wheeled toys or using wheeled equipment. Approved helmets should meet the standards of the U.S. Consumer Product Safety Commission (CPSC) (5). The standards sticker should be</td>
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<table>
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<tr>
<th>STANDARD 6.5.1.1: Competence and Training of Transportation Staff</th>
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<tbody>
<tr>
<td>At least one adult who accompanies or drives children for field trips and out-of-facility activities should receive training by a professional knowledgeable about child development and procedures, to ensure the safety of all children. The caregiver should hold a valid pediatric first aid certificate, including rescue breathing and management of blocked airways. Any emergency medications that a child might require, such as self-injecting epinephrine for life-threatening allergy, should also be available at all times as well as a mobile phone to call for medical assistance. Child:staff ratios should be maintained on field trips and during transport, the driver should not be included in these ratios. No child should ever be left alone in the vehicle. All drivers, passenger monitors, chaperones, and assistants should receive instructions in safety precautions. Transportation procedures should include:</td>
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<tr>
<td>a) Use of developmentally appropriate safety restraints;</td>
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<tr>
<td>b) Proper placement of the child in the motor vehicle in accordance with state and federal child restraint laws and regulations and recognized best practice;</td>
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<tr>
<td>c) Training in handling of emergency medical situations. If a child has a chronic medical condition or special health care needs that could result in an emergency (such as asthma, diabetes, or seizures), the driver or chaperone should have written instructions including parent/guardian emergency contacts, child summary health information, special needs and treatment plans, and should:</td>
</tr>
<tr>
<td>1) Recognize the signs of a medical emergency;</td>
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<tr>
<td>2) Know emergency procedures to follow (3);</td>
</tr>
<tr>
<td>3) Have on hand any emergency supplies or medications necessary, properly stored out of reach of children;</td>
</tr>
<tr>
<td>591-1-1.36 Transportation (3) Staffing Requirements for Transportation of Children.</td>
</tr>
<tr>
<td>(a) Driver. Whenever the center transports children for any reason, the driver of the vehicle shall be at least eighteen (18) years of age and possess a valid driver's license as required for the class of vehicle that the driver will be operating for the center.</td>
</tr>
<tr>
<td>(b) Additional Staff. When transporting children, the following supervision must be maintained: Driver + One (1) Staff Member When transporting three (3) or more children: The additional staff must be at least eighteen (18) years of age or older. When seven (7) or more children under five (5) years of age occupy the vehicle: When eighteen (18) or more children five (5) years of age or older occupy the vehicle. Driver + Two (2) Staff When eight (8) or more children: Members [One (1) of the under three (3) years of age occupy additional staff must be at the vehicle with other children; least eighteen (18) years of age or older] When more than twenty (20) children under five years of age occupy the vehicle with other children. (c) CPR and First Aid Training. Either the driver or another staff person present on the vehicle must have current evidence of successful completion of a biennial training.</td>
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</table>

| Partially meets. | The rule addresses staff to child ratios and training regarding first aid and CPR but does not address the other developmentally related trainings and procedures. |

DECAL should consider adding the other developmentally related trainings and procedures.
4) Know specific medication administration (ex. a child who requires EpiPen or diazepam);
5) Know about water safety when field trip is to a location with a body of water.

d) Knowledge of appropriate routes to emergency facility;
f) Child supervision during transport, including never leaving a child unattended in or around a vehicle;
g) Issues that may arise in transporting children with behavioral issues (e.g., temper tantrums or oppositional behavior).

The receipt of such instructions should be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities.

Vehicles should be equipped with a first aid kit, fire extinguisher, seat belt cutter, and maps. At least one adult should have a functioning cell phone at hand. Information, names of the children and parent/guardian contact information should be carried in the vehicle along with identifying information (name, address, and telephone number) about the child care center.

### STANDARD 6.5.1.2: Qualifications for Drivers

Any driver who transports children for a child care program should be at least twenty-one years of age and should have:

a) A valid commercial driver’s license that authorizes the driver to operate the vehicle being driven;
b) Evidence of a safe driving record for more than five years, with no crashes where a citation was issued;
c) No alcohol, prescription or over-the-counter medications, or other drugs associated with impaired ability to drive, within twelve hours prior to transporting children. Drivers should ensure that any prescription or over-the-counter drugs taken will not impair their ability to drive;
d) No tobacco, alcohol, or drug use while driving;
e) No criminal record of crimes against or

<table>
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<tr>
<th>Training Program</th>
<th>Standard</th>
<th>Partially Meets</th>
<th>Rule States 18 Years of Age</th>
<th>DECAL Should Consider</th>
</tr>
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<tbody>
<tr>
<td>Training Program in Cardiopulmonary Resuscitation (CPR) and a triennial training program in first aid offered by certified or licensed health care professionals and which dealt with the provision of emergency care to infants and children.</td>
<td>591-1-1-.36 Transportation (3) Staffing Requirements for Transportation of Children. (a) Driver. Whenever the center transports children for any reason, the driver of the vehicle shall be at least eighteen (18) years of age and possess a valid driver's license as required for the class of vehicle that the driver will be operating for the center. Under five years of age occupy the vehicle with other children. (c) CPR and First Aid Training. Either the driver or another staff person present on the vehicle must have current evidence of successful completion of a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid offered by certified or licensed health care professionals and which dealt with the provision of emergency care to infants and children.</td>
<td>Partially meets.</td>
<td>Rule states 18 years of age while Stepping Stones standard states 21. No mention in the rule about evidence of a safe driving record, no alcohol or other drugs associated with impaired ability to drive within 12 hours prior to transporting children, no criminal record of crimes against or involving children, no medical condition that would compromise driving.</td>
<td>DECAL should consider adding the Stepping Stones standards specific language.</td>
</tr>
</tbody>
</table>
involving children, child neglect or abuse, substance abuse, or any crime of violence;
  f) No medical condition that would compromise driving, supervision, or evacuation capability including fatigue and sleep deprivation;
  g) 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. The child care program should require drug testing when noncompliance with the restriction on the use of alcohol or other drugs is suspected.

<table>
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<tr>
<th>STANDARD 6.5.2.2: Child Passenger Safety</th>
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<tbody>
<tr>
<td>When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following should apply:</td>
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<tr>
<td>a) A child should be transported only if the child is restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child’s weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according to the manufacturer’s instructions, in a developmentally appropriate child restraint system.</td>
</tr>
<tr>
<td>b) Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-feet-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance.</td>
</tr>
<tr>
<td>c) For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat’s weight limit or is taller than the height limit.</td>
</tr>
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</table>

| licensed health care professionals and which dealt with the provision of emergency care to infants and children. |
| Not addressed. |

DECAL may want to address this specific standard and add it to their rules.
Caregivers/teachers should check the labels on the seat or manufacturer’s instructions if they are unsure of the limits. Manufacturer’s instructions that include these specifications can also be found on the manufacturer’s Website.
d) Child passenger restraint systems should be installed and used in accordance with the manufacturer’s instructions and should be secured in back seats only.
e) All children under the age of thirteen should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat), should have an individual lap-and-shoulder seat belt (2).
f) For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer’s instructions (1). Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until reaching the upper height or weight limit of the seat, in accordance with the manufacturer’s instructions (10). Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place.
g) A booster seat should be used when, according to the manufacturer’s instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and twelve years of age) (1).
h) Car safety seats, whether provided by the child’s parents/guardians or the child care program, should be labeled with the child passenger’s name and emergency contact information.
i) 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 (3,11).
j) The temperature of all metal parts of vehicle child
restraint systems should be checked before use to prevent burns to child passengers. If the child care 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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<tr>
<th>STANDARD 6.5.2.4: Interior Temperature of Vehicles</th>
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<tr>
<td>The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle’s interior temperature exceeds 82°F and providing fresh air through open windows cannot reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.</td>
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<tr>
<th>STANDARD 6.5.3.1: Passenger Vans</th>
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<tr>
<td>Child care facilities that provide transportation to children, parents/guardians, staff, and others should avoid the use of fifteen-pASenger vans whenever possible. Other vehicles, such as vehicles meeting the definition of a “school bus,” should be used to fulfill transportation of child passengers in particular. Conventional twelve- to fifteen-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration (NHTSA) standards (2,4), and thus cannot be sold or leased, as new vehicles, to carry students on a regular basis. Caregivers/teachers should be knowledgeable about the</td>
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| Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
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laws of the state(s) in which their vehicles, including passenger vans, will be registered and used.

STANDARD 7.2.0.2: Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child’s primary 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.

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. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011” from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the “Recommended Immunization Schedules” (6).

If a vaccine-preventable disease to which children are susceptible occurs in the facility 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.

(g) Evidence of age-appropriate immunizations or a signed affidavit against such immunizations. The items shall be maintained for each child enrolled in the center on a form approved by the Department, and no child shall continue enrollment in the center for more than thirty (30) days without such evidence.

Partially meets.

The rule does not address the unimmunized children being exposed to a vaccine preventable disease and how to handle this occurrence.

DECAL may want to address this issue.
<table>
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<tr>
<th>STANDARD 7.2.0.3: Immunization of Caregivers/Teachers</th>
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<tr>
<td>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” at <a href="http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/">http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/</a>. This schedule is updated annually at the beginning of the calendar year and can be found in Appendix H. Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2) 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): 1) Tdap/Td; 2) Varicella-zoster; 3) MMR (measles, mumps, and rubella); 4) Seasonal influenza; 5) Human papillomaviruses (HPV) (eleven through twenty-six years of age); 6) Others as determined by the ACIP and state and local public health authorities. b) Recommended if a specific risk factor is present: 1) Pneumococcal; 2) Hepatitis A; 3) Hepatitis B; 4) Meningococcal; 5) Others as determined by the ACIP and state and local public health authorities. c) If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason. d) 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</td>
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| Not addressed. |

| DECAL may want to address this specific standard and add it to their rules. |
Validating the Georgia Child Care Center Regulations

<table>
<thead>
<tr>
<th>STANDARD 7.3.3.1: Influenza Immunizations for Children and Caregivers/Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized annually beginning when they reach six months of age. Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.</td>
</tr>
<tr>
<td>Not addressed.</td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<table>
<thead>
<tr>
<th>STANDARD 7.3.3.2: Influenza Control</th>
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<tbody>
<tr>
<td>When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least twenty-four hours without use of fever reducing medication. Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least twenty-four hours.</td>
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<tr>
<td>Not addressed.</td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<table>
<thead>
<tr>
<th>STANDARD 7.3.5.1: Recommended Control Measures for Invasive Meningococcal Infection in Child Care</th>
</tr>
</thead>
</table>
| Identification of an individual with invasive meningococcal infection in the child care setting should result in the following:  
   a) Immediate notification of the local or state health department;  
   b) Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection;  
   c) Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care |
| Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
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<table>
<thead>
<tr>
<th>STANDARD 7.3.5.2: Informing Public Health Authorities of Meningococcal Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal disease is designated as notifiable at the national level, and local and/or state public health department authorities should be notified immediately about the occurrence of invasive meningococcal disease in a child care facility. Timely reporting results in early recognition of outbreaks and prevention of additional infections. Facilities should cooperate with their local or state health department officials in notifying parents/guardians of children who attend the facility about exposures to children with invasive meningococcal infections. Early intervention minimizes anxiety and concern that may result from identification of an attendee with an invasive meningococcal infection. This may include providing local health officials with the names and telephone numbers of parents/guardians of children in involved classrooms or facilities.</td>
</tr>
<tr>
<td>Not addressed.</td>
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<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<thead>
<tr>
<th>STANDARD 7.3.9.1: Immunization with <em>Streptococcus Pneumoniae</em> Conjugate Vaccine (PCV13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcal conjugate (PCV13) vaccine is recommended for all children from two through fifty-nine months of age, including children in child care facilities. The vaccine is recommended to be administered at two, four, six, and twelve through fifteen months of age (1-3,5). Healthy children between twenty-four and fifty-nine months of age who are not immunized completely for their age should be administered one dose of PCV13 (3,5). Children two years of age or older at high risk of invasive disease caused by <em>Streptococcus pneumoniae</em> (including sickle cell disease, asplenia, HIV, chronic illness, cochlear implant or immunocompromised) who have received their recommended doses of PCV should receive <em>S. pneumoniae</em> polysaccharide vaccine two or more months after receipt of</td>
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the last dose of PCV (1-3.5).

STANDARD 7.4.0.1: Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections
Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1-3):

a) Toilet trained children who cannot use a toilet for all bowel movements while attending the facility and who develop diarrhea, as defined in Standard 3.6.1.1, should be removed from the facility by their parent/guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This should be accomplished by removing the child who is ill to a separate area of the child care program or, if not possible, to a separate area of the child’s room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as occurs in small family child care homes, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric

Not addressed.

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b) A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care should be separated from other children and the child’s parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child from the facility.

c) Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for hepatitis A virus (HAV) should continue for one week after onset of jaundice.

d) Alternate care for children with diarrhea or hepatitis A in special facilities for children who are ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A.

e) Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with *Shigella*, Shiga toxin-producing *E. coli* (STEC), or *Salmonella* enterica serotype Typhi. For *Shigella* and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For *Salmonella* serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For *Salmonella* species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care.

f) The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility.

g) Recommended post-exposure prophylaxis for hepatitis A includes administration of hepatitis A vaccine or immune globulin to all previously unimmunized staff members and attendees of a child care facility in which a person with hepatitis A is identified.

h) If there has been an exposure to a person with
hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.

**STANDARD 7.5.10.1: Staphylococcus Aureus Skin Infections Including MRSA**

The following should be implemented when children or staff with lesions suspicious for *Staphylococcus aureus* infections are identified:

- a) Lesions should be covered with a dressing;
- b) Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider;
- c) Exclusion is not warranted unless the individual meets any of the following criteria:
  1) Care for other children would be compromised by care required for the person with the *S. aureus* infection;
  2) The individual with the *S. aureus* infection has fever or a change in behavior;
  3) The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent changing;
  4) A health care professional or health department official recommends exclusion of the person with *S. aureus* infection.

Meticulous hand hygiene following contact with lesions should be practiced. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of *S. aureus* infection and referred for evaluation, if indicated.

A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered. *S. aureus* skin infections initially may appear as red raised areas that may become pus-filled abscesses or “boils.”

| Not addressed. |  | DECAL may want to address this specific standard and add it to their rules. |  |
surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these signs or symptoms occur, the child should be evaluated by his/her primary care provider.

<table>
<thead>
<tr>
<th>STANDARD 7.5.6.1: Immunization for Measles</th>
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<tbody>
<tr>
<td>All children in a child care facility should have received age-appropriate immunizations with measles, mumps, and rubella (MMR) vaccine or with measles, mumps, rubella, and varicella (MMRV) vaccine (1). If a case of measles occurs in a child care setting, interrupting subsequent spread depends on prompt immunization of people at risk of exposure or people already exposed who cannot provide documentation of measles immunity, including date of immunization. Children and adults in child care who are not immunized or not age-appropriately immunized against measles should be excluded from care immediately if the child care facility has been notified of a documented case of measles occurring in a child or adult in the center. These children should not be allowed to return to the facility until at least two weeks after the onset of rash in the last case of measles, as determined by health department officials. Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive one or more doses of MMR vaccine unless they have a medical contraindication, documentation of one or more dose of vaccine, history of measles based on primary care provider diagnosis, or laboratory evidence of immunity.</td>
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<tr>
<td>Not addressed.</td>
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<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<tr>
<th>STANDARD 9.2.3.12: Infant Feeding Policy</th>
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<tr>
<td>A policy about infant feeding should be developed with the input and approval from the nutritionist/registered dietitian and should include the following:</td>
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<tr>
<td>a) Storage and handling of expressed human milk;</td>
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<tr>
<td>b) Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate;</td>
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<tr>
<td>c) Preparation, storage, and handling of infant formula;</td>
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<tr>
<td>591-1-1.15 Food Service and Nutrition (a) Center personnel shall hold and feed infants less than six (6) months of age and older children who cannot hold their own bottles or sit alone. Baby bottles shall never be propped; the infant's head shall be elevated while feeding.</td>
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<tr>
<td>(b) Honey shall not be served to children less than one (1) year of age.</td>
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<td>(c) As soon as the feeding plan indicates that a child is ready for solid foods, the</td>
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<tr>
<td>Partially meets.</td>
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<tr>
<td>This rule addresses infant feeding policy in a general way but does not have the specificity as contained in the Stepping Stones standard.</td>
</tr>
<tr>
<td>DECAL should add the specificity from the Stepping Stones standard.</td>
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</table>
d) Proper handwashing of the caregiver/teacher and the children;

e) Use and proper sanitizing of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers;

f) Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;

h) Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;

i) Holding infants during bottle-feeding or feeding them sitting up;

j) Prohibiting bottle propping during feeding or prolonging feeding;

k) Introduction and feeding of age-appropriate solid foods (complementary foods);

l) Handling of food intolerance or allergies (e.g., cow’s milk, peanuts, orange juice, eggs, wheat).

Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant’s primary care provider and parents/guardians.

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<tr>
<th>STANDARDS</th>
<th>OUTCOMES</th>
<th>ASSESSMENT</th>
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<tr>
<td>9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances</td>
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<tr>
<td>Facilities should have written policies addressing the use and possession of tobacco products, alcohol, illegal drugs, prescription medications that have not been prescribed for the user, and unauthorized potentially toxic substances. Policies should include that all of these substances are prohibited inside the facility, on facility grounds, and in any vehicles that transport children at all times. Policies should specify that smoking is prohibited at all times and in all areas used by the children in the program. Smoking is also prohibited at home.</td>
<td>Partially meets.</td>
<td>Rule addresses the prohibited substances but doesn’t address the policies.</td>
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<tr>
<td>591-1-1.28 Prohibited Substances.</td>
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<tr>
<td>(1) Alcohol and Illegal Drugs. Staff, chaperons and students in training shall not be under the influence of or consume alcohol, marijuana or other controlled substances on the center premises during the hours of operation or at any other time or place where there are children present for whom the center staff is responsible. (2) No Smoking. Smoking is prohibited on the premises of a center during the hours of operation and no smoking signs must be</td>
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DECAL may or may not want to address the issue of policies.
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<tr>
<th>Prohibited in any vehicles that transport children. Policies must also specify that use and possession of all substances referred to above is prohibited during all times when caregivers/teachers are responsible for the supervision of children, including times when children are transported, when playing in outdoor play areas not attached to the facility, and during field trips. Child care centers and large family child care homes should provide information to employees about available drug, alcohol, and tobacco counseling and rehabilitation, and any available employee assistance programs.</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
</table>
| STANDARDS 9.2.3.2: Content and Development of the Plan for Care of Children and Staff Who Are Ill All child care facilities should have written policies for the management and care of children and staff who are ill. The facility’s plan for the care of children and staff who are ill should be developed in consultation with the facility’s child care health consultant and other health care professionals to address current understanding of the technical issues of contagion and other health risks. This plan should include:  
a) Policies and procedures for urgent and emergency care;  
b) Admission and inclusion/exclusion policies;  
c) A description of illnesses common to children in child care, their management, and precautions to address the needs and behavior of the child who is ill, as well as to protect the health of other children and staff;  
d) A procedure to obtain and maintain updated individual care plans for children and staff with special health care needs;  
e) A procedure for documenting the name of person affected, date and time of illness, a description of symptoms, the response of the caregiver/teacher or other staff to these symptoms, who was notified (such as a parent/guardian, primary care provider, nurse, physician, or health department), and the response;  
f) Medication policy;  
g) Seasonal and pandemic influenza policy;  
h) Staff illness-guidelines for exclusion and re-entry. In group care, the facility should address the well-being of | | |
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<thead>
<tr>
<th>STANDARD 9.2.3.9: Written Policy on Use of Medications</th>
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<tr>
<td>The facility should have a written policy for the administration of any prescription or non-prescription (over-the-counter [OTC]) medication. The policy should address at least the following:</td>
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<tr>
<td>1) The use of written parental/guardian consent forms for each prescription and OTC medication to be administered at the child care facility. The consent form should include:</td>
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<tr>
<td>a) The child’s name;</td>
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<td>b) The name of the medication;</td>
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<tr>
<td>c) The date(s) and times the medication is to be given;</td>
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<tr>
<td>d) The dose or amount of medication to be given;</td>
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<tr>
<td>e) How the medication is to be administered;</td>
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<tr>
<td>591-1-1-.20 Medications.</td>
</tr>
<tr>
<td>(1) Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child’s physician or parent. Such authorization will include when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.</td>
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<tr>
<td>(2) Dispensing Medication. Written authorization to dispense medications shall be limited to two (2) weeks unless otherwise prescribed by a physician. Medication shall</td>
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<tr>
<td>Rule addresses use of medications but nothing about written policy.</td>
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<tr>
<td>DECAL may want to add the specific language from the Stepping Stones standard on written policy regarding the use of medications.</td>
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</table>
6) The period of time the consent form is valid, which may not exceed the length of time the medication is prescribed for, the expiration date of the medication or one year, whichever is less.

b) The use of the prescribing health professional’s authorization forms for each prescription and OTCmedication to be administered at the child care facility.

c) The circumstances under which the facility will agree to administer medication. This may include the administration of:

1) Topical medications such as non-medicated diaper creams, insect repellants, and sun screens;
2) OTC medicines for fever including acetaminophen and ibuprofen;
3) Long-term medications that are administered daily for children with chronic health conditions that are managed with medications;
4) Controlled substances, such as psychotropic medications;
5) Emergency medications for children with health conditions that may become life-threatening such as asthma, diabetes, and severe allergies;
6) One-time medications to prevent conditions such as febrile seizures.

d) The circumstances under which the facility will not administer medication. This should include:

1) No authorization from parent/guardian and/or prescribing health professional;
2) Prohibition of administering OTC cough and cold medication;
3) Not administering a new medication for the first time to a child while he or she is in child care;
4) If the instructions are unclear or the supplies needed to measure doses or administer the medication are not available or not in good working condition;
5) The medication has expired;
6) If a staff person or his/her backup who has been trained to give that particular medication is not present (in the case of training for medications that require specific skills to administer properly, such as inhalers, only be dispensed out of its original container which must be labeled with the child's name).

(3) Dispensing Records. The center shall maintain a record of all medications dispensed to children by personnel to include the date, time and amount of medication that was administered; any noticeable adverse reactions to the medication; and the signature or initials of the person administering the medication.

(4) Storage. Medications shall be kept in a locked storage cabinet or container which is not accessible to the children and stored separate from cleaning chemicals, supplies or poisons. Medications requiring refrigeration shall be placed in a leakproof container in a refrigerator that is not accessible to the children.

(5) Unused Medication. Medicines which are no longer to be dispensed shall be returned to the child's parents immediately.

(6) Non-Emergency Injections. Non-emergency injections shall only be administered by appropriately licensed persons unless the parent and physician of the child sign a written authorization for the child to self-administer the injection.
e) The process of accepting medication from parents/guardians. This should include:
   1) Verifying the consent form;
   2) Verifying the medication matches what is on the consent form;
   3) Accepting authorization for prescription medications from the child’s prescribing health professional only if the medications are in their original container and have the child’s name, the name of the medication, the dose and directions for giving the medication, the expiration date of the medication, and a list of warnings and possible side effects;
   4) Accepting authorization for OTC medications from the child’s prescribing health professional only if the authorization indicates the purpose of the medication and time intervals of administration, and if the medications are in their original container and include the child’s name, the name of the medication, dose and directions for use, an expiration date for the medication, and a list of warnings and possible side effects;
   5) Verifying that a valid Care Plan accompanies all long-term medications (i.e., medications that are to be given routinely or available routinely for chronic conditions such as asthma, allergies, and seizures);
   6) Verifying any special storage requirements and any precautions to take while the child is on the prescription or OTC medication.

f) The proper handling and storage of medications, including:
   1) Emergency medications – totally inaccessible to children but readily available to supervising caregivers/teachers trained to give them;
   2) Medications that require refrigeration;
   3) Controlled substances;
   4) Expired medications;
   5) A policy to insure confidentiality;
   6) Storing and preparing distribution in a quiet area completely out of access to children;
   7) Keeping all medication at all times totally inaccessible to children (e.g., locked storage);
   8) Whether to require even short-term medications be kept at the facility overnight.
g) The procedures to follow when administering medications. These should include:
   1) Assigning administration only to an adequately trained, designated staff;
   2) Checking the written consent form;
   3) Adhering to the “six rights” of safe medication administration (child, medication, time/date, dose, route, and documentation) (1);
   4) Documenting and reporting any medication errors;
   5) Documenting and reporting adverse effects of the medication;
   6) Documenting and reporting whether the child vomited or spit up the medication.

h) The procedures to follow when returning medication to the family, including:
   1) An accurate account of controlled substances being administered and the amount being returned to the family;
   2) When disposing of unused medication, the remainder of a medication, including controlled substances.

i) The disposal of medications that cannot be returned to the parent/guardian.

A medication administration record should be maintained on an ongoing basis by designated staff and should include the following:
   a) Specific, signed parental/guardian consent for the caregiver/teacher to administer medication including documentation of receiving controlled substances and verification of the amount received;
   b) Specific, signed authorization from the child’s prescribing health professional, prescribing the medication, including medical need, medication, dosage, and length of time to give medication.
   c) Information about the medication including warnings and possible side effects;
   d) Written documentation of administration of medication and any side effects;
   e) Medication errors log.

The facility should consult with the State Board of Nursing, other interested organizations and their child care health consultant about required training and documentation for medication administration. Based on the information, the facility should develop and implement a plan regarding medication administration training (9).
STANDARD 9.2.4.1: Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents

The facility should have a written plan for reporting and managing what they assess to be an incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. The facility should also include procedures of staff training on this plan. The management, documentation, and reporting of the following types of incidents, at a minimum, that occur at the child care facility should be addressed in the plan:

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 child care facility;
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 child care facility, even if the death occurred outside of child care hours;
i) The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

The following procedures, at a minimum, should be addressed in the plan for urgent care:

a) Provision for a caregiver/teacher to accompany a child to a source of urgent care and remain with the child until the parent/guardian assumes responsibility for the child;
b) Provision for the caregiver/teacher to provide the medical care personnel with an authorization form signed by the parent/guardian for emergency care.

591-1-1-21 Operational Policies and Procedures
(h) A description of handling medical emergencies (see rule .07 about children's health);

591-1-1-33 Staff Training
(1) Orientation. Prior to assignment to children or task, all employees must receive initial orientation on the following subjects:
(a) The center's policies and procedures;
(b) The portions of these rules dealing with the care, health and safety of children;
(c) The employee's assigned duties and responsibilities;
(d) Reporting requirements for suspected cases of child abuse, neglect or deprivation; communicable diseases and serious injuries;
(e) Emergency weather plans;
(f) Childhood injury control;
(g) The administration of medicine;
(h) Reducing the risk of Sudden Infant Death Syndrome (SIDS);
(i) Hand washing;
(j) Fire Safety;
(k) Water Safety;
(l) Prevention of HIV/AIDS and blood borne pathogens.
(2) First Year Training - Direct Care Staff. Within the first year of employment, all staff who provide any direct care to children shall obtain ten (10) clock hours of training or instruction in child care issues from an accredited school or Department-approved source. At least six (6) of the clock hours must be Partially meets.
The rule does not contain the details as specified in the Stepping Stones Standard.
DECAL may want to add the details as specified in the Stepping Stones Standard.
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medical care and a written informed consent form signed by the parent/guardian allowing the facility to share the child’s health records with other service providers;
c) Provision for a backup caregiver/teacher or substitute for large and small family child care homes to make the arrangement for urgent care feasible (child:staff ratios must be maintained at the facility during the emergency);
d) Notification of parent/guardian(s);
e) Pre-planning for the source of urgent medical and dental care (such as a hospital emergency room, medical or dental clinic, or other constantly staffed facility known to caregivers/teachers and acceptable to parents/guardians);
f) Completion of a written incident/injury report and the program’s response;
g) Assurance that the first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a monthly review of the contents;
h) Policy for scheduled reviews of staff members’ ability to perform first aid for averting the need for emergency medical services;
i) Policy for staff supervision following an incident when a child is lost, missing, or seriously injured.
divided as follows:
(a) Four (4) clock hours of training in any of the following topics: disease control, cleanliness, basic hygiene, illness detection, illness disposition and childhood injury control.
(b) Two (2) clock hours of training in identifying, reporting and meeting the needs of abused, neglected or deprived children.
(3) First Year Training - Food Preparation. Within the first year of employment, the director and the person primarily responsible for food preparation hired after the effective date of these rules shall receive four (4) clock hours of training in food nutrition planning, preparation, serving, proper dish washing and food storage.
(4) Ongoing Training. On an annual basis, all supervisory and caregiver personnel shall attend ten (10) clock hours of training which is task-focused in early childhood education or child development or subjects relating to job assignment and is offered by an accredited college, university or vocational program or other Department-approved source.

STANDARD 9.2.4.3: Disaster Planning, Training, and Communication
Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child,

591-1-1-.33 Staff Training
(1) Orientation. Prior to assignment to children or task, all employees must receive initial orientation on the following subjects:
(a) The center’s policies and procedures;
(b) The portions of these rules dealing with the care, health and safety of children;
(c) The employee’s assigned duties and responsibilities;
(d) Reporting requirements for suspected

Partially meets. The rule does not contain the details as specified in the Stepping Stones Standard. DECAL may want to add the details as specified in the Stepping Stones Standard.
power outage, and other situations that may require evacuation, lock-down, or shelter-in-place.

**Written Emergency/Disaster Plan:**
Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include:

a) Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning;
b) Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises;
c) Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or posting of flyers at the facility and other community locations);
d) Mechanisms for notifying and communicating with emergency management public officials;
e) Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care needs, transporting necessary medical equipment obtaining emergency medical care, responding to an intruder, etc.;
f) Identification of primary and secondary meeting places and plans for reunification of parents/guardians with their children;
g) Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services);
h) Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as cases of child abuse, neglect or deprivation; communicable diseases and serious injuries;
    (e) Emergency weather plans;
    (f) Childhood injury control;
    (g) The administration of medicine;
    (h) Reducing the risk of Sudden Infant Death Syndrome (SIDS);
    (i) Hand washing;
    (j) Fire Safety;
    (k) Water Safety;
    (l) Prevention of HIV/AIDS and blood borne pathogens.

(2) First Year Training - Direct Care Staff.
Within the first year of employment, all staff who provide any direct care to children shall obtain ten (10) clock hours of training or instruction in child care issues from an accredited school or Department-approved source.

At least six (6) of the clock hours must be divided as follows:

(a) Four (4) clock hours of training in any of the following topics: disease control, cleanliness, basic hygiene, illness detection, illness disposition and childhood injury control.

(b) Two (2) clock hours of training in identifying, reporting and meeting the needs of abused, neglected or deprived children.

(3) First Year Training - Food Preparation.
Within the first year of employment, the director and the person primarily responsible for food preparation shall receive four (4) clock hours of training in food nutrition planning.
Validating the Georgia Child Care Center Regulations

purchasing employees and bills during the aftermath of the disaster;
i) Contingency plans for various situations that address:
   1) Emergency contact information and procedures;
   2) How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care;
   3) Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required;
   4) Administering medicine and implementing other instructions as described in individual special care plans;
   5) Procedures that might be implemented in the event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);
   6) Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;
   7) Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).

Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or lessons learned into the document.

Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or preparation, serving, proper dish washing and food storage.

(4) Ongoing Training. On an annual basis, all supervisory and caregiver personnel shall attend ten (10) clock hours of training which is task-focused in early childhood education or child development or subjects relating to job assignment and is offered by an accredited college, university or vocational program or other Department-approved source.

591-1-1-.27 Posted Notices

(h) Emergency plans for severe weather and fire;

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Training:
Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address:

a) Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan;

b) Different types of emergency and disaster situations and when and how they may occur;
   1) Natural Disasters;
   2) Terrorism (i.e., biological, chemical, radiological, nuclear);
   3) Outbreaks, epidemics, or other infectious disease emergencies;

c) The special and unique needs of children, appropriate response to children’s physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts;

d) Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources;

e) Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations;

f) Developing personal and family preparedness plans;

g) Supporting and communicating with families;

h) Floor plan safety and layout;

i) Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs;

j) Typical community, county, and state emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure);

k) Community resources for post-event support such as mental health consultants, safety consultants;

l) Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur;
m) Insurance and liability issues;
 n) New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children’s needs.

Communicating with Parents/Guardians:
Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including:
 a) Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public;
 b) Procedures and instructions for what parents/guardians can expect if something happens at the facility;
 c) Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation;
 d) Situations that might require parents/guardians to have a contingency plan regarding how their children will be cared for in the unlikely event of a facility closure.
 Facilities should conduct an annual drill, test, or “practice use” of the communication options/mechanisms that are selected.

STANDARD 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy
The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as:
 a) Fire, monthly;
 b) Tornadoes, on a monthly basis in tornado season;
 c) Floods, before the flood season;
 d) Earthquakes, every six months;
 e) Hurricanes, annually;
 f) Threatening person outside or inside the facility;
 g) Rabid animal;
 h) Toxic chemical spill;
 i) Nuclear event.
All drills/exercises should be recorded. Please see Standard 9.4.1.16: Evacuation and Shelter-in-Place Drill Record for more information.

591-1-1-.21 Operational Policies and Procedures
(p) A written plan for handling emergencies, including but not limited to severe weather, loss of electrical power or water and death, serious injury or loss of a child, which may occur at the center. Such plan shall include assurance that no center personnel will impede in any way the delivery of emergency care or services to a child by licensed or certified emergency health care professionals.

(3) The center shall conduct drills for fire, tornado and other emergency situations. The fire drills will be conducted monthly and tornado and other emergency situation drills will be conducted every six months. The center shall maintain documentation.
A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards.

Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice.

The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel. Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation route(s).

of the dates and times of these drills for two years.

STANDARD 9.4.1.10: Documentation of Parent/Guardian Notification of Injury, Illness, or Death in Program
The facility should document that a child’s parent/guardian was notified immediately in the event of a death of their child, of an injury or illness of their child that required professional medical attention, or if their child was lost/missing.

Documentation should also occur noting when law enforcement was notified (immediately) in the event of a death of a child or a lost/missing child.

The facility should document in accordance with state regulations, its response to any of the following events:

- a) Death;
- b) Serious injury or illness that required medical attention;
- c) Reportable infectious disease;
- d) Any other significant event relating to the health

591-1-1-.07 Children's Health.
(2) Parental Notification. Parents must be notified of a child's illness or injury as follows:

- Notification When Immediately notify parents and obtain specific instructions until child can be picked up or returned to group.
- When professional medical attention is required, or
- When child experiences symptoms of moderate discomfort such as elevated temperature, vomiting or diarrhea.

Notify parents by the end of the day.
When professional medical attention is not required, or
- When child experiences symptoms of less than moderate discomfort, or

Meets.
and safety of a child (such as a lost child, a fire or other structural damage, work stoppage, or closure of the facility). The caregiver/teacher should call 9-1-1 to insure immediate emergency medical support for a death or serious injury or illness. They should follow state regulations with regard to when they should notify state agencies such as the licensing agency and the local or state health department about any of the above events.

When child experiences an adverse reaction to prescribed medication which does not constitute moderate discomfort.

(3) Communicable Diseases. The Department’s current communicable disease chart of recommendations for exclusion of sick children from the center and their readmission shall be followed. Parents of all children enrolled shall be notified in writing of the occurrence of any of the illnesses on the communicable disease chart, as provided by the Department, within twenty-four (24) hours after the center becomes aware of the illness or the next working day.

<table>
<thead>
<tr>
<th>STANDARD 9.4.1.12: Record of Valid License, Certificate, or Registration of Facility</th>
<th>591-1-1.16 Governing Body and Licenses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every facility should hold a valid license or certificate, or documentation of, registration prior to operation as required by the local and/or state statute.</td>
<td>(c) License. No person shall operate a child care learning center without a license. A separate license is required for each address or location at which a center is proposed to be operated even when all of the proposed centers are owned by the same person or entity. A separate license is also required for each center operated at a single location by the same governing body. 1. Temporary License. The Department may at its discretion issue a temporary license if the health and safety of the children to be served by the center will not be endangered. A temporary license will be valid for a specified period not to exceed one (1) year and may be issued when the child care learning center is not in full compliance with these rules but has demonstrated satisfactory evidence that it is making progress toward meeting these rules and has submitted an acceptable plan of correction. 2. Restricted License. The Department</td>
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<td>Meets.</td>
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</table>
may at its discretion issue a restricted license in lieu of a temporary or regular license. The restricted license may be granted either in connection with the initial application process for a license or as a result of a subsequent determination made by the Department concerning compliance with these rules. The restriction shall appear on the face of the license and shall restrict a center from providing care or services which are beyond the capability of the licensee to provide. The restriction may also limit the number and/or age of the children served by the center.

3. Regular License. A license will be issued upon presentation of evidence satisfactory to the Department that the center is in compliance with applicable statutes and these rules. The license is valid for one year unless voluntarily surrendered by the holder, reduced to a restricted or temporary license or suspended or revoked by the Department.

4. Qualification Requirement. In order to obtain or retain a license, the director of the center and its employees must be qualified as defined in these rules to administer or work in a center. The Department may presume that the director and center employees are qualified subject to satisfactory determinations on the criminal records checks. However, the Department may require additional reasonable verification of the qualifications of the director and center employees either at the time of application for a license or at any time during the license period whenever the Department has reason to believe that a director or center employee is not qualified under these rules to administer or work in
a child care learning center. Reasonable verification which may be required by the Department may include, but need not be limited to, any or all of the following: statement(s) from an attending physician or other health care professionals attesting to the mental and/or physical health of the applicant and/or staff member; letters of reference from designated persons in the community where the applicant and/or staff member intends to work or is working; certified copies of court orders and additional criminal records checks.

d) License is Non-transferable. A license to operate a child care learning center is not transferable in any way. Each license shall be returned to the Department immediately upon the expiration, suspension, revocation, restriction of the license or termination of the operation.

e) Amended License. If there is a change in the name of the program or center, changes in the ages of the children to be served, an increase in the regular hours of operation such that the center would be providing evening or night-time care in addition to day-time care, changes in the services provided, additions to or changes in the use of the building by the licensed center, an application for an amended license shall be submitted at least thirty (30) days prior to the change, except in the case of an emergency. If an emergency situation arises which makes it impossible to give thirty (30) days notice, the management of the center shall notify the Department by telephone and shall submit an application for an amended license as soon as management becomes aware of the change that will be necessitated by the emergency situation. In no case, however, shall a new owner operate the child care learning
Validating the Georgia Child Care Center Regulations

center without first securing a new license from the Department.

<table>
<thead>
<tr>
<th>STANDARD 9.4.2.6: Contents of Medication Record</th>
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</thead>
<tbody>
<tr>
<td>The file for each child should include a medication record maintained on an ongoing basis by designated staff for all prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. The medication record for prescription and non-prescription medications should include the following:</td>
</tr>
<tr>
<td>a) A separate consent signed by the parent/guardian for each medication the caregiver/teacher has permission to administer to the child; each consent should include the child’s name, medication, time, dose, how to give the medication, and start and end dates when it should be given;</td>
</tr>
<tr>
<td>b) Authorization from the prescribing health professional for each prescription and non-prescription medication; this authorization should also include potential side effects and other warnings about the medication (exception: non-prescription sunscreen and insect repellent always require parental/guardian consent but do not require instructions from each child’s individual medical provider);</td>
</tr>
<tr>
<td>c) Administration log which includes the child’s name, the medication that was given, the dose, the route of administration, the time and date, and the signature or initials of the person administering the medication. For medications given “as needed,” record the reason the medication was given. Space should be available for notations of any side-effects noted after the medication was given or if the dose was not retained because of the child vomiting or spitting out the medication. Documentation should also be made of attempts to give medications that were refused by the child;</td>
</tr>
<tr>
<td>d) Information about prescription medication brought to the facility by the parents/guardians in the original, labeled container with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/ instructions, and relevant warnings. Potential side effects and other warnings</td>
</tr>
</tbody>
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<tr>
<th>591-1-1-20 Medications.</th>
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<tbody>
<tr>
<td>(3) Dispensing Records. The center shall maintain a record of all medications dispensed to children by personnel to include the date, time and amount of medication that was administered; any noticeable adverse reactions to the medication; and the signature or initials of the person administering the medication.</td>
</tr>
</tbody>
</table>

| Partially meets. | Rule states the need to maintain a record of medications but does not contain the details as outlined in the Stepping Stones standard. | DECAL should add the specific language from the Stepping Stones standard regarding the contents of medication records. |
Validating the Georgia Child Care Center Regulations

<table>
<thead>
<tr>
<th>Medication Management</th>
<th>Compliance Requirements</th>
</tr>
</thead>
</table>
| a) Medications for which the indication is written on the
| authorization form; |
| e) Non-prescription medications should be brought to the facility in the original container, labeled with the child’s complete name and administered according to the authorization completed by the person with prescriptive authority; |
| f) For medications that are to be given or available to be given for the entire year, a Care Plan should also be in place (for instance, inhalers for asthma or epinephrine for possible allergy); |
| g) Side effects. |

591-1-.37 Inspections and Investigations.

The Department is authorized and empowered to conduct on-site inspections and investigations of centers.

(a) Conduct of Inspections and Investigations. The Department may conduct inspections and investigations in the following instances:

1. At regular intervals as the Department may determine or at the expiration of the current license;
2. Upon receiving a report alleging child abuse, neglect or deprivation which occurred while the child was in the care of the center director or employees;
3. Upon receiving a complaint concerning the center which could endanger the health, safety or welfare of the children in care;
4. Upon receipt and review of a request for an amended license where the Department determines that an on-site inspection is advisable;
5. Upon the Department or its duly authorized representative being made aware of any flagrant abuses, derelictions or deficiencies

STANDARD 10.4.2.1: Frequency of Inspections for Child Care Centers

The licensing inspector shall make an on-site inspection to measure compliance with licensing rules prior to issuing an initial license and at least two inspections each year to each center and large and small family child care home thereafter. At least one of the inspections should be unannounced and more if needed for the facility to achieve satisfactory compliance or is closed at any time (1). Sufficient numbers of licensing inspectors should be hired to provide adequate time visiting and inspecting facilities to insure compliance with regulations.

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 are encouraged to post the results of licensing inspections, including complaints, on the Internet for parent and public review. Parents/guardians should be provided easy access to the licensing rules and made aware of how to report complaints to the licensing agency.
6. Subsequent to the receipt of a plan of correction, as determined necessary by the Department to monitor whether the plan of correction is being complied with by the center personnel.

(b) Consent to Entry. An application for a license to operate a center or issuance of a license by the Department constitutes consent by the applicant, the proposed holder of the license and the owner of the premises for the Department’s representative after displaying identification to any center staff to enter the premises at any time during operating hours for the purpose of inspecting the facility, including both scheduled and unscheduled inspections and includes consent for meaningful access to all staff, parts of the premises, all children present and all records required by these rules. The Department shall have the right to photocopy or reproduce by any means any record required by these rules to be maintained and as needed for any inspection or investigation.

(c) Failure to Allow Access. Failure to allow access of the Department’s representative to the center, center staff, the children receiving care at the center or the records required by these rules or failure to cooperate with a Department inspection or investigation shall constitute good cause for the denial, restriction, revocation or suspension of a license or commission.
Validating the Georgia Family Child Care Home Regulations by Crosswalking to *Stepping Stones 3rd Edition*

Richard Fiene, Ph.D.

**Introduction**
This analysis is part of the overall Validation Study of the Georgia Licensing System. This is an in-depth comparison in which the key risk assessment standards of the 3rd Edition of *Stepping Stones to Caring for Our Children* were crosswalked to the Georgia Family Child Care Home Regulations in order to validate their relevance and content. This is a continuation of the first approach to validation (Zellman & Fiene, 2012) that was initiated in the first phase of this Validation Study (see Fiene, 2013 for the results of the first phase of the study). This is a necessary analysis that all states should complete in order to validate their child care regulations. By having *Stepping Stones (AAP, APHA, NRC, 2013)* and *Caring for Our Children (AAP, APHA, NRC, 2011)*, we now have national health and safety performance standards as a benchmark for regulatory development.

For additional information regarding this analysis, please contact:
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**References:**


**Validating the Georgia Family Child Care Home Regulations 2013**

**LEGEND:**

*STEPPING STONES STANDARD =* STEPPING STONES ARE THE SUBSET STANDARDS FROM *CARING FOR OUR CHILDREN.*

*DECAL LICENSING RULE =* GEORGIA CHILD CARE LICENSING RULE/REGULATION.

*ANALYSIS =* EXCEEDS, MEETS, PARTIALLY MEETS, DOES NOT MEET, NOT Addressed.

*ANALYSIS CLARIFICATION =* PROVIDES DETAILS OF THE ANALYSIS, WHAT IT MEANS TO DECAL.

*RECOMMENDATION =* BASED UPON THE ANALYSIS CLARIFICATION, RECOMMENDATION(S) ARE MADE REGARDING CHANGES TO DECAL RULE FORMULATION.

*NEXT STEPS =* STEPS THAT DECAL WILL FORMULATE BASED UPON THE CROSSWALK AND ANALYSES.

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**FOOTNOTE:** It should be noted that the Core Rules are all contained within the crosswalk to Stepping Stones which validates their selection as key risk assessment rules.

*October 2013*
### Stepping Stones Standard

**STANDARD 1.1.1.: Ratios Small Homes**

- If the small family child care home caregiver/teacher has no children under two years of age in care, then the small family child care home caregiver/teacher may have one to six children over two years of age in care.

- If the small family child care home caregiver/teacher has one child under two years of age in care, then the small family child care home caregiver/teacher may have one to three children over two years of age in care.

- If the small family child care home caregiver/teacher has two children under two years of age in care, then the small family child care home caregiver/teacher may have no children over two years of age in care.

### DECAL Licensing Rule

- **290-2-3-.07 Staffing and Supervision**
  - (6) Notwithstanding the limitation to six children prescribed by the definition of a family day care home, a provider may care for two additional children who are three years and older for two designated one hour periods daily upon approval by the department.
  - (7) At least one adult shall supervise children at all times. Such adult, if not the provider, shall receive orientation regarding these rules; the provider's policies regarding discipline, injuries and illnesses, and release of children; the provider's written plan for handling emergencies; and appropriate information about any child's specific health needs. Plans shall be made to obtain additional adult help in cases of emergencies.
  - (8) Effective one year from the effective date of this chapter, whenever other children are present in the home (the provider's own children, other related children, other children who also reside in the home, children for whom no pay or compensation is received, etc.) the total number of children present under the age of thirteen years may not exceed twelve, and the space requirement of 35 square feet per child (Rule .13(1)(a)) must be met.
  - (a) Effective one year from the effective date of this chapter, an employee who must be at least 16 years of age must be present to assist with supervision whenever:
    - 1. more than three children under the age of 12 months are present; or

### Analysis

- Does not Meet.

### Analysis Clarification

- None of the ratios meet the Stepping Stones standard.

### Recommendation

- Revise rules according to the ratios within Stepping Stones. If DECAL cannot revise all the ratios to start with then it is recommended to start with infants and toddlers followed by preschoolers and school age children. One always wants to start with our most vulnerable children who would be the youngest age children.

### Next Steps
### STANDARD 1.1.1.4: Ratios and Supervision During Transportation

Child:staff ratios established for out-of-home child care should be maintained on all transportation the facility provides or arranges. Drivers should not be included in the ratio. No child of any age should be left unattended in or around a vehicle, when children are in a car, or when they are in a car seat. A face-to-name count of children should be conducted prior to leaving for a destination, when the destination is reached, before departing for return to the facility and upon return. Caregivers/teachers should also remember to take into account in this head count if any children were picked up or dropped off while being transported away from the facility.

<table>
<thead>
<tr>
<th>Developmental Levels</th>
<th>Child:Staff Ratio</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1:1</td>
</tr>
<tr>
<td>Toddlers</td>
<td>1:1</td>
</tr>
<tr>
<td>Preschoolers</td>
<td>4:1</td>
</tr>
<tr>
<td>School-age Children</td>
<td>6:1</td>
</tr>
</tbody>
</table>

Constant and active supervision should be maintained when any child is in or around water (4). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an infant at all times during swimming or water play (4).

### STANDARD 1.1.1.5: Ratios and Supervision for Swimming, Wading, and Water Play

The following child:staff ratios should apply while children are swimming, wading, or engaged in water play:

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### 290-2-3-.07 Staffing and Supervision

(a) For water-related activities where water is over two feet in depth, the following staff:child ratios shall be maintained:

<table>
<thead>
<tr>
<th>Ages of Children</th>
<th>Staff:Child Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 2 1/2</td>
<td>1:2</td>
</tr>
<tr>
<td>2 1/2 to 4 years</td>
<td>1:5</td>
</tr>
<tr>
<td>4 years &amp; older</td>
<td>1:8</td>
</tr>
</tbody>
</table>

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</table>

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<th>Developmental Levels</th>
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<tr>
<td>Infants</td>
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</tr>
<tr>
<td>Toddlers</td>
<td>1:1</td>
</tr>
<tr>
<td>Preschoolers</td>
<td>4:1</td>
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<td>School-age Children</td>
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Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm’s length providing “touch supervision” (6). The attention of an adult who is supervising children of any age should be focused on the child, and the adult should never be engaged in other distracting activities (4), such as talking on the telephone, socializing, or tending to chores. A lifeguard should not be counted in the child-staff ratio.

**STANDARD 1.2.0.2: Background Screening**

The background screening should include:

- a) Name and address verification;
- b) Social Security number verification;
- c) Education verification;
- d) Employment history;
- e) Alias search;
- f) Driving history through state Department of Motor Vehicles records;
- g) Background screening of:
  1) State and national criminal history records;
  2) Child abuse and neglect registries;
  3) Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.);
  4) Fingerprints; and
  5) Sex offender registries;
- h) Court records;
- i) References.

All family members over age ten living in family child care homes should also have background screenings.

**290-2-3-.04 Registration Requirements and Applications**

(c) Criminal Records Check Required. The provider and employees of a home must submit to criminal records checks in connection with any application for a registration.

1. Preliminary Records Check. Before a registration to operate a home may be issued there shall be on file with the department a satisfactory preliminary criminal records check determination on the provider and a preliminary records check application for all employees, to include adult persons who reside at the home or who, with or without compensation, perform duties at the home which include personal contact between that adult person and children in care.

2. Ongoing Requirements. Before a person may work in a registered home, the provider shall cause the person to be employed to submit a preliminary records check application to the department. The provider shall also cause any adult person, as defined in subparagraph 1. above, to submit a preliminary records check application to the department.

   (i) No person having an unsatisfactory determination as to his or her criminal record may be a provider or employee of a home. No adult person having an unsatisfactory determination as to his or her criminal record may reside at the home.

Partially meets. The DECAL Rule calls for a criminal records check for caregivers but does not provide any of the detail as delineated in the Stepping Stone Standard. Revise the Rule so that a comprehensive background screening with all the items in the Stepping Stone standard are included.
Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having physically or sexually abused children, or are known to have committed such acts.

Background screenings should be repeated periodically taking into consideration state laws and/or requirements. Screenings should be repeated more frequently if there are additional concerns.

**STANDARD 1.3.3.1: General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home**

All caregivers/teachers in small family child care homes should be at least twenty-one years of age, hold an official credential as granted by the authorized state agency, and should have the following education, experience, and skills: a) Current accreditation by the National Association for Family Child Care (NAFCC) (including entry-level qualifications and participation in required training) and a college certificate representing a minimum of three credit hours of early childhood education leadership or master caregiver/teacher training or hold an Associate’s degree in early childhood education or child development; b) A provider who has been in the field less than twelve months should be in the self-study phase of NAFCC accreditation; c) A valid certificate in pediatric first aid, including CPR; d) Pre-service training in health management in child care, including the ability to recognize signs of illness, knowledge of infectious disease prevention and safety injury hazards; e) If caring for infants, knowledge on safe sleep practices including reducing the risk of sudden infant death syndrome (SIDS) and prevention of shaken baby syndrome/abusive head trauma (including how to cope with a crying infant); f) Knowledge of normal child development, as well as knowledge of indicators that a child is not developing typically; g) The ability to respond appropriately to children’s needs; h) Good oral and written communication skills; i) Willingness to receive ongoing mentoring from other teachers; j) Pre-service training in business practices; k) Knowledge of the importance of nurturing adult-child relationships on self-efficacy development; l) Medication administration training.

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<tr>
<th>290-2-3-.07 Staffing and Supervision.</th>
<th>Meets.</th>
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<tr>
<td>(1) The provider shall be at least 21 years of age.</td>
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<tr>
<td>(2) Effective July 1, 2009, providers who apply for initial registration shall submit valid evidence/documentation of one of the following credentials/degrees issued by either the organizations listed below, an accredited educational institution, or another organization approved/recognized by the department:</td>
<td></td>
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<tr>
<td>(a) Child Development Associate (CDA) credential (issued by the Council for Professional Recognition);</td>
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<tr>
<td>(b) Technical Certificate of Credit (TCC) in Early Childhood Education;</td>
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<tr>
<td>(c) Technical College Diploma (TCD) in Early Childhood Education;</td>
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<tr>
<td>(d) Associate Degree in Early Childhood Education (AA, AAS, AAT);</td>
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<tr>
<td>(e) Paraprofessional Certificate (issued by the Georgia Professional Standards Commission);</td>
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<tr>
<td>(f) Bachelor’s degree in Early Childhood Education; or</td>
<td></td>
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<tr>
<td>(g) Master’s degree in Early Childhood Education.</td>
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<tr>
<td>(3) Family day care home providers and applicants who have submitted an application for registration or re-registration on or before June 30, 2009 shall be exempt from the requirement stated in (2)(a) through (g)</td>
<td></td>
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</tbody>
</table>
Validating the Georgia Family Child Care Home Regulations above, except if the family day care home closes for business and then submits a new application for registration on or after July 1, 2009. Any family day care home provider who submits an application for registration on or after July 1, 2009 must meet one of the education requirements listed above. Any family day care home provider who submits a new application for registration on or before June 30, 2009 shall have a high school diploma, General Education Diploma (GED), or similar credentials and shall submit valid evidence/documentation of such credential.

(4) The provider shall have current evidence of successful completion of a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid which have been offered by certified or licensed health care professionals and which dealt with emergency care for infants and children. Additionally, within one year of the effective date of these rules and thereafter on an annual basis, the provider shall attend ten clock hours of diverse training which is related to care of children and which is offered by an accredited college, university or vocational program or other department approved source. Records of completion of such training programs shall be maintained in the home by the provider, as required by Rule .08(5). The ten clock hours of training shall be chosen from the following fields:

(a) Child Development: including discipline, guidance, nutrition, injury control and safety;
(b) Health: including sanitation, disease

| RESEARCH INSTITUTE FOR KEY INDICATORS (RIKI) | 7 |
control, cleanliness, detection and disposition of illness;
(c) Child Abuse and Neglect: including identification and reporting, and meeting the needs of abused and/or neglected children; and
(d) Business Related Topics: including parental communication, recordkeeping, etc.; provided however that such business related training shall be limited to no more than two of the required ten clock hours of training.

**290-2-3-.04 Registration Requirements and Applications**
1. Qualifications Requirement. In order to obtain or retain a registration, the provider of the home and its employees must be qualified, as defined in these rules, to administer or work in a home. The department may presume that the provider and employees are qualified, subject to satisfactory determinations on the criminal records checks. However, the department may require additional reasonable verification of the qualifications of the provider and employees either at the time of application for a registration or at any other time whenever the department has reason to believe or is shown by credible evidence that a provider or employee is not qualified under these rules to administer or work in a home.

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### STANDARD 1.4.1.1: Pre-service Training

In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers

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<th><strong>290-2-3-.04 Registration Requirements and Applications</strong></th>
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<tbody>
<tr>
<td>(a) Pre-Service Training. Prior to the submission of the registration application, the applicant who will be responsible for the day-to-day operations shall complete the preservice training listed below that has been approved by the department and which will include:</td>
</tr>
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| **Partially meets.** | **This DECAL rule has the basic training areas but not the detail as specified in the Stepping Stones standard.** | **DECAL should see about adding the detail from the Stepping Stones standard.** |

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<tbody>
<tr>
<td>Should see about adding the detail from the Stepping Stones standard.</td>
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</table>
may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements.

All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:

1. Orientation that provides, at a minimum, instruction on the application process and gives an overview of the department’s rules and regulations that relate to the operation of the family day care home;
2. Training course that includes the provider competencies that serve as a framework for professional development, which includes, but is not limited to, early learning standards, communication, developmentally appropriate practices, professional and leadership development, business management, and advocacy for the family day care home, parents, children, and staff;
3. Cardiopulmonary resuscitation (CPR) and first aid training programs offered by certified or licensed health care professionals and approved by the department, which include emergency care for infants and children.

a) Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility;

b) Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;

c) Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children’s unique developmental needs;

d) Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;

e) Teaching child care staff and children about infection control and injury prevention through role modeling;

f) Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);

g) Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant;

h) Poison prevention and poison safety;

i) Immunization requirements for children and staff;

j) Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness;

k) Reduction of injury and illness through environmental design and maintenance;

l) Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports;

m) Staff occupational health and safety practices,
such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;

n) Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;
o) Promotion of health and safety in the child care setting, including staff health and pregnant workers;
p) First aid including CPR for infants and children;
q) Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment;
r) Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;
s) Physical activity, including age-appropriate activities and limiting sedentary behaviors;
t) Prevention of childhood obesity and related chronic diseases;
u) Knowledge of environmental health issues for both children and staff;
v) Knowledge of medication administration policies and practices;
w) Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA);
x) Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities;
y) Positive approaches to support diversity;
z) Positive ways to promote physical and intellectual development.

**STANDARD 1.4.2.2: Orientation for Care of Children with Special Health Care Needs**

When a child care facility enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child’s special health care needs and have the skills to work with Not addressed.
Validating the Georgia Family Child Care Home Regulations

that child in a group setting.

Caregivers/teachers in small family child care homes, who care for a child with special health care needs, should meet with the parents/guardians and meet or speak with the child’s primary care provider (if the parent/guardian has provided prior, informed, written consent) or a child care health consultant to ensure that the child’s special health care needs will be met in child care and to learn how these needs may affect his/her developmental progression or play with other children.

The orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child’s primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child’s care. Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics:

a) Positioning for feeding and handling, and risks for injury for children with physical/mental disabilities;

b) Toileting techniques;

c) Knowledge of special treatments or therapies (e.g., PT, OT, speech, nutrition/diet therapies, emotional support and behavioral therapies, medication administration, etc.) the child may need/receive in the child care setting;

d) Proper use and care of the individual child’s adaptive equipment, including how to recognize defective equipment and to notify parents/guardians that repairs are needed;

e) How different disabilities affect the child’s ability to participate in group activities;

f) Methods of helping the child with special health care needs or behavior problems to participate in the facility’s programs, including physical activity programs;

g) Role modeling, peer socialization, and interaction;

h) Behavior modification techniques, positive behavioral supports for children, promotion of self-esteem, and other techniques for managing
behavior;
  i) Grouping of children by skill levels, taking into account the child’s age and developmental level;
  j) Health services or medical intervention for children with special health care problems;
  k) Communication methods and needs of the child;
  l) Dietary specifications for children who need to avoid specific foods or for children who have their diet modified to maintain their health, including support for continuation of breastfeeding;
  m) Medication administration (for emergencies or on an ongoing basis);
  n) Recognizing signs and symptoms of impending illness or change in health status;
  o) Recognizing signs and symptoms of injury;
  p) Understanding temperament and how individual behavioral differences affect a child’s adaptive skills, motivation, and energy;
  q) Potential hazards of which staff should be aware;
  r) Collaborating with families and outside service providers to create a health, developmental, and behavioral care plan for children with special needs;
  s) Awareness of when to ask for medical advice and recommendations for non-emergent issues that arise in school (e.g., head lice, worms, diarrhea);
  t) Knowledge of professionals with skills in various conditions, e.g., total communication for children with deafness, beginning orientation and mobility training for children with blindness (including arranging the physical environment effectively for such children), language promotion for children with hearing-impairment and language delay/disorder, etc.;
  u) How to work with parents/guardians and other professionals when assistive devices or medications are not consistently brought to the child care program or school;
  v) How to safely transport a child with special health care needs.

<table>
<thead>
<tr>
<th>STANDARD 1.4.2.3: Orientation Topics</th>
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<tbody>
<tr>
<td>During the first three months of employment, the caregiver/teacher in a small family home should document satisfactory knowledge of the following topics:</td>
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<table>
<thead>
<tr>
<th>290-2-3-.04 Registration Requirements and Applications.</th>
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<tbody>
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<td>1. Orientation that provides, at a minimum, instruction on the application process and gives an overview of the department’s</td>
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<tr>
<th>Partially meets.</th>
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<tbody>
<tr>
<td>The staff training rule meets certain aspects of the Stepping Stones standard but does not contain all the specific content areas.</td>
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</table>

| DECAL could see about adding the additional items listed in the Stepping Stones standard to this rule. |
a) Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility;

b) Exclusion and readmission procedures and policies;

c) Cleaning, sanitation, and disinfection procedures and policies;

d) Procedures for administering medication to children and for documenting medication administered to children;

e) Procedures for notifying parents/guardians of an infectious disease occurring in children or staff within the facility;

f) Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease;

g) Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters;

h) Procedure for accessing the child care health consultant for assistance;

i) Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.;

j) Proper hand hygiene.

Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child care home caregivers/teachers should not commence operation before receiving orientation on these topics in pre-service training rules and regulations that relate to the operation of the family day care home;

2. Training course that includes the provider competencies that serve as a framework for professional development, which includes, but is not limited to, early learning standards, communication, developmentally appropriate practices, professional and leadership development, business management, and advocacy for the family day care home, parents, children, and staff;

290-2-3-.07 Staffing and Supervision

(7) At least one adult shall supervise children at all times. Such adult, if not the provider, shall receive orientation regarding these rules; the provider’s policies regarding discipline, injuries and illnesses, and release of children; the provider’s written plan for handling emergencies; and appropriate information about any child’s specific health needs. Plans shall be made to obtain additional adult help in cases of emergencies

STANDARD 1.4.3.1: First Aid and CPR Training for Staff

The caregiver/teacher of a small family child care home should have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training.

290-2-3-.07 Staffing and Supervision

(4) The provider shall have current evidence of successful completion of a biennial training program in cardiopulmonary resuscitation (CPR) and a triennial training program in first aid which have been offered by certified or licensed health care professionals and which dealt with emergency care for infants and children.

Meets
Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.

<table>
<thead>
<tr>
<th>STANDARD 1.4.3.2: Topics Covered in First Aid Training</th>
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<tr>
<td>First aid training should present an overview of Emergency Medical Services (EMS), accessing EMS, poison center services, accessing the poison center, safety at the scene, and isolation of body substances. First aid instruction should include, but not be limited to, recognition and first response of pediatric emergency management in a child care setting of the following situations:</td>
</tr>
<tr>
<td>a) Management of a blocked airway and rescue breathing for infants and children with return demonstration by the learner (pediatric CPR);</td>
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<tr>
<td>b) Abrasions and lacerations;</td>
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<tr>
<td>c) Bleeding, including nosebleeds;</td>
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<tr>
<td>d) Burns;</td>
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<td>e) Fainting;</td>
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<td>f) Poisoning, including swallowed, skin or eye contact, and inhaled;</td>
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<td>g) Puncture wounds, including splinters;</td>
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<tr>
<td>h) Injuries, including insect, animal, and human bites;</td>
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<tr>
<td>i) Poison control;</td>
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<td>j) Shock;</td>
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<td>k) Seizure care;</td>
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<td>l) Musculoskeletal injury (such as sprains, fractures);</td>
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<td>m) Dental and mouth injuries/trauma;</td>
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<td>n) Head injuries, including shaken baby syndrome/abusive head trauma;</td>
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<td>o) Allergic reactions, including information about when epinephrine might be required;</td>
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<tr>
<td>p) Asthmatic reactions, including information about when rescue inhalers must be used;</td>
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<td>q) Eye injuries;</td>
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<tr>
<td>r) Loss of consciousness;</td>
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<tr>
<td>s) Electric shock;</td>
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<tr>
<td>t) Drowning;</td>
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<tr>
<td>u) Heat-related injuries, including heat exhaustion/heat stroke;</td>
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<tr>
<td>v) Cold related injuries, including frostbite;</td>
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Not addressed.

DECAL may want to address this specific standard and add it to their rules.
| w) Moving and positioning injured/ill persons; x) Illness-related emergencies (such as stiff neck, inexplicable confusion, sudden onset of blood-red or purple rash, severe pain, temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method, and looking/acting severely ill); y) Standard Precautions; z) Organizing and implementing a plan to meet an emergency for any child with a special health care need; aa) Addressing the needs of the other children in the group while managing emergencies in a child care setting; ab) Applying first aid to children with special health care needs. |
|---|---|---|---|
| **STANDARD 1.4.3.3: CPR Training for Swimming and Water Play**  For small family child care homes, the person trained in water safety and CPR should be the caregiver/teacher. Written verification of successful completion of CPR and lifesaving training, water safety instructions, and emergency procedures should be kept on file. |
| **290-2-3-.07 Staffing and Supervision**  9) If children are allowed to participate in water activities where the water is over two feet in depth, the provider or an adult shall supervise such activities and must have successfully completed a training program in lifeguarding offered by a water-safety instructor certified by the American Red Cross or YMCA or other recognized standard setting agency for water safety instruction. |
| Partially meets. | This rule states that the caregiver/teacher have completed a training program in lifeguarding but does not have any wording about CPR. | DECAL may want to add the specific language regarding CPR training. |
| **STANDARD 1.4.5.1: Training of Staff Who Handle Food**  All staff members with food handling responsibilities should obtain training in food service and safety. The director of a center or a large family child care home or the designated supervisor for food service should be a certified food protection manager or equivalent as demonstrated by completing an accredited food protection manager course. |
| **290-2-3-.07 Staffing and Supervision**  (c) Child Abuse and Neglect: including |
| Partially meets. | The rule addresses training in identifying, reporting and meeting the needs of abused, neglected or deprived children; but does not go into | DECAL may want to add the additional language from the Stepping Stones standard. |
| **STANDARD 1.4.5.2: Child Abuse and Neglect Education**  Caregivers/teachers should use child abuse and neglect |
| **290-2-3-.07 Staffing and Supervision**  The ten clock hours of training shall be chosen from the following fields: |
| Partially meets. | | |
Validating the Georgia Family Child Care Home Regulations 2013

<table>
<thead>
<tr>
<th>Prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. The dangers of shaking infants and toddlers and repeated exposure to domestic violence should be included in the education and prevention materials. Caregivers/teachers should also receive education on promoting protective factors to prevent child maltreatment. Caregivers/teachers should be able to identify signs of stress in families and assist families by providing support and linkages to resources when needed. Children with disabilities are at a higher risk of being abused. Special training in child abuse and neglect and children with disabilities should be provided (2). 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. Child abuse reporting requirements are known and available from the child care regulation department in each state.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification and reporting, and meeting the needs of abused and/or neglected children;</td>
</tr>
<tr>
<td>Any details regarding this training as stated in the Stepping Stones standard.</td>
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</tbody>
</table>

**STANDARD 1.5.0.2: Orientation of Substitutes**

The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program’s policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.

All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics:
- a) Safe infant sleep practices if an infant is enrolled in the program;
- b) Any emergency medical procedure/medication needs of the children;
- c) Any nutrition needs of the children.

All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:

**290-2.3-.07 Staffing and Supervision**

(7) At least one adult shall supervise children at all times. Such adult, if not the provider, shall receive orientation regarding these rules; the provider's policies regarding discipline, injuries and illnesses, and release of children; the provider's written plan for handling emergencies; and appropriate information about any child's specific health needs. Plans shall be made to obtain additional adult help in cases of emergencies.

| 290-2.3-.07 Staffing and Supervision  |
| Partially meets. |

The rule addresses the need for substitutes to receive orientation training but provides not details of what this orientation should be.

DECAL may want to add the specifics from this standard.
| a) The names of the children for whom the caregiver/teacher will be responsible, and their specific developmental needs; |
| b) The planned program of activities at the facility; |
| c) Routines and transitions; |
| d) Acceptable methods of discipline; |
| e) Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies); |
| f) Emergency health and safety procedures; |
| g) General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following: |
| 1) Hand hygiene techniques, including indications for hand hygiene; |
| 2) Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves; |
| 3) The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages; |
| 4) Correct food preparation and storage techniques, if employee prepares food; |
| 5) Proper handling and storage of human milk when applicable and formula preparation if formula is handled; |
| 6) Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles; |
| 7) Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations; |
| 8) Injury prevention and safety including the role of mandatory child abuse reporter to report any suspected abuse/neglect. |
| h) Emergency plans and practices; |
| i) Access to list of authorized individuals for releasing children. |

**STANDARD 2.1.1.4: Monitoring Children’s Development/Obtaining Consent for Screening**

| Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
Child care settings provide daily indoor and outdoor opportunities for promoting and monitoring children’s development. Caregivers/teachers should monitor the children’s development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations, and early intervention and treatment. Caregivers/teachers should work in collaboration to monitor a child’s development with parents/guardians and in conjunction with the child’s primary care provider and health, education, mental health, and early intervention consultants. Caregivers/teachers should utilize the services of health and safety, education, mental health, and early intervention consultants to strengthen their observation skills, collaborate with families, and be knowledgeable of community resources.

Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child’s placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The use of authentic assessment and curricular-based assessments should be an ongoing part of the services provided to all children (5-9). The facility’s formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation.

Parents/guardians should be explicitly invited to:

a) Discuss reasons for a health or developmental assessment;

b) Participate in discussions of the results of their child’s evaluations and the relationship of their child’s needs to the caregivers’/teachers’ ability to serve that child appropriately;

c) Give alternative perspectives;

d) Share their expectations and goals for their child and have these expectations and goals integrated with any plan for their child;

e) Explore community resources and supports that might assist in meeting any identified needs that child care centers and family child care homes can provide;

f) Give written permission to share health information with primary health care professionals (medical home), child care health consultants and
Validating the Georgia Family Child Care Home Regulations

| other professionals as appropriate; The facility should document parents’/guardians’ presence at these meetings and invitations to attend. If the parents/guardians do not attend the screening, the caregiver/teacher should inform the parents/guardians of the results, and offer an opportunity for discussion. Efforts should be made to provide notification of meetings in the primary language of the parents/guardians. Formal evaluations of a child’s health or development should also be shared with the child’s medical home with parent/guardian consent. Programs are encouraged to utilize validated screening tools to monitor children’s development, as well as various measures that may inform their work facilitating children’s development and providing an enriching indoor and outdoor environment, such as authentic-based assessment, work sampling methods, observational assessments, and assessments intended to support curricular implementation (5,9). Programs should have clear policies for using reliable and valid methods of developmental screening with all children and for making referrals for diagnostic assessment and possible intervention for children who screen positive. All programs should use methods of ongoing developmental assessment that inform the curricular approaches used by the staff. Care must be taken in communicating the results. Screening is a way to identify a child at risk of a developmental delay or disorder. It is not a diagnosis. If the screening or any observation of the child results in any concern about the child’s development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may also be required. |
|-----------------|-----------------|-----------------|-----------------|
| **STANDARD 2.1.2.2: Interactions with Infants and Toddlers** Caregivers/teachers should provide consistent, continuous and inviting opportunities to talk, listen to, and otherwise interact with young infants throughout the day (indoors and outdoors) including feeding, changing, playing with, and cuddling them. |
| Not addressed. | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
### STANDARD 2.2.0.1: Methods of Supervision of Children
Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside.

School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity.

Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times. Developmentally appropriate child:staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child:staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.

| 290-2.3-.07 Staffing and Supervision | Partially meets. | This rule addresses supervision but lacks specificity, such as: regularly counting children at transitions. | DECAL may want to add the additional language from the Stepping Stones standard to be more specific regarding supervision of children. |
| ________________________________ | ____________________________ | ____________________________________________________________ | _______________________________________________________________ |
| (7) At least one adult shall supervise children at all times. | | | |

### STANDARD 2.2.0.10: Using Physical Restraint
When a child with special behavioral or mental health is-

| 290-2.3-.11 Health, Safety, and Discipline | Partially meets. | This rule addresses the use of physical restraints but does not address a behavioral plan. | DECAL may want to add the development and use of a behavioral plan. |
| ________________________________ | ____________________________ | ____________________________________________________________ | _______________________________________________________________ |
| (a) A provider or a home's employees shall not: | | | |

| | | | |
| | | | |
sues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child’s primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint.

That behavioral care plan should include:

a) An indication and documentation of the use of other behavioral strategies before the use of restraint and a precise definition of when the child could be restrained;

b) That the restraint be limited to holding the child as gently as possible to accomplish the restraint;

c) That such child restraint techniques do not violate the state’s mental health code;

d) That the amount of time the child is physically restrained should be the minimum necessary to control the situation and be age-appropriate; reevaluation and change of strategy should be used every few minutes;

e) That no bonds, ties, blankets, straps, car seats, heavy weights (such as adult body sitting on child), or abusive words should be used;

f) That a designated and trained staff person, who should be on the premises whenever this specific child is present, would be the only person to carry out the restraint.

6. Use mechanical or physical restraints or devices to discipline children;

<table>
<thead>
<tr>
<th>STANDARD 2.2.0.4: Supervision Near Bodies of Water</th>
<th>290-2.3-.07 Staffing and Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant and active supervision should be maintained when any child is in or around water (1). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm’s length providing “touch supervision”. Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and</td>
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<tr>
<td>The rule addresses supervision in water related activities but does not address the ratios suggested in the Stepping Stones standard for infants or toddlers, nor is there specific language regarding the Virginia Graeme Baker Pool and Spa Safety Act.</td>
<td></td>
</tr>
<tr>
<td>Partially meets.</td>
<td>DECAL may want to add language about ratios for infants and toddlers and add specific language regarding the Virginia Graeme Baker Act.</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>STANDARD 2.2.0.6: Discipline Measures</th>
<th>Partially Meets</th>
<th>The rule as written is very general with none of the specificity contained in the Stepping Stones standard.</th>
<th>DECAL should look at the exact wording from Stepping Stones to determine where this rule can be strengthened by adding the greater specificity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers should care for children without ever resorting to physical punishment or abusive language. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult’s guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. This process should include:</td>
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<tr>
<td>a) Forming a positive relationship with the child. When children have a positive relationship with the adult, they are more likely to follow that person’s directions. This positive relationship occurs when the adult spends time talking to the child, listening to the child, following the child’s lead, playing with the child, and responding to the child’s needs;</td>
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<tr>
<td>b) Basing expectations on children’s developmental level;</td>
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<tr>
<td>c) Establishing simple rules children can understand (e.g., you can’t hurt others, our things, or yourself) and being proactive in teaching and supporting children in learning the rules;</td>
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<tr>
<td>d) Adapting the physical indoor and outdoor learning/play environment or family child care home to encourage positive behavior and self-regulation by providing engaging materials based on children’s interests and ensuring that the learning environment promotes active participation of each child. Well-designed child care environments are ones that are supportive of appropriate behavior in children, and are designed to help children learn about what to expect in that</td>
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</table>

290-2-3-.11 Health, Safety, and Discipline (3) Discipline. Disciplinary actions used to correct a child’s behavior, guidance techniques and any activities in which the children participate or observe at the home shall not be detrimental to the physical or mental health of any child.
environment and to promote positive interactions and engagement with others;

e) Modifying the learning/play environment (e.g., schedule, routine, activities, transitions) to support the child’s appropriate behavior;

f) Creating a predictable daily routine and schedule. When a routine is predictable, children are more likely to know what to do and what is expected of them. This may decrease anxiety in the child. When there is less anxiety, there may be less acting out. Reminders need to be given to the children so they can anticipate and prepare themselves for transitions within the schedule. Reminders should be individualized such that each child understands and anticipates the transition;

g) Using encouragement and descriptive praise. When clear encouragement and descriptive praise are used to give attention to appropriate behaviors, those behaviors are likely to be repeated. Encouragement and praise should be stated positively and descriptively. Encouragement and praise should provide information that the behavior the child engaged in was appropriate. Examples: “I can tell you are ready for circle time because you are sitting on your name and looking at me.” “Your friend looked so happy when you helped him clean up his toys.” “You must be so proud of yourself for putting on your coat all by yourself.” Encouragement and praise should label the behaviors, not the child (e.g., good listening, good eating, instead of good boy);

h) Using clear, direct, and simple commands. When clear commands are used with children, they are more likely to follow them. The caregiver/teacher should tell the child what to do rather than what NOT to do. The caregiver/teacher should limit the number of commands. The caregiver/teacher should use if/ then and when/then statements with logical and natural consequences. These practices help children understand they can make choices and that choices have consequences;

i) Showing children positive alternatives rather than just telling children “no”;

j) Modeling desired behavior;

k) Using planned ignoring and redirection. Certain behaviors can be ignored while at the same time
the adult is able to redirect the children to another activity. If the behavior cannot be ignored, the adult should prompt the child to use a more appropriate behavior and provide positive feedback when the child engages in the behavior; l) Individualizing discipline based on the individual needs of children. For example, if a child has a hard time transitioning, the caregiver/teacher can identify strategies to help the child with the transition (individualized warning, job during transition, individual schedule, peer buddy to help, etc.) If a child has a difficult time during a large group activity, the child might be taught to ask for a break; m) Using time-out for behaviors that are persistent and unacceptable. Time-out should only be used in combination with instructional approaches that teach children what to do in place of the behavior problem. (See guidance for time-outs below.) Expectations for children’s behavior and the facility’s policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children’s appropriate behaviors before it becomes a problem.

STANDARD 2.2.0.8: Preventing Expulsions, Suspensions, and Other Limitations in Services
Child care programs should not expel, suspend, or otherwise limit the amount of services (including denying outdoor time, withholding food, or using food as a reward/punishment) provided to a child or family on the basis of challenging behaviors or a health/safety condition or situation unless the condition or situation meets one of the two exceptions listed in this standard.
Expulsion refers to terminating the enrollment of a child or family in the regular group setting because of a challenging behavior or a health condition. Suspension and other limitations in services include all other reductions in the amount of time a child may be in attendance of the regular group setting, either by requiring the child to cease attendance for a particular period of time or reducing the number of days or amount of time that a child may attend.
Requiring a child to attend the program in a special place away from the other children in the regular group setting is included in this definition.

Child care programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program’s protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises.

Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children’s health conditions in collaboration with parents/guardians and the child’s primary care provider. Programs should attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children’s mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. Mental health consultation may be obtained from a variety of sources, as described in Standard 1.6.0.3.

When children exhibit or engage in challenging behaviors that cannot be resolved easily, as above, staff should:

a) Assess the health of the child and the adequacy of the curriculum in meeting the developmental and educational needs of the child;

b) Immediately engage the parents/guardians/family in a spirit of collaboration regarding how the child’s behaviors may be best handled, including appropriate solutions that have worked at home or in other settings;

c) Access an early childhood mental health consultant to assist in developing an effective plan to address the child’s challenging behaviors and to assist the child in developing age-appropriate, pro-
social skills;
d) Facilitate, with the family’s assistance, a referral for an evaluation for either Part C (early intervention) or Part B (preschool special education), as well as any other appropriate community-based services (e.g., child mental health clinic);
e) Facilitate with the family communication with the child’s primary care provider (e.g., pediatrician, family medicine provider, etc.), so that the primary care provider can assess for any related health concerns and help facilitate appropriate referrals.

The only possible reasons for considering expelling, suspending or otherwise limiting services to a child on the basis of challenging behaviors are:

a) Continued placement in the class and/or program clearly jeopardizes the physical safety of the child and/or his/her classmates as assessed by a qualified early childhood mental health consultant AND all possible interventions and supports recommended by a qualified early childhood mental health consultant aimed at providing a physically safe environment have been exhausted; or

b) The family is unwilling to participate in mental health consultation that has been provided through the child care program or independently obtain and participate in child mental health assistance available in the community; or

c) Continued placement in this class and/or program clearly fails to meet the mental health and/or social-emotional needs of the child as agreed by both the staff and the family AND a different program that is better able to meet these needs has been identified and can immediately provide services to the child.

In either of the above three cases, a qualified early childhood mental health consultant, qualified special education staff, and/or qualified community-based mental health care provider should be consulted, referrals for special education services and other community-based services should be facilitated, and a detailed transition plan from this program to a more appropriate setting should be developed with the family and followed. This transition could include a different private or public-funded child care or early education program in the community that is better
equipped to address the behavioral concerns (e.g., therapeutic preschool programs, Head Start or Early Head Start, prekindergarten programs in the public schools that have access to additional support staff, etc.), or public-funded special education services for infants and toddlers (i.e., Part C early intervention) or preschoolers (i.e., Part B preschool special education).

To the degree that safety can be maintained, the child should be transitioned directly to the receiving program. The program should assist parents/guardians in securing the more appropriate placement, perhaps using the services of a local child care resource and referral agency. With parent/guardian permission, the child’s primary care provider should be consulted and a referral for a comprehensive assessment by qualified mental health provider and the appropriate special education system should be initiated. If abuse or neglect is suspected, then appropriate child protection services should be informed. Finally, no child should ever be expelled or suspended from care without first conducting an assessment of the safety of alternative arrangements (e.g., Who will care for the child? Will the child be adequately and safely supervised at all times?)

### STANDARD 2.2.0.9: Prohibited Caregiver/Teacher Behaviors

The following behaviors should be prohibited in all child care settings and by all caregivers/teachers:

- **a)** The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to:
  1. Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting;
  2. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
  3. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
  4. 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;

### 290-2-3-.11 Health, Safety, and Discipline

(3) Discipline. Disciplinary actions used to correct a child's behavior, guidance techniques and any activities in which the children participate or observe at the home shall not be detrimental to the physical or mental health of any child.

- (a) A provider or a home's employees shall not:
  1. Physically or sexually abuse a child, or engage in or permit others to engage in sexually overt conduct in the presence of any child enrolled in the home; or
  2. Inflict corporal/physical punishment upon a child; or
  3. Shake, jerk, pinch or handle roughly a child; or
  4. Verbally abuse or humiliate a child which includes, but is not limited to, the use of threats, profanity, or belittling remarks

Meets to Exceeds.
c) Binding or tying to restrict movement, such as in a car seat (except when travelling) or taping the mouth;  
d) Using or withholding food as a punishment or reward;  
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, either as an incident of discipline or otherwise. Any child care program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child’s family;  
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;  
j) Physical activity/outdoor time should not be taken away as punishment.

<table>
<thead>
<tr>
<th>290-2.3-.08 Children’s Records.</th>
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<tbody>
<tr>
<td>(1) The home shall maintain current and updated individual records on each child in care.</td>
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<tr>
<td>The home shall maintain the records outlined herein while the child is in care and for a period of one (1) year after such child is no longer in care at the family day care home.</td>
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<tr>
<td>Such records shall include:</td>
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<tr>
<td>(a) Identifying information (child’s name, birth date, parents name, or guardian’s name if applicable, home and business addresses, telephone numbers);</td>
</tr>
<tr>
<td>(b) Name, address and telephone number of persons including child’s physician to contact in emergencies;</td>
</tr>
<tr>
<td>(c) Evidence of age-appropriate</td>
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</tbody>
</table>

Meets to Exceeds.

**STANDARD 2.3.3.1: Parents'/Guardians’ Provision of Information on Their Child’s Health and Behavior**

The facility should ask parents/guardians for information regarding the child’s health, nutrition, level of physical activity, and behavioral status upon registration or when there has been an extended gap in the child’s attendance at the facility. The child’s health record should be updated if s/he have had any changes in their health or immunization status. Parents/guardians should be encouraged to sign a release of information/agreement so that child care workers can communicate directly with the child’s medical home/primary care provider.
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- Immunizations, or a signed affidavit certifying that the required immunizations conflict with the religious belief of the parent or guardian or a physician statement that immunization is contraindicated;
- Written authorization for the child to receive emergency medical treatment when the parent or guardian is not available;
- Documentation of any medications given as described in rule .11 (1)(e);
- Record of any allergies and other known medical problems;
- Description of accidents or serious illnesses occurring while child is in the family day care home, including date, time and condition under which it occurred and the action taken;
- Parental or guardian agreements for transportation, field trips, swimming and other activities away from the home if the child will be participating in these activities;
- Name of person(s) to whom the child may be released. Such information shall contain the authorized person’s address, telephone numbers, relationships to child and to parent(s) or guardian, and other identifying information.
- Documentation that the child has been signed in and signed out of the family day care home at the time of each arrival and departure by the parent, guardian or person(s) authorized by the parent to drop off or pick up the child, which includes at least the following information: child’s name, date, drop-off and pick-up times, and initials of parent, guardian or other authorized person, and which need not be filed in the child’s individual record. The family day care home shall ensure that children are only released to authorized person(s), and the home shall take
<table>
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<tr>
<th>STANDARD 3.1.2.1: Routine Health Supervision and Growth Monitoring</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility should require that each child has routine health supervision by the child’s primary care provider, according to the standards of the American Academy of Pediatrics (AAP). For all children, health supervision includes routine screening tests, immunizations, and chronic or acute illness monitoring. For children younger than twenty-four months of age, health supervision includes documentation and plotting of sex-specific charts on child growth standards from the World Health Organization (WHO), available at <a href="http://www.who.int/childgrowth/standards/en/">http://www.who.int/childgrowth/standards/en/</a>, and assessing diet and activity. For children twenty-four months of age and older, sex-specific height and weight graphs should be plotted by the primary care provider in addition to body mass index (BMI), according to the Centers for Disease Control and Prevention (CDC). BMI is classified as underweight (BMI less than 5%), healthy weight (BMI 5%–84%), overweight (BMI 85%–94%), and obese (BMI equal to or greater than 95%). Follow-up visits with the child’s primary care provider that include a full assessment and laboratory evaluations should be scheduled for children with weight for length greater than 95% and BMI greater than 85%. School health services can meet this standard for school-age children in care if they meet the AAP’s standards for school-age children and if the results of each child’s examinations are shared with the caregiver/teacher as well as with the school health system. With parental/guardian consent, pertinent health information should be exchanged among the child’s routine source of health care and all participants in the child’s care, including any school health personnel.</td>
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<table>
<thead>
<tr>
<th>STANDARD 3.1.3.1: Active Opportunities for Physical Activity</th>
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<tbody>
<tr>
<td>The facility should promote children’s active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. All children, birth to six years, should participate daily in:</td>
</tr>
<tr>
<td>a) Two to three occasions of active play outdoors, weather permitting;</td>
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<tr>
<td>b) Two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day—indoor or outdoor;</td>
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<tr>
<td>c) Continuous opportunities to develop and practice age-appropriate gross motor and movement skills.</td>
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<tr>
<td>The total time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions.</td>
</tr>
<tr>
<td>a) Outdoor play:</td>
</tr>
<tr>
<td>1) Infants (birth to twelve months of age) should be taken outside two to three times per day, as tolerated. There is no recommended duration of infants’ outdoor play;</td>
</tr>
<tr>
<td>2) Toddlers (twelve months to three years) and preschoolers (three to six years) should be allowed sixty to ninety total minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise should remain the same;</td>
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<tr>
<td>b) Total time allotted for moderate to vigorous activities:</td>
</tr>
<tr>
<td>1) Toddlers should be allowed sixty to ninety minutes per eight-hour day for moderate to vigorous physical activity, including running;</td>
</tr>
<tr>
<td>2) Preschoolers should be allowed ninety to one hundred and twenty minutes per eight-hour day.</td>
</tr>
<tr>
<td>Infants should have supervised tummy time every day.</td>
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</tbody>
</table>

290-2-3-.09 Children's Activities. (1) The family day care home shall provide a variety of daily activities appropriate for the children's chronological ages and developmental levels. Children with special needs shall be integrated into the activities provided by the family day care home unless contraindicated medically or by parental agreement. Activities shall be planned for each group to allow for: |
| (a) Indoor and outdoor play; |
| (b) A balance of quiet and active periods; |
| (c) A balance of supervised free choice and caregiver-directed activities; |
| (d) Individual, small group, and large group activities; |
| (e) Large muscle activities, such as, but not limited to, running, riding, climbing, balancing, jumping, throwing, or digging; |
| (f) Small muscle activities, such as, but not limited to, building with blocks or construction toys, use of puzzles, nesting or stacking toys, pegs, lacing, sorting beads, or clay; |
| (g) Language experiences, such as, but not limited to, listening, talking, rhymes, finger plays, stories, use of film strips, recordings or flannel boards; |
| (h) Arts and crafts, such as, but not limited to, painting, coloring, cutting, or pasting; |
| (i) Dramatic play, such as, but not limited to, play in a home center, with dolls, puppets, or dress up; |
| (j) Rhythm and music, such as, but not limited to, listening, singing, dancing, or making music; and |
| (k) Nature and science experiences, such as, but not limited to, measuring, pouring, activities related to the “world around us” such as nature walks, plants, leaves or

Partially Meets. This rule has some of the basic elements contained in the Stepping Stones standard but not the details (number of occasions, etc.) and in some cases time frames are not adequate, such as: infants should not be seated for more than fifteen minutes at a time.

RESEARCH INSTITUTE FOR KEY INDICATORS (RIKI)
When they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity. Time spent outdoors has been found to be a strong, consistent predictor of children’s physical activity. Children can accumulate opportunities for activity over the course of several shorter segments of at least ten minutes each. Because structured activities have been shown to produce higher levels of physical activity in young children, it is recommended that caregivers/teachers incorporate two or more short structured activities (five to ten minutes) or games daily that promote physical activity.

Opportunities to be actively enjoying physical activity should be incorporated into part-time programs by prorating these recommendations accordingly, i.e., twenty minutes of outdoor play for every three hours in the facility.

Active play should never be withheld from children who misbehave (e.g., child is kept indoors to help another caregiver/teacher while the rest of the children go outside). However, children with out-of-control behavior may need five minutes or less to calm themselves or settle down before resuming cooperative play or activities.

Infants should not be seated for more than fifteen minutes at a time, except during meals or naps. Infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. if used should only be used for short periods of time. A least restrictive environment should be encouraged at all times. Children should have adequate space for both inside and outside play.

### STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.

290-2.3-.19 Infant-Sleeping Safety Requirements.

In order to reduce the risk of Sudden Infant Death Syndrome (SIDS), staff shall put an infant to sleep on the infant’s back unless the home has been provided a physician’s written statement authorizing another sleep position for that particular infant. The infant shall be placed for sleeping on a weather, or experiences in using the five senses through sensory play.

| (2) Children shall be helped to develop skills in all areas (washing, dressing, toileting, etc.) appropriate to the age and ability of the child. |
| (3) Children shall spend some time of each day outside when the children's health and the weather permits. |
| (4) There shall be a supervised nap period during the day for preschool age children. |
| (5) Infants and toddlers shall not routinely be left in cribs, or playpens except for rest or sleep. |
| (6) The use of entertainment media, such as television programs or video tapes, and computer games shall be limited to programs, tapes, and software that are produced for the benefit of audiences comprised of young children. Such uses of entertainment media shall be used only in addition to other activities, shall not be the primary source of children's activities, and should be limited to no more than two hours daily. |
| (7) The provider shall not engage in or allow children or other adults to engage in activities that could be detrimental to a child’s health or well-being such as, but not limited to, horse play, rough play, wrestling, and picking up a child in a manner that could cause injury. |

| 290-2.3-.19 Infant-Sleeping Safety Requirements. |
| In order to reduce the risk of Sudden Infant Death Syndrome (SIDS), staff shall put an infant to sleep on the infant’s back unless the home has been provided a physician’s written statement authorizing another sleep position for that particular infant. The infant shall be placed for sleeping on a |
| Partially meets. |

This rule contains the basic elements of the Stepping Stones standard but more specific citations to the US Consumer Product Safety Commission (CPSC) and ASTM standards and guidelines are not present.

DECAL should add the specific wording regarding cribs meeting the standards and guidelines reviewed/approved by the CPSC and ASTM.
All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/ subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.

All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):

a) Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant’s primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;

b) Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child’s primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;

c) Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards);

d) If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant’s assigned crib);

e) If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately place the infant in a firm, tight-fitting mattress in a sturdy and safe crib. If the crib has side bars, the bars will be no more than two and three eighths inches (2 3/8”) apart. Any crib used for sleeping shall have a tight-fitting bottom crib sheet with no pillows, quilts, comforters, bumper pads, sleepkins, stuffed toys, or other soft items in the crib. If a blanket is required for the comfort of the infant, the infant’s feet shall be placed at the foot of the crib and the infant shall be covered with the blanket only to chest level with the blanket tucked firmly under the crib mattress. The infant’s sleeping area shall be maintained within a temperature range of sixty-five (65) to eighty-five (85) degrees depending upon the season. When an infant can easily turn over onto his or her stomach, staff shall continue to put the infant to sleep initially on the infant’s back but allow the infant to roll over onto his or her stomach as the infant prefers. Positioning devices that restrict an infant’s movement in the crib shall not be used unless a physician’s written statement authorizing its use is provided for that particular infant.
Validating the Georgia Family Child Care Home Regulations

move the infant and place them in the supine position in their crib;
f) Only one infant should be placed in each crib (stackable cribs are not recommended);
g) Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used;
h) Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;
i) When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);
j) Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;
k) Bedding should be changed between children, and if mats are used, they should be cleaned between uses.
The lighting in the room must allows the caregiver/teacher to see each infant’s face, to view the color of the infant’s skin, and to check on the infant’s breathing and placement of the pacifier (if used).
A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant’s head remains uncovered and re-adjust clothing as needed.
The construction and use of sleeping rooms for infants
## STANDARD 3.2.1.4: Diaper Changing Procedure

The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be simple and should be in multiple languages if caregivers/teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them.

An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

**Step 1:** Get organized. Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area:

- Non-absorbent paper liner large enough to cover the changing surface from the child’s shoulders to beyond the child’s feet;
- Unused diaper, clean clothes (if you need them);
Validating the Georgia Family Child Care Home Regulations

<table>
<thead>
<tr>
<th>Step 1: Prepare for diaper changing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) Wipes for cleaning the child’s genitalia and buttocks removed from the container or dispensed so the container will not be touched during diaper changing;</td>
</tr>
<tr>
<td>d) A wet cloth or paper towel;</td>
</tr>
<tr>
<td>e) A plastic bag for any soiled clothes or cloth diapers;</td>
</tr>
<tr>
<td>f) Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing;</td>
</tr>
<tr>
<td>g) A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue.</td>
</tr>
</tbody>
</table>

Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change.

| a) Always keep a hand on the child; |
| b) If the child’s feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child’s shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing. |

Step 3: Clean the child’s diaper area.

| a) Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child; |
| b) If safety pins are used, close each pin immediately once it is removed and keep pins out of the child’s reach (never hold pins in your mouth); |
| c) Lift the child’s legs as needed to use disposable wipes to clean the skin on the child’s genitalia and buttocks and prevent recontamination from a soiled diaper. If there is a need to clean between the labia of an infant girl, use only a wet cloth or paper towel. Remove stool and urine from front to back and use a fresh wipe each time you swipe. Put the soiled wipes into the soiled diaper or directly into a plastic-lined, hands-free covered can. |

Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool.
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or urine.

a) Fold the soiled surface of the diaper inward;
b) Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service;
c) Put soiled clothes in a plastic-lined, hands-free plastic bag;
d) If gloves were used, remove them using the proper technique (see Appendix D) and put them into the plastic-lined, hands-free covered can;
e) Whether or not gloves were used, use a disposable antibacterial wipe or alcohol-based hand sanitizer to clean the surfaces of the caregiver/teacher’s hands and an application to clean the child’s hands, and put the wipes, if used, into the plastic-lined, hands-free covered can. Allow sanitized hands to dry completely before proceeding;
f) Check for spills under the child. If there are any, use the paper that extends under the child’s feet to fold over the soiled area so a fresh, unsoiled paper surface is now under the child’s buttocks.

Step 5: Put on a clean diaper and dress the child.
a) Slide a fresh diaper under the child;
b) Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can;
c) Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
d) Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin.

Step 6: Wash the child’s hands and return the child to a supervised area.
a) Use soap and warm water, between 60°F and 120°F, at a sink to wash the child’s hands, if you can.

Step 7: Clean and disinfect the diaper-changing surface.
a) Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-
### VALIDATING THE GEORGIA FAMILY CHILD CARE HOME REGULATIONS

2013

Free covered can;

b) If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;

c) Remove any visible soil from the changing surface with a water saturated disposable paper towel or wipe;

d) Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer’s instructions for use;

e) Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

**Step 8:** Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child’s daily log.

a) In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary.

### STANDARD 3.2.2.1: Situations that Require Hand Hygiene

All staff, volunteers, and children should follow the procedure in Standard 3.2.2.2 for hand hygiene at the following times:

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

b) Before and after:

1) Preparing food or beverages;
2) Eating, handling food, or feeding a child;
3) 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;
4) Playing in water (including swimming) that is used by more than one person;
5) Diapering;

c) After:

1) Using the toilet or helping a child use a toilet;
2) Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;

### 290-2.3-.11 Health, Safety, and Discipline

(j) Personnel shall wash their hands with liquid soap and warm running water:

1. Immediately before and after each diaper change;
2. Immediately upon the first child’s arrival in the home for care and upon re-entering the home after outside play;
3. Before and after dispensing oral medications and applying topical medications, ointments, creams or lotions, handling and preparing food, eating, drinking, preparing bottles, feeding each child, assisting children with eating and drinking; and
4. After toileting or helping children with toileting, using tobacco products, handling garbage and organic waste, touching animals or pets, handling bodily fluids, such as, but not limited to, mucus, saliva, vomit or blood, or contamination by any

Meets.
## STANDARD 3.2.2.2: Handwashing Procedure

Children and staff members should wash their hands using the following method:

- **a)** Check to be sure a clean, disposable paper (or single-use cloth) towel is available;
- **b)** Turn on warm water, between 60°F and 120°F, to a comfortable temperature;
- **c)** Moisten hands with water and apply soap (not antibacterial) to hands;
- **d)** Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice) (2). Rub areas between fingers, around nailbeds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not worn (3);
- **e)** Rinse hands under running water, between 60°F and 120°F, until they are free of soap and dirt. Leave the water running while drying hands;
f) Dry hands with the clean, disposable paper or single use cloth towel;  
g) If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel;  
h) Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.

The use of alcohol based hand sanitizers is an alternative to traditional handwashing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces and hands should be permitted to air dry.

Situations/times that children and staff should wash their hands should be posted in all handwashing areas.

Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps.

Children and staff who need to open a door to leave a bathroom or diaper changing area should open the door with a disposable towel to avoid possibly re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.

<table>
<thead>
<tr>
<th>STANDARD 3.2.2.3: Assisting Children with Hand Hygiene</th>
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<tbody>
<tr>
<td>Caregivers/teachers should provide assistance with handwashing at a sink for infants who can be safely cradled in one arm and for children who can stand but not wash their hands independently. A child who can stand should either use a child-height sink or stand on a safety step at a height at which the child’s hands can hang freely under the running water. After assisting the child with handwashing, the staff member should wash his or her own hands. Hand hygiene with an alcohol-based sanitizer is an alternative to handwashing with soap and water by children over twenty-four months of age and adults when there is no visible soiling of hands.</td>
</tr>
<tr>
<td>290-2.3-.11 Health, Safety, and Discipline</td>
</tr>
<tr>
<td>(k) Children’s hands shall be washed with liquid soap and warm running water: 1. Immediately upon arrival for the day and re-entering the child care area after outside play; 2. Before and after eating meals and snacks, handling or touching food, and playing in water; 3. After toileting and diapering, playing in sand, touching animals or pets, contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood, and after contamination by any other means; and</td>
</tr>
<tr>
<td>Partially meets.</td>
</tr>
<tr>
<td>There appears to be a discrepancy in that the rule suggests using a washcloth and does not address the use of an alcohol-based sanitizer as an alternative to handwashing with soap and water.</td>
</tr>
<tr>
<td>May want to consider the use of an alcohol-based sanitizer as an alternative to hand-washing with soap and water.</td>
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</tbody>
</table>
4. Washcloth handwashing is permitted for infants when the infant is too heavy to hold for handwashing or cannot stand safely to wash hands at a sink and for children with special needs who are not capable of washing their own hands. An individual washcloth shall be used only once for each child before laundering.

**STANDARD 3.2.3.4: Prevention of Exposure to Blood and Body Fluids**

Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention (CDC). Standard Precautions should be used to handle potential exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids.

In child care settings:
- a) Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering;
- b) Gowns and masks are not required;
- c) Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection.

Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of bloodborne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration (OSHA).

Procedures for Standard Precautions should include:
- a) Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required.
- b) The staff should use barriers and techniques that:
  1) Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and

<table>
<thead>
<tr>
<th>290-2.3.11 Health, Safety, and Discipline</th>
<th>Partially meets.</th>
<th>No reference to CDC Standard Precautions.</th>
<th>DECAL may want to add this reference to CDC Standard Precautions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The home must also maintain written directions for the use of universal precautions for handling blood and bodily fluids. The directions on the use of universal precautions must be kept with the first aid kit at all times.</td>
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</tr>
<tr>
<td>Personnel shall wash their hands with liquid soap and warm running water: 1. Immediately before and after each diaper change; 2. Immediately upon the first child’s arrival in the home for care and upon re-entering the home after outside play; 3. Before and after dispensing oral medications and applying topical medications, ointments, creams or lotions, handling and preparing food, eating, drinking, preparing bottles, feeding each child, assisting children with eating and drinking; and 4. After toileting or helping children with toileting, using tobacco products, handling garbage and organic waste, touching animals or pets, handling bodily fluids, such as, but not limited to, mucus, saliva, vomit or blood, or contamination by any other means.</td>
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<tr>
<td>(k) Children’s hands shall be washed with liquid soap and warm running water: 1. Immediately upon arrival for the day</td>
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<td></td>
</tr>
<tr>
<td>1) For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7;</td>
<td>2) For spills of blood or other potentially infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucus membrane (eyes, nose, mouth);</td>
<td>3) Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie;</td>
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<tr>
<td>4) Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting. Prior to using a disinfectant, clean the surface with a detergent and rinse well with water. Facilities should follow the manufacturer’s instruction for preparation and use of disinfectant. If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure</td>
<td>and re-entering the child care area after outside play;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Before and after eating meals and snacks, handling or touching food, and playing in water;</td>
<td>3. After toileting and diapering, playing in sand, touching animals or pets, contact with bodily fluids such as, but not limited to, mucus, saliva, vomit or blood, and after contamination by any other means</td>
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</tbody>
</table>
should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to bloodborne pathogens.

STANDARD 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs
Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises during the child care program’s paid time including break time.

STANDARD 3.4.3.1: Emergency Procedures
When an immediate emergency medical response is required, the following emergency procedures should be utilized:

a) First aid should be employed and an emergency medical response team should be called such as 9-1-1 and/or the poison center if a poison emergency (1-800-222-1222);
b) The program should implement a plan for emergency transportation to a local emergency medical facility;
c) The parent/guardian or parent/guardian’s emergency contact person should be called as soon as practical;
d) A staff member should accompany the child to the hospital and will stay with the child until the parent/guardian or emergency contact person arrives. Child to staff ratio must be maintained, so staff may need to be called in to maintain the required ratio.

290-2-3-.11 Health, Safety, and Discipline
(l)When children are present for care, providers, employees, and any other persons shall not smoke or use tobacco except in areas which are totally separated from areas used for child care. If smoking occurs in other areas of the home, the provider shall so advise parent or guardian. Meets.

290-2-3-.11 Health, Safety, and Discipline
(a) A home shall have a written plan for handling emergencies, including but not limited to fire, severe weather, loss of electrical power or water, and death, serious injury or loss of a child, which may occur at the home. No home personnel shall impede in any way the delivery of emergency care or services to a child by licensed or certified emergency health care professionals.

290-2-3-.08 Children’s Records
10. Identification of others providing care. The provider must inform the parents or guardians of children in care of the names of any caregiver and their responsibilities, and the names of the persons who would be called upon in an emergency; Partially meets.

The rule specifies a written plan for emergency medical services but does not specify the procedures.

DECAL should adopt the emergency procedures for an emergency medical response as outlined in Stepping Stones.
Validating the Georgia Family Child Care Home Regulations 2013

Programs should develop contingency plans for emergencies or disaster situations when it may not be possible or feasible to follow standard or previously agreed upon emergency procedures (see also Standard 9.2.4.3, Disaster Planning, Training, and Communication). Children with known medical conditions that might involve emergent care require a Care Plan created by the child’s primary care provider. All staff need to be trained to manage an emergency until emergency medical care becomes available.

**STANDARD 3.4.4.1: Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation**

Each facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect. The facility should report to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws, in any instance where there is reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. Phone numbers and reporting system as required by state or local agencies should be clearly posted by every phone.

Caregivers/teachers should receive initial and ongoing training to assist them in preventing child abuse and neglect and in recognizing signs of child abuse and neglect. Programs are encouraged to partner with primary care providers, child care health consultants and/or child protection advocates to provide training and to be available for consultation.

Parents/guardians should be notified upon enrollment of the facility’s child abuse and neglect reporting requirement and procedures.

**290-2-3-.14 Reporting.**

1. Within twenty-four (24) hours or the next work day, the home shall report the following to the Child Care Licensing Office:
2. Any suspected incident of child abuse, neglect or deprivation shall be reported to the local county Department of Family and Children Services in accordance with O.C.G.A. Sec. 19-7-5, and to the Child Care Licensing Office.

**290-2-3-.07 Staffing and Supervision**

The ten clock hours of training shall be chosen from the following fields:

(c) Child Abuse and Neglect: including identification and reporting, and meeting the needs of abused and/or neglected children

**STANDARD 3.4.4.3: Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma**

All child care facilities should have a policy and procedure to identify and prevent shaken baby syndrome/abusive head trauma. All caregivers/teachers who are in direct contact with children including substitute

<table>
<thead>
<tr>
<th>290-2-3-.14 Reporting.</th>
<th>Partially meets.</th>
<th>The rule covers staff training but does not have a requirement for a written policy or phone numbers posted by the phone.</th>
<th>DECAL may want to add the wording from the Stepping Stones standard.</th>
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</thead>
<tbody>
<tr>
<td>290-2-3-.07 Staffing and Supervision</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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</tbody>
</table>
Caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/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.

| STANDARD 3.4.4.4: Care for Children Who Have Been Abused/Neglected |
| Caregivers/teachers should have access to specialized training and expert advice for children with behavioral abnormalities related to abuse or neglect are enrolled. |
| 290-2.3-.07 Staffing and Supervision |
| The ten clock hours of training shall be chosen from the following fields: |
| (c) Child Abuse and Neglect: including identification and reporting, and meeting the needs of abused and/or neglected children |
| Partially meets. | Rule addresses training but not expert advice. | DECAL may want to add the additional working related to expert advice. |

| STANDARD 3.4.4.5: Facility Layout to Reduce Risk of Child Abuse and Neglect |
| The physical layout of facilities should be arranged so that there is a high level of visibility in the inside and outside areas as well as diaper changing areas and toileting areas used by children. All areas should be viewed by at least one other adult in addition to the caregiver/teacher at all times when children are in care. For center-based programs, rooms should be designed so that there are windows to the hallways to keep classroom activities from being too private. Ideally each area of the facility should have two adults at all times. Such an arrangement reduces the risk of child abuse and neglect and the likelihood of extended periods of time in isolation for individual caregivers/teachers with children, especially in areas where children may be partially undressed or in the nude. |
| Not addressed. | DECAL may want to address this specific standard and add it to their rules. |

| STANDARD 3.5.0.1: Care Plan for Children with Special Health Care Needs |
| Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. There should be: |
| 290-2.3-.09 Children's Activities. |
| (1) The family day care home shall provide a variety of daily activities appropriate for the children's chronological ages and developmental levels. Children with special needs shall be integrated into |
| Does not Meet. | No Routine and Emergent Care Plan mentioned. | Need to add reference to Care Plan. |
a) A list of the child’s diagnosis/diagnoses;  
b) Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.);  
c) Medications to be administered on a scheduled basis;  
d) Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language;  
e) Procedures to be performed;  
f) Allergies;  
g) Dietary modifications required for the health of the child;  
h) Activity modifications;  
i) Environmental modifications;  
j) Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid;  
k) Symptoms for caregiver/teachers to observe;  
l) Behavioral modifications;  
m) Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire;  
n) Suggested special skills training and education for staff.  

The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.

<table>
<thead>
<tr>
<th>STANDARD 3.5.0.2: Caring for Children Who Require Medical Procedures</th>
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<tbody>
<tr>
<td>A facility that enrolls children who require the following medical procedures: tube feedings, endotracheal suctioning, supplemental oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own), checking blood sugars or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, should receive a written plan of care from the primary care provider who</td>
<td>the activities provided by the family day care home unless contraindicated medically or by parental agreement.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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</table>
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prescribed the special treatment (such as a urologist for catheterization). Often, the child’s primary care provider may be able to provide this information. This plan of care should address any special preparation to perform routine and/or urgent procedures (other than those that might be required in an emergency for any typical child, such as cardiopulmonary resuscitation [CPR]). This plan of care should include instructions for how to receive training in performing the procedure, performing the procedure, a description of common and uncommon complications of the procedure, and what to do and who to notify if complications occur. Specific/relevant training for the child care staff should be provided by a qualified health care professional in accordance with state practice acts. Facilities should follow state laws where such laws require RN’s or LPN’s under RN supervision to perform certain medical procedures. Updated, written medical orders are required for nursing procedures.

<table>
<thead>
<tr>
<th>STANDARD 3.6.1.1: Inclusion/Exclusion/ Dismissal of Children</th>
<th>290-2.3-.11 Health, Safety, and Discipline.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing for managing illness: Caregivers/teachers should: a) Encourage all families to have a backup plan for child care in the event of short or long term exclusion; b) Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program’s inclusion/exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program; c) Develop, with a child care health consultant, protocols and procedures for handling children’s illnesses, including care plans and an inclusion/exclusion policy; d) Request the primary care provider’s note to readmit a child if the primary care provider’s advice is needed to determine whether the child is a health risk to others, or if the primary care</td>
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<tr>
<td>Meets</td>
<td>DECAL has a current communicable disease chart.</td>
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</table>

DECAL should review the Dept’s current communicable disease chart for specific content to make sure this standard is fully met.
Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent/guardian when a child develops 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 the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before reentering care.

**Conditions/symptoms that do not require exclusion:**

- a) Common colds, runny noses (regardless of color or consistency of nasal discharge);
- b) A cough not associated with a infectious disease (such as pertussis) or a fever;
- c) Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;
- d) Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);
- e) Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/guardians should discuss care of this condition with their child’s primary care provider, and follow the primary care provider’s advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the
conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted;
f) Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body’s response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102°F per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone;
g) Rash without fever and behavioral changes;
h) Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day);
i) Ringworm (exclusion for treatment may be delayed until the end of the day);
j) Molluscum contagiosum (do not require exclusion or covering of lesions);
k) Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);
l) Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;
m) Methicillin-resistant Staphylococcus aureus, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded;
n) Cytomegalovirus infection;
o) Chronic hepatitis B infection;
p) Human immunodeficiency virus (HIV) infection;
q) Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These
agents are not common and caregivers/teachers will usually not know the cause of most cases of diarrhea;
- Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

**Key criteria for exclusion of children who are ill:**
When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily “excluded” from child care). Most illnesses do not require exclusion. 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.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected.

**Temporary exclusion is recommended when the child has any of the following conditions:**

- a) The illness prevents the child from participating comfortably in activities;
- b) The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
- c) An acute change in behavior - this could include lethargy/lack of responsiveness, irritability,
persistent crying, difficult breathing, or having a quickly spreading rash;
d) Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures;
e) Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2):

1) Toxin-producing *E. coli* or *Shigella* infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms;
2) *Salmonella* serotype Typhi infection, until diarrhea resolves. In children younger than five years with *Salmonella* serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;
f) Blood or mucus in the stools not explained by
<table>
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<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>g) Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;</td>
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<tr>
<td>h) Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;</td>
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<tr>
<td>i) Mouth sores with drooling unless the child’s primary care provider or local health department authority states that the child is noninfectious;</td>
</tr>
<tr>
<td>j) Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease;</td>
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<tr>
<td>k) Active tuberculosis, until the child’s primary care provider or local health department states child is on appropriate treatment and can return;</td>
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<tr>
<td>l) Impetigo, until treatment has been started;</td>
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<tr>
<td>m) Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started;</td>
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<tr>
<td>n) Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day);</td>
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<tr>
<td>o) Scabies, until after treatment has been given;</td>
</tr>
<tr>
<td>p) Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash);</td>
</tr>
<tr>
<td>q) Rubella, until six days after the rash appears;</td>
</tr>
<tr>
<td>r) Pertussis, until five days of appropriate antibiotic treatment;</td>
</tr>
<tr>
<td>s) Mumps, until five days after onset of parotid gland swelling;</td>
</tr>
<tr>
<td>t) Measles, until four days after onset of rash;</td>
</tr>
<tr>
<td>u) Hepatitis A virus infection, until one week after onset of illness or jaundice if the child’s symptoms are mild or as directed by the health department.</td>
</tr>
<tr>
<td>(Note: immunization status of child care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care provider for further guidance.)</td>
</tr>
</tbody>
</table>
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| Provider for dosage and recommendations; |  |
|-----------------------------------------|  |
| v) Any child determined by the local health department to be contributing to the transmission of illness during an outbreak. |  |

**STANDARD 3.6.1.2: Staff Exclusion for Illness**

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member.

A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists. The staff member should be excluded as follows:

- a) Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;
- b) Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;
- c) Rash with fever or joint pain, until diagnosed not to be measles or rubella;
- d) Measles, until four days after onset of the rash (if the staff member or substitute is immunocompetent);
- e) Rubella, until six days after onset of rash;
- f) Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if *E. coli* 0157:H7 or *Shigella* is isolated, until diarrhea resolves and two stool cultures are negative, for *Salmonella* serotype Typhi, three stool cultures collected at twenty-four hour intervals and resolution of diarrhea is required;
- g) Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions;
- h) Hepatitis A virus, until one week after symptom onset or as directed by the health department;
- i) Pertussis, until after five days of appropriate antibiotic therapy;
- j) Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;

| Not addressed. |  |
| DECAL may want to address this specific standard and add it to their rules. |  |
k) Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider;
l) Strep throat or other streptococcal infection, until twenty-four hours after initial antibiotic treatment and end of fever;
m) Head lice, from the end of the day of discovery until after the first treatment;
n) Scabies, until after treatment has been completed;
o) Haemophilus influenzae type b (Hib), prophylaxis, until antibiotic treatment has been initiated;
p) Meningococcal infection, until appropriate therapy has been administered for twenty-four hours;
q) Respiratory illness, if the illness limits the staff member’s ability to provide an acceptable level of child care and compromises the health and safety of the children.

Caregivers/teachers who have herpes cold sores should not be excluded from the child care facility, but should:

- Cover and not touch their lesions;
- Carefully observe hand hygiene policies.

**STANDARD 3.6.1.4: Infectious Disease Outbreak Control**

During the course of an identified outbreak of any reportable illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is contributing to transmission of the illness at the facility, 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 care provider who made the initial determination decides that the risk of transmission is no longer present.

**STANDARD 3.6.2.10: Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Not Addressed.**

DECAL may want to address this specific standard and add it to their rules.

**290-2-3-.14 Reporting**

(3) Any cases or suspected cases of notifiable communicable diseases shall be reported to the local county health department in accordance with rules of the department regarding Notification of Disease, Chapter 290-5-3, and to the Child Care Licensing Office.

Partially meets. The rule addresses reporting the case but says nothing about excluding the staff or child who may be contributing to the outbreak.

DECAL may want to include the wording from the Stepping Stones standard.
### III
Facilities that care for children who are ill who have conditions that require additional attention from the caregiver/teacher, should arrange for or ask the child care health consultant to arrange for a clinical health evaluation, by a licensed primary care provider, for each child who is admitted to the facility. These facilities should include children with conditions listed in Standard 3.6.1.1 if their policies and plans address the management of these conditions, except for the following conditions which require exclusion from all types of child care facilities that are not medical care institutions (such as hospitals or skilled nursing facilities):

   a) Fever (see COMMENTS section for definition of fever) and a stiff neck, lethargy, irritability, or persistent crying;
   b) Diarrhea (loose stools, not contained in the diaper, that are two or more greater than normal frequency) and one or more of the following:
      1) Signs of dehydration, such as dry mouth, no tears, lethargy, sunken fontanelle (soft spot on the head);
      2) Blood or mucus in the stool until it is evaluated for organisms that can cause dysentery;
      3) Diarrhea caused by *Salmonella*, *Campylobacter*, *Giardia*, *Shigella*, or *E.coli* 0157:H7 until specific criteria for treatment and return to care are met.
   c) Vomiting with signs of dehydration and inability to maintain hydration with oral intake;
   d) Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness;
   e) Untreated infestation of scabies or head lice;
   f) Untreated infectious tuberculosis;
   g) Undiagnosed rash WITH fever or behavior change;
   h) Abdominal pain that is intermittent or persistent and is accompanied by fever, diarrhea, or vomiting;
   i) Difficulty in breathing;
   j) An acute change in behavior;
   k) Undiagnosed jaundice (yellow skin and whites of eyes);
l) Other conditions as may be determined by the director or child care health consultant;  
m) Upper or lower respiratory infection in which signs or symptoms require a higher level of care than can be appropriately provided.

| **STANDARD 3.6.2.2: Space Requirements for Care of Children Who Are Ill** |
| Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group should meet all requirements for well children and include the following additional requirements: |
| a) If the program for children who are ill is in the same facility as the well-child program, well children should not use or share furniture, fixtures, equipment, or supplies designated for use with children who are ill unless it has been cleaned and sanitized before use by well children;  
b) Indoor space that the facility uses for children who are ill, including hallways, bathrooms, and kitchens, should be separate from indoor space used with well children; this reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal;  
c) Children whose symptoms indicate infections of the gastrointestinal tract (often with diarrhea) who receive care in special facilities for children who are ill should receive this care in a space separate from other children with other illnesses to reduce the likelihood of disease being transmitted between children by limiting child-to-child interaction, separating staff responsibilities, and not mixing supplies, toys, and equipment;  
d) If the facility cares for children with chickenpox, these children require a room with separate ventilation with exhaust to, and air exchange with, the outside (3);  
e) Each child care room should have a handwashing sink that can provide a steady stream | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
of water, between 60°F and 120°F, at least for ten seconds. Soap and disposable paper towels should be available at the handwashing sink at all times. A hand sanitizing dispenser is an alternative to traditional handwashing;

f) Each room where children who wear diapers receive care should have its own diaper changing area adjacent to a handwashing sink and/or hand sanitizer dispenser.

STANDARD 3.6.2.5: Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill

Each caregiver/teacher in a facility that cares for children who are ill should have at least two years of successful work experience as a caregiver/teacher in a regular well-child facility prior to employment in the special facility. In addition, facilities should document, for each caregiver/teacher, twenty hours of pre-service orientation training on care of children who are ill beyond the orientation training specified in Standards 1.4.2.1 through Standard 1.4.2.3. This training should include the following subjects:

a) Pediatric first aid and CPR, and first aid for choking;

b) General infection-control procedures, including:
   1) Hand hygiene;
   2) Handling of contaminated items;
   3) Use of sanitizing chemicals;
   4) Food handling;
   5) Washing and sanitizing of toys;
   6) Education about methods of disease transmission.

c) Care of children with common mild childhood illnesses, including:
   1) Recognition and documentation of signs and symptoms of illness including body temperature;
   2) Administration and recording of medications;
   3) Nutrition of children who are ill;
   4) Communication with parents/guardians of children who are ill;
   5) Knowledge of immunization requirements;
   6) Recognition of need for medical assistance and how to access;

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
7) Knowledge of reporting requirements for infectious diseases;
8) Emergency procedures.
d) Child development activities for children who are ill;
e) Orientation to the facility and its policies.

This training should be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these evaluations, the training on care of children who are ill should be updated with a minimum of six hours of annual training for individuals who continue to provide care to children who are ill.

<table>
<thead>
<tr>
<th>STANDARD 3.6.3.1: Medication Administration</th>
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<tbody>
<tr>
<td>The administration of medicines at the facility should be limited to:</td>
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<tr>
<td>a) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;</td>
</tr>
<tr>
<td>b) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings).</td>
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Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family.

No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child’s prescribing health professional.

Documentation that the medicine/agent is administered to the child as prescribed is required.

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<tr>
<th>290-2-3-.11 Health, Safety, and Discipline</th>
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<tr>
<td>Except for first aid, personnel shall not dispense prescription or nonprescription medications to a child without specific written authorization from the child's physician, parent or guardian. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children. Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication.</td>
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Meets.
“Standing orders” guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child’s primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child’s parents/guardians must be obtained on the special care plan. Care plans should be updated as needed, but at least yearly.

STANDARD 3.6.3.2: Labeling, Storage, and Disposal of Medications

Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:

- The child’s first and last names;
- The date the prescription was filled;
- The name of the prescribing health professional who wrote the prescription, the medication’s expiration date;
- The manufacturer’s instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- The name and strength of the medication.

Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child’s name and specific instructions given by the child’s prescribing health professional for administration.

All medications, refrigerated or unrefrigerated, should:

- Have child-resistant caps;
- Be kept in an organized fashion;
- Be stored away from food;
- Be stored at the proper temperature;
- Be completely inaccessible to children.

Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian.

290-2-3-.11 Health, Safety, and Discipline

(e) Except for first aid, personnel shall not dispense prescription or nonprescription medications to a child without specific written authorization from the child’s physician, parent or guardian. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children.

Each dose of medication given to a child shall be documented showing the child’s name, name of medication, date and time given, and the name of the person giving the medication.

Partially meets.

This rule has all the major areas from the Stepping Stones standard with the exception of what to do with medications if they cannot be returned to the parents. There are guidelines for doing this as stated in the standard.

DECAL should adopt the language in the Stepping Stones standard on what to do if medications cannot be returned to the parents.
Validating the Georgia Family Child Care Home Regulations

| guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:  
  
  a) If a medication lists any specific instructions on how to dispose of it, follow those directions.  
  b) If there are community drug take back programs, participate in those.  
  c) Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash. |
| STANDARD 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 trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to:  
  
  a) Check that the name of the child on the medication and the child receiving the medication are the same;  
  b) Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child’s name;  
  c) Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the medication. |
| Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
medication:
  d) Observe and report any side effects from medications;
  e) Document the administration of each dose by the time and the amount given;
  f) Document the person giving the administration and any side effects noted;
  g) Handle and store all medications according to label instructions and regulations.

The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse (APRN), MD, Physician’s Assistant, or Pharmacist.

STANDARD 4.2.0.10: Care for Children with Food Allergies
When children with food allergies attend the early care and education facility, the following should occur:
  a) Each child with a food allergy should have a care plan prepared for the facility by the child’s primary care provider, to include:
     1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;
     2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include specific symptoms that would indicate the need to administer one or more medications;
  b) Based on the child’s care plan, the child’s caregivers/teachers should receive training, demonstrate competence in, and implement measures for:
     1) Preventing exposure to the specific food(s) to which the child is allergic;
     2) Recognizing the symptoms of an allergic reaction;
     3) Treating allergic reactions;
  c) Parents/guardians and staff should arrange for the facility to have necessary medications, proper storage of such medications, and the equipment

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
and training to manage the child’s food allergy while the child is at the early care and education facility;
d) Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;
e) The facility should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;
f) The facility should recommend to the family that the child’s primary care provider be notified if the child has required treatment by the facility for a food allergic reaction;
g) The facility should contact the emergency medical services system immediately whenever epinephrine has been administered;
h) Parents/guardians of all children in the child’s class should be advised to avoid known allergens in class treats or special foods brought into the early care and education setting;
i) Individual child’s food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served;
j) 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.

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<thead>
<tr>
<th>STANDARD 4.2.0.6: Availability of Drinking Water</th>
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<tr>
<td>Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. Water should not be a substitute for milk at meals or snacks where milk is a required food component unless it is recommended by the child’s primary care provider. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle. Toddlers and older children will need additional water as physical activity and/or hot temperatures cause their needs to increase. Children should</td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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</table>
learn to drink water from a cup or drinking fountain without mouthing the fixture. They should not be allowed to have water continuously in hand in a “sippy cup” or bottle. Permitting toddlers to suck continuously on a bottle or sippy cup filled with water, in order to soothe themselves, may cause nutritional or in rare instances, electrolyte imbalances. When tooth brushing is not done after a feeding, children should be offered water to drink to rinse food from their teeth.

STANDARD 4.2.0.8: Feeding Plans and Dietary Modifications
Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child, including use of human milk or any special feeding utensils. The staff should review this history with the child’s parents/guardians, clarifying and discussing how parental/guardian home feeding routines may differ from the facility’s planned routine. The child’s primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the early care and education program and these plans should be shared with the child’s parents/guardians upon request.

If dietary modifications are indicated, based on a child’s medical or special dietary needs, the caregiver/teacher should modify or supplement the child’s diet to meet the individual child’s specific needs. Dietary modifications should be made in consultation with the parents/guardians and the child’s primary care provider. Caregivers/teachers can consult with a nutritionist/registered dietitian.

Reasons for modification of a child’s diet may be related to food sensitivity. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life threatening. Modification of a child’s diet may be related to a food allergy, inability to digest or to tolerate certain foods, need for extra calories, need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues. Examples include celiac disease, phenylketonuria, diabetes, severe food allergy (anaphylaxis), and others. In some

290-2-3-.10 Nutrition and Food Services.
(4) The provider shall secure from the parents infant formula and a feeding plan for children under 1 year of age.

Partially meets.

The rule addresses the need for a written feeding plan but the rule does not deal with the specific written instructions for a child identified with special health care needs other than that a written statement from a medical authority shall be on file.

DECAL should adopt the specific language from the standard regarding the written instructions for a child identified with special health care needs.
cases, a child may become ill if the child is unable to eat, so missing a meal could have a negative consequence, especially for diabetics.

For a child identified with special health care needs for dietary modification or special feeding techniques, written instructions from the child’s parent/guardian and the child’s primary care provider should be provided in the child’s record and carried out accordingly. Dietary modifications should be recorded. These written instructions must identify:

- The child’s full name and date of instructions;
- The child’s special needs;
- Any dietary restrictions based on the special needs;
- Any special feeding or eating utensils;
- Any foods to be omitted from the diet and any foods to be substituted;
- Limitations of life activities;
- Any other pertinent special needs information;
- What, if anything, needs to be done if the child is exposed to restricted foods.

The written history of special nutrition or feeding needs should be used to develop individual feeding plans and, collectively, to develop facility menus. Disciplines related to special nutrition needs, including nutrition, nursing, speech, occupational therapy, and physical therapy, should participate when needed and/or when they are available to the facility. The nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications.

The feeding plan should include steps to take when a situation arises that requires rapid response by the staff, such as a child’s choking during mealtime or a child with a known history of food allergies demonstrating signs and symptoms of anaphylaxis (severe allergic reaction, e.g., difficulty breathing or severe redness and swelling of the face or mouth). The completed plan should be on file and accessible to the staff and available to parents/guardians upon request.

| STANDARD 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child’s parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child’s nutritional and developmental needs.

For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement the human milk. Modification of basic food patterns should be provided in writing by the child’s primary care provider. Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two- to seven-day intervals (1).

<table>
<thead>
<tr>
<th>STANDARD 4.3.1.3: Preparing, Feeding, and Storing Human Milk</th>
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<tbody>
<tr>
<td>Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used in feeding. The bottle or container should be properly labeled with the infant’s full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival. The mother’s own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother’s written permission. Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable. Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child’s full name.</td>
</tr>
</tbody>
</table>

DECAL may want to address this specific standard and add it to their rules.
Validating the Georgia Family Child Care Home Regulations

Filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.

Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother’s milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant’s full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.

Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the storage guidelines of the Academy of Breastfeeding Medicine as shown later in this standard, should be returned to the mother.

Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child’s fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.

Human milk can be stored using the following guidelines:
Validating the Georgia Family Child Care Home Regulations

from the Academy of Breastfeeding Medicine:

<table>
<thead>
<tr>
<th>Location</th>
<th>Temperature</th>
<th>Duration</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Countertop, table</td>
<td>Room temperature (up to 77°F or 25°C)</td>
<td>6-8 hours</td>
<td>Containers should be covered and kept as cool as possible; covering with a cool towel may keep milk cooler.</td>
</tr>
<tr>
<td>Insulated cooler bag</td>
<td>5°F – 39°F or -15°C to 4°C</td>
<td>24 hours</td>
<td>Keep ice packs in contact with milk containers at all times, limit opening cooler bag.</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>39°F or 4°C</td>
<td>5 days</td>
<td>Store milk in the back of the main body of the refrigerator.</td>
</tr>
<tr>
<td>Freezer compartment of a refrigerator</td>
<td>5°F or -15°C</td>
<td>2 weeks</td>
<td>Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality.</td>
</tr>
<tr>
<td>Freezer compartment of refrigerator with separate doors</td>
<td>0°F or -18°C</td>
<td>3-6 months</td>
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</tr>
<tr>
<td>Chest or upright deep freezer</td>
<td>-4°F or -20°C</td>
<td>6-12 months</td>
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**STANDARD 4.3.1.5: Preparing, Feeding, and Storing Infant Formula**

Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer’s instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer’s directions. 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 at http://www.who.int/health-topics栞 Nutrition and Food Services.

(5) Infant formula bottles shall be labeled with the individual child's name. Any unused formula or milk shall be discarded or returned to the parent at the end of the day.

Does not meet.

Rule only addresses that infant formula bottles should be labeled and what to do with unused formula or milk.

DECAL should add language from the Stepping Stones standard regarding the details for preparing, feeding, and storing infant formula.
Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child’s primary care provider provides written documentation that the child has a medical reason for this type of feeding.

Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.

Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child’s full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child’s full name, and may be stored in the refrigerator for up to twenty-four hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child’s full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer’s instructions for mixing and storing of any formula preparation.

Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant’s care plan, on how to prepare the formula.

<table>
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<tr>
<th>STANDARD 4.5.0.10: Foods that Are Choking Hazards</th>
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<tr>
<td>Caregivers/teachers should not offer to children under four years of age foods that are associated with young children’s choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts,</td>
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| Not addressed. |

| DECAL may want to address this specific standard and add it to their rules. |
popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).

**STANDARD 4.5.0.6: Adult Supervision of Children Who Are Learning to Feed Themselves**
Children in mid-infancy who are learning to feed themselves should be supervised by an adult seated within arm’s reach of them at all times while they are being fed. Children over twelve months of age who can feed themselves should be supervised by an adult who is seated at the same table or within arm’s reach of the child’s highchair or feeding table. When eating, children should be within sight of an adult at all times.

**STANDARD 4.5.0.9: Hot Liquids and Foods**
Adults should not consume hot liquids above 120°F in child care areas. Hot liquids and hot foods should be kept out of the reach of infants, toddlers, and preschoolers. Hot liquids and foods should not be placed on a surface at a child’s level, at the edge of a table or counter, or on a tablecloth that could be yanked down. Appliances containing hot liquids, such as coffee pots and crock pots, should be kept out of the reach of children. Electrical cords from any appliance, including coffee pots, should not be allowed to hang within the reach of children. Food preparers should position pot handles toward the back of the stove and use only back burners when possible.

**STANDARD 4.8.0.1: Food Preparation Area**
The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. The food preparation area should not be used as a passageway while food is being prepared. Food preparation areas should be separated by a door, gate, counter, or room divider from areas the...
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<tr>
<th>STANDARD 4.8.0.3: Maintenance of Food Service Surfaces and Equipment</th>
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<tr>
<td>All surfaces that come into contact with food, including tables and countertops, as well as floors and shelving in the food preparation area should be in good repair, free of cracks or crevices, and should be made of smooth, non-porous material that is kept clean and sanitized. All kitchen equipment should be clean and should be maintained in operable condition according to the manufacturer’s guidelines for maintenance and operation. The facility should maintain an inventory of food service equipment that includes the date of purchase, the warranty date, and a history of repairs.</td>
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<tr>
<th>290-2-3-.10 Nutrition and Food Services</th>
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<tr>
<td>12 Food preparation surface areas shall be nonporous with no cracks or unsealed seams.</td>
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<tr>
<td>13 Food preparation areas and equipment shall be kept clean and free of accumulation of dust, dirt, food particles, and grease deposits.</td>
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| Meets. |

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<thead>
<tr>
<th>STANDARD 4.9.0.2: Staff Restricted from Food Preparation and Handling</th>
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<tr>
<td>Anyone who has signs or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannot be covered, or who potentially or actually is infected with bac-</td>
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<tr>
<th>290-2-3-.10 Nutrition and Food Services</th>
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<tr>
<td>14 The person preparing meals shall wash their hands and arms thoroughly with soap and warm water before starting food service work and as often as necessary during food preparation and serving to</td>
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| Partially meets. |

| Rule only addresses washing of hands. |

| DECAL needs to add the additional language of the Stepping Stones standard regarding staff restrictions. |
Validating the Georgia Family Child Care Home Regulations

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<tr>
<th>STANDARDS</th>
<th>REQUIREMENTS</th>
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| **STANDARD 4.9.0.3: Precautions for a Safe Food Supply** | All foods stored, prepared, or served should be safe for human consumption by observation and smell. The following precautions should be observed for a safe food supply:  
- a) Home-canned food; food from dented, rusted, bulging, or leaking cans, and food from cans without labels should not be used;  
- b) Foods should be inspected daily for spoilage or signs of mold, and foods that are spoiled or moldy should be promptly and appropriately discarded;  
- c) Meat should be from government-inspected sources or otherwise approved by the governing health authority (3); |
| **290-2-3-.10 Nutrition and Food Services** |  
- (7) Food shall be in sound condition, free from spoilage and contamination, and shall be safe for human consumption. |
| | Partially meets. |
| | Rule does not contain the specific detailed language as in the Stepping Stones standard but does exceed the Stepping Stones standard. |
| | DECAL should consider adding the additional specific and detailed language contained in the Stepping Stones standard. |
d) All dairy products should be pasteurized and Grade A where applicable; 
e) Raw, unpasteurized milk, milk products; unpasteurized fruit juices; and raw or undercooked eggs should not be used. Freshly squeezed fruit or vegetable juice prepared just prior to serving in the child care facility is permissible; 
f) Unless a child’s health care professional documents a different milk product, children from twelve months to two years of age should be served only human milk, formula, whole milk or 2% milk (6). Note: For children between twelve months and two years of age for whom overweight or obesity is a concern or who have a family history of obesity, dyslipidemia, or CVD, the use of reduced-fat milk is appropriate only with written documentation from the child’s primary health care professional (4). Children two years of age and older should be served skim or 1% milk. If cost-saving is required to accommodate a tight budget, dry milk and milk products may be reconstituted in the facility for cooking purposes only, provided that they are prepared, refrigerated, and stored in a sanitary manner, labeled with the date of preparation, and used or discarded within twenty-four hours of preparation; 
g) Meat, fish, poultry, milk, and egg products should be refrigerated 
or frozen until immediately before use (5); 
h) Frozen foods should be defrosted in one of four ways: In the refrigerator; under cold running water; as part of the cooking process, or by removing food from packaging and using the defrost setting of a microwave oven (5). Note: Frozen human milk should not be defrosted in the microwave; 
i) Frozen foods should never be defrosted by leaving them at room temperature or standing in water that is not kept at refrigerator temperature (5); 
j) All fruits and vegetables should be washed thoroughly with water prior to use (5); 
k) Food should be served promptly after preparation or cooking or should be maintained at temperatures of not less than 135°F for hot foods and not more than 41°F for cold foods (12);
1) All opened moist foods that have not been served should be covered, dated, and maintained at a temperature of 41°F or lower in the refrigerator or frozen in the freezer, verified by a working thermometer kept in the refrigerator or freezer (12);

m) Fully cooked and ready-to-serve hot foods should be held for no longer than thirty minutes before being served, or promptly covered and refrigerated;

n) Pasteurized eggs or egg products should be substituted for raw eggs in the preparation of foods such as Caesar salad, mayonnaise, meringue, eggnog, and ice cream. Pasteurized eggs or egg products should be substituted for recipes in which more than one egg is broken and the eggs are combined, unless the eggs are cooked for an individual child at a single meal and served immediately, such as in omelets or scrambled eggs; or the raw eggs are combined as an ingredient immediately before baking and the eggs are fully cooked to a ready-to-eat form, such as a cake, muffin or bread;

o) Raw animal foods should be fully cooked to heat all parts of the food to a temperature and for a time of; 145°F or above for fifteen seconds for fish and meat; 160°F for fifteen seconds for chopped or ground fish, chopped or ground meat or raw eggs; or 165°F or above for fifteen seconds for poultry or stuffed fish, stuffed meat, stuffed pasta, stuffed poultry or stuffing containing fish, meat or poultry.

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<tr>
<th><strong>STANDARD 5.1.1.2: Inspection of Buildings</strong></th>
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<tr>
<td>Newly constructed, renovated, remodeled, or altered buildings should be inspected by a public inspector to assure compliance with applicable building and fire codes before the building can be made accessible to children.</td>
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<tr>
<th><strong>STANDARD 5.1.1.3: Compliance with Fire Prevention Code</strong></th>
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<td>Every twelve months, the child care facility should obtain written documentation to submit to the regulatory licensing authority that the facility complies with a state-approved or nationally recognized Fire Prevention Code. If available,</td>
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| Not addressed. | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |

| DECAL may want to address this specific standard and add it to their rules. |
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This documentation should be obtained from a fire prevention official with jurisdiction where the facility is located. Where fire safety inspections or a Fire Prevention Code applicable to child care centers is not available from local authorities, the facility should arrange for a fire safety inspection by an inspector who is qualified to conduct such inspections using the National Fire Protection Association’s NFPA 101: Life Safety Code.

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<th>STANDARD 5.1.1.5: Environmental Audit of Site Location</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
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<tbody>
<tr>
<td>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 (1,3). The environmental audit should include assessments of: a) Potential air, soil, and water contamination on child care facility sites and outdoor play spaces; b) Potential toxic or hazardous materials in building construction; and c) Potential safety hazards in the community surrounding the site. A written environmental audit report that includes any remedial action taken should be kept on file.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 5.1.6.6: Guardrails and Protective Barriers</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardrails, a minimum of thirty-six inches in height, 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 thirty-inch vertical distance to fall. Spaces below the thirty-six inches height guardrail should be further divided with intermediate rails or balusters as detailed in the next paragraph. For preschoolers, bottom guardrails greater than nine inches but less or equal to twenty-three inches above the floor should be provided for all porches, landings, balconies, and similar structures. For school age children, bottom guardrails should be greater than nine inches but less or equal to twenty inches above the floor, as specified above.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For infants and toddlers, protective barriers should be less than three and one-half inches above the floor, as specified above. All spaces in guardrails should be less than three and a half inches. All spaces in protective barriers should be less than three and one-half inches. If spaces do not meet the specifications as listed above, a protective material sufficient to prevent the passing of a three and one-half inch diameter sphere should be provided. Where practical or otherwise required by applicable codes, guardrails should be a minimum of forty-two inches in height to help prevent falls over the open side by staff and other adults in the child care facility.

<table>
<thead>
<tr>
<th>STANDARD 5.2.1.10: Gas, Oil, or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unvented gas or oil heaters and portable open-flame kerosene space heaters should be prohibited. Gas cooking appliances, including portable gas stoves, should not be used for heating purposes. Charcoal grills should not be used for space heating or any other indoor purposes. Heat in units that involve flame should be vented properly to the outside and should be supplied with a source of combustion air that meets the manufacturer’s installation requirements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>290-2.3-.13 Building and Grounds.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e) When in use, radiators, open fire, oil or wood burning stoves, floor furnaces and similar hazards shall have barriers or screens to prevent children from being burned. (f) Unvented fuel fired heaters shall not be used unless equipped with an oxygen depletion safety shut off system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Partially meets.</th>
</tr>
</thead>
<tbody>
<tr>
<td>290-2.3-.13 Building and Grounds.</td>
</tr>
<tr>
<td>(g) Multiple plugs and electric extension cords shall not be used. Electrical outlets within reach of children shall be plugged or covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule does not contain GFCI.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DECAL should add the reference to GFCI.</td>
</tr>
</tbody>
</table>
All newly installed or replaced electrical outlets that are accessible to children should use “tamper-resistant electrical outlets.” In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed. A GFCI is designed to trip before a deadly electrical shock can occur. To ensure that GFCIs are functioning correctly, they should be tested at least monthly. GFCIs are also available in a tamper-resistant design.

### STANDARD 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.

### STANDARD 5.2.5.1: Smoke Detection Systems and Smoke Alarms
In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system or are of the wireless signal-monitored-alarm system type should be installed. Battery-operated smoke alarms should be permitted provided that the facility demonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve. Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages.

### 290-2-3-.11 Health, Safety, and Discipline

#### (h) At least one UL Approved smoke detector shall be on each floor of the home and such detectors shall be maintained in working order. At least one 2-A:5-B:C fire extinguisher shall be kept in the child care area to be located no more than thirty feet from the kitchen. The extinguisher shall be maintained in working order and shall be inaccessible to the children.

### STANDARD 5.2.7.6: Storage and Disposal of Infectious and Toxic Wastes
Infectious and toxic wastes should be stored separately from other wastes, and should be disposed of in a manner

### Not addressed.

### DECAL may want to address this specific standard and add it to their rules.
Validating the Georgia Family Child Care Home Regulations

STANDARD 5.2.8.1: Integrated Pest Management
Facilities should adopt an integrated pest management program (IPM) 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. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment (2,4).

Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises (5).

Pest Monitoring: Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frass, rub marks).

Pesticide Use: If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator who has the licenses or certifications required by state and local laws.

Facility managers should follow all instructions on pesticide product labels and should not apply any pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility. Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to.

Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about...
Validating the Georgia Family Child Care Home Regulations

<table>
<thead>
<tr>
<th>Pesticide usage at the facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which children may come in direct contact (3).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification: Notification should be given to parents/guardians and staff before using pesticides, to determine if any child or staff member is sensitive to the product. A member of the child care staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Registry: Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warning Signs: Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Record Keeping: Child care facilities should keep records of pesticide use at the facility and make the records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pesticide Storage: Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.</td>
</tr>
<tr>
<td>STANDARD 5.2.9.1: Use and Storage of Toxic Substances</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>The following items should be used as recommended by the manufacturer and should be stored in the original labeled containers:</td>
</tr>
<tr>
<td>a) Cleaning materials;</td>
</tr>
<tr>
<td>b) Detergents;</td>
</tr>
<tr>
<td>c) Automatic dishwasher detergents;</td>
</tr>
<tr>
<td>d) Aerosol cans;</td>
</tr>
<tr>
<td>e) Pesticides;</td>
</tr>
<tr>
<td>f) Health and beauty aids;</td>
</tr>
<tr>
<td>g) Medications;</td>
</tr>
<tr>
<td>h) Lawn care chemicals;</td>
</tr>
<tr>
<td>i) Other toxic materials.</td>
</tr>
<tr>
<td>Material Safety Data Sheets (MSDS) must be available on-site for each hazardous chemical that is on the premises.</td>
</tr>
<tr>
<td>These substances should be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistant opening device, inaccessible to children, and separate from stored medications and food.</td>
</tr>
<tr>
<td>Chemicals used in lawn care treatments should be limited to those listed for use in areas that can be occupied by children.</td>
</tr>
<tr>
<td>Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely (see Standard 3.6.3.1) and disposed of properly (see Standard 3.6.3.2).</td>
</tr>
<tr>
<td>The telephone number for the poison center should be posted in a location where it is readily available in emergency situations (e.g., next to the telephone). Poison centers are open twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.</td>
</tr>
<tr>
<td>STANDARD 5.2.9.13: Testing for Lead</td>
</tr>
<tr>
<td>In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or</td>
</tr>
</tbody>
</table>
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physical means or made inaccessible to children, regardless of the condition of the surface.
In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or non-toxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or lead abatement activities.
Any surface and the grounds around and under surfaces that children use at a child care facility, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/teachers should check the U.S. Consumer Product Safety Commission’s Website, http://www.cpsc.gov, for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only nontoxic paints should be used.

STANDARD 5.2.9.2: Use of a Poison Center
The poison center should be called for advice about any exposure to toxic substances, or any potential poisoning emergency. The national help line for the poison center is 1-800-222-1222, and specialists will link the caregiver/teacher with their local poison center. The advice should be followed and documented in the facility’s files. The caregiver/teacher should be prepared for the call by having the following information for the poison center specialist:
a) The child’s age and sex;
b) The substance involved;
c) The estimated amount;
d) The child’s condition;
e) The time elapsed since ingestion or exposure.
The caregiver/teacher should not induce vomiting unless instructed by the poison center.

STANDARD 5.2.9.3: Informing Staff Regarding Presence of Toxic Substances
Not addressed.
DECAL may want to address this specific standard and add it to their rules.
Employers should provide staff with hazard information, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxic substances such as formaldehyde, cleaning and sanitizing supplies, insecticides, herbicides, and other hazardous chemicals in use in the facility. Staff should always read the label prior to use to determine safety in use. For example, toxic products regulated by the Environmental Protection Agency (EPA) will have an EPA signal word of CAUTION, WARNING, or DANGER. Where nontoxic substitutes are available, these nontoxic substitutes should be used instead of toxic chemicals. If a nontoxic product is not available, caregivers/teachers should use the least toxic product for the job. A CAUTION label is safer than a WARNING label, which is safer than a DANGER label.

<table>
<thead>
<tr>
<th>STANDARD 5.2.9.5: Carbon Monoxide Detectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbon monoxide detector(s) should be installed in child care settings if one of the following guidelines is met:</td>
</tr>
<tr>
<td>a) The child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage;</td>
</tr>
<tr>
<td>b) If detectors are required by state/local law or state licensing agency.</td>
</tr>
<tr>
<td>Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every five years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 5.3.1.12: Availability and Use of a Telephone or Wireless Communication Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use:</td>
</tr>
<tr>
<td>a) On the premises of the child care facility;</td>
</tr>
<tr>
<td>b) In each vehicle used when transporting children;</td>
</tr>
<tr>
<td>c) On field trips.</td>
</tr>
<tr>
<td>Drivers, while transporting children should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>290-2.3-.11 Health, Safety, and Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) An operable telephone shall be readily available in the home with the following telephone numbers posted in a conspicuous place next to the telephone. In those areas of the state serviced by the 911 emergency number, 911 may be posted in lieu of the phone numbers required for 2., 3., and 4. below:</td>
</tr>
<tr>
<td>1. A physician or hospital;</td>
</tr>
<tr>
<td>2. An ambulance or rescue squad service;</td>
</tr>
</tbody>
</table>

| Partially meets and exceeds. |
| Within this rule it is met by requiring the phone and exceeds that standard by specifying numbers to be posted; but there is on mention about use and transportation. |
| DECAL may want to add the additional sections regarding use and lack of use during transporting children. |
part of traffic, with the exception of use of a navigational
system or global positioning system device.

3. The local fire department;
4. The local police department;
5. The county health department; and
6. The regional poison control center.

STANDARD 5.4.5.2: Cribs
Facilities should check each crib before its purchase and
use to ensure that it is in compliance with the current U.S.
Consumer Product Safety Commission (CPSC) and ASTM
safety standards.

Recalled or “second-hand” cribs should not be used or
stored in the facility. When it is determined that a crib is no
longer safe for use in the facility, it should be dismantled
and disposed of appropriately.

Staff should only use cribs for sleep purposes and should
ensure that each crib is a safe sleep environment. No child
of any age should be placed in a crib for a time-out or for
disciplinary reasons. When an infant becomes large enough
or mobile enough to reach crib latches or potentially climb
out of a crib, they should be transitioned to a different
sleeping environment (such as a cot or sleeping mat).

Each crib should be identified by brand, type, and/or prod-
uct number and relevant product information should be
kept on file (with the same identification information) as
long as the crib is used or stored in the facility.

Staff should inspect each crib before each use to ensure that
hardware is tightened and that there are not any safety
hazards. If a screw or bolt cannot be tightened securely, or
there are missing or broken screws, bolts, or mattress sup-
port hangers, the crib should not be used.

Safety standards document that cribs used in facilities
should be made of wood, metal, or plastic. Crib slats
should be spaced no more than two and three-eighths
inches apart, with a firm mattress that is fitted so that no
more than two fingers can fit between the mattress and the
crib side in the lowest position. The minimum height from
the top of the mattress to the top of the crib rail should be
twenty inches in the highest position. Cribs with drop sides
should not be used. The crib should not have corner post
extensions (over one-sixteenth inch). The crib should have
no cutout openings in the head board or footboard structure
in which a child’s head could become entrapped. The

290-2.3-.19 Infant-Sleeping Safety .
If the crib has side bars, the bars will be no
more than two and three-eights inches
apart. Any crib used for sleeping shall
have a tight-fitting bottom crib sheet with
no pillows, quilts, comforters, bumper
pads, shee skins, stuffed toys or other soft
items in the crib.

Partially meets.

This rule does not address
many of the key elements in
the Stepping Stones standard
and there is no reference to
the CPSC or ASTM safety
standards.

DECAL may want to add
the reference to CPSC and
ASTM safety standards and
the specific language from
Stepping Stones.
mattress support system should not be easily dislodged from any point of the crib by an upward force from underneath the crib. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b 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.
Crib should be placed away from window blinds or draperies.
As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabric, mesh, or other strong coverings over the top of the crib. Cribs intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.

<table>
<thead>
<tr>
<th>STANDARD 5.5.0.6: Inaccessibility to Matches, Candles, and Lighters</th>
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</thead>
<tbody>
<tr>
<td>Matches, candles, and lighters should not be accessible to children.</td>
</tr>
<tr>
<td>Not addressed.</td>
</tr>
<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 5.5.0.7: Storage of Plastic Bags</th>
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</thead>
<tbody>
<tr>
<td>Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children.</td>
</tr>
<tr>
<td>Not addressed.</td>
</tr>
<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<table>
<thead>
<tr>
<th>STANDARD 5.5.0.8: Firearms</th>
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<tbody>
<tr>
<td>If present in a small or large family child care home, these items must 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.</td>
</tr>
<tr>
<td>Partially meets.</td>
</tr>
<tr>
<td>Rule states that firearms shall not be accessible to children but doesn’t have the additional precautions.</td>
</tr>
<tr>
<td>Additional precautions should be added.</td>
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<thead>
<tr>
<th>290-2-3-.11 Health, Safety, and Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>(g) Firearms shall be stored so they are not accessible to children</td>
</tr>
<tr>
<td>Partially meets.</td>
</tr>
<tr>
<td>Rule states that firearms shall not be accessible to children but doesn’t have the additional precautions.</td>
</tr>
<tr>
<td>Additional precautions should be added.</td>
</tr>
<tr>
<td>STANDARD 6.1.0.3: Rooftops as Play Areas</td>
</tr>
<tr>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>A rooftop used as a play area should be enclosed with a fence from four to six feet high, in accordance with local ordinance, and the bottom edge should be less than three and one-half inches from the base (1). The fence should be designed to prevent children from climbing it. An approved fire escape should lead from the roof to an open space at the ground level that meets the safety standards for outdoor play areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 6.1.0.4: Elevated Play Areas</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevated play areas that have been created using a retaining wall should have a guardrail, protective barrier, or fence running along the top of the retaining wall. If the exposed side of the retaining wall is higher than two feet, a fence not less than six feet high should be installed. The bottom edge of the fence should be less than three and one-half inches from the base and should be designed to prevent children from climbing it. Fences should be designed so all spaces are less than three and one-half inches (1). If the height of the exposed side of the retaining wall is two feet or lower, a guardrail should be installed if caring for preschool and school-age children. The space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-three inches. For school-age children, the space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-eight inches. If caring for infants or toddlers, a protective barrier should be installed. The space between the barrier and the ground should be less than three and one-half inches and should be from four to six feet in height.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD 6.1.0.6: Location of Play Areas Near Bodies of Water</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside play areas should be free from the following bodies of water:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Unfenced swimming and wading pools;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STANDARD 6.1.0.8: Enclosures for Outdoor Play Areas

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. 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. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed.

Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.

### 290-2-3-.13 Building and Grounds

(2) Outside grounds and play areas shall be kept clean and free of obvious hazards to the children's health and safety.

(c) Such outside play areas shall be protected from traffic or other hazards by fencing or other barriers at least four feet in height and approved by the department. Fencing material shall not present a hazard to children. A fence shall be provided around swimming pools to make them inaccessible when not in use.

Partially meets.

No mention of self-closing or positive self-latching closure mechanisms. No mention about testing for CCA. No mention about having at least two exits.

DECAL should add the additional wording to this rule.

### STANDARD 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 such as asphalt, concrete, dirt, grass, or flooring covered by carpet or gym mats not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over and surrounded by a shock-absorbing surface. This material may be either the unitary or the loose-fill type, as defined.

### 290-2-3-.13 Building and Grounds

(b) Climbing and swinging equipment that are not portable shall be securely anchored to eliminate accidents or injuries and have a resilient surface beneath the equipment and the fall zone from such equipment which is adequately maintained by the family day care home to assure continuing resiliency.

Partially meets.

Rule does not address the CPSC or ASTM standards.

DECAL should add the references to the CPSC and ASTM standards.
Validating the Georgia Family Child Care Home Regulations 2013

by the U.S. Consumer Product Safety Commission (CPSC) guidelines and ASTM International (ASTM) standards, extending at least six feet beyond the perimeter of the stationary equipment. These shock-absorbing surfaces must conform to the standard stating that the impact of falling from the height of the structure will be less than or equal to peak deceleration of 200G and a Head Injury Criterion (HIC) of 1000 and should be maintained at all times. Organic materials that support colonization of molds and bacteria should not be used. All loose fill materials must be raked to retain their proper distribution, shock-absorbing properties and to remove foreign material. This standard applies whether the equipment is installed outdoors or indoors.

**STANDARD 6.2.4.4: Trampolines**

Trampolines, both full and mini-size, should be prohibited from being used as part of the child care program activities both on-site and during field trips.

**STANDARD 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 the following:

- 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.

Observations should be documented and filed, and the problems corrected. Facilities should conduct a monthly inspection.

**290-2-3-.13 Building and Grounds**

(2) Outside grounds and play areas shall be kept clean and free of obvious hazards to the children's health and safety.

(a) Outside play areas shall be free of hazards such as, but not limited to exposed sharp edges of concrete or equipment, broken glass, debris, open drainage ditches, holes and stagnant water.

-partially meets-

No mention of when observations are made and it should be done monthly.

DECAL should consider adding this minor addition.

**STANDARD 6.3.1.1: Enclosure of Bodies of Water**

A fence shall be provided around

Partially meets.

Rule addresses having a fence but no specifications about

Specifications should be added.
All water hazards, such as pools, swimming pools, stationary wading pools, ditches, fish ponds, and water retention or detention basins should be enclosed with a fence that is four to six feet high or higher and comes within three and one-half inches of the ground. Openings in the fence should be no greater than three and one-half inches. The fence should be constructed to discourage climbing and kept in good repair.

If the fence is made of horizontal and vertical members (like a typical wooden fence) and the distance between the tops of the horizontal parts of the fence is less than forty-five inches, the horizontal parts should be on the swimming pool side of the fence. The spacing of the vertical members should not exceed one and three-quarters inches.

For a chain link fence, the mesh size should not exceed one and one-quarter square inches.

Exit and entrance points should have self-closing, positive latching gates with locking devices a minimum of fifty-five inches from the ground.

A wall of the child care facility should not constitute one side of the fence unless the wall has no openings capable of providing direct access to the pool (such as doors, windows, or other openings).

If the facility has a water play area, the following requirements should be met:

- a) Water play areas should conform to all state and local health regulations;
- b) Water play areas should not include hidden or enclosed spaces;
- c) Spray areas and water-collecting areas should have a non-slip surface, such as asphalt;
- d) Water play areas, particularly those that have standing water, should not have sudden changes in depth of water;
- e) Drains, streams, water spouts, and hydrants should not create strong suction effects or water-jet forces;
- f) All toys and other equipment used in and around the water play area should be made of sturdy plastic or metal (no glass should be permitted);
- g) Water play areas in which standing water is maintained for more than twenty-four hours should be treated according to Standard 6.3.4.1, and inspected for glass, trash, animal excrement, and other foreign material.
<p>| STANDARD 6.3.1.2: Accessibility to Above-Ground Pools | 290-2-3-.13 Building and Grounds | Meets. | This rule addresses accessibility but does not contain the additional specificity regarding non-climbable sidewalls, fencing, or steps. | DECAL may want to add this specificity to the rule. |
| Above-ground pools should have non-climbable sidewalls that are at least four feet high or should be enclosed with an approved fence. When the pool is not in use, steps should be removed from the pool or otherwise protected to ensure that they cannot be accessed. | A fence shall be provided around swimming pools to make them inaccessible when not in use | |
| STANDARD 6.3.1.4: Safety Covers for Swimming Pools | | Not addressed. | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
| When not in use, in-ground and above-ground swimming pools should be covered with a safety cover that meets or exceeds the ASTM International (ASTM) standard “F1346-03: Standard performance specification for safety covers and labeling requirements for all covers for swimming pools, spas, and hot tubs” (2). | | | |
| STANDARD 6.3.1.6: Pool Drain Covers | | Not addressed. | Not addressed. | DECAL may want to address this specific standard and add it to their rules. |
| All covers for the main drain and other suction ports of swimming and wading pools should be listed by a nationally recognized testing laboratory in accordance with ASME/ANSI standard “A112.19.8: Standard for Suction Fittings for Use in Swimming Pools, Wading Pools, Spas and Hot Tubs,” and should be used under conditions that do not exceed the approved maximum flow rate, be securely anchored using manufacturer-supplied parts installed per manufacturer’s specifications, be in good repair, and be replaced at intervals specified by manufacturer. Facilities with one outlet per pump, or multiple outlets per pump with less than thirty-six inches center-to-center distance for two outlets, must be equipped with a Safety Vacuum Release System (SVRS) meeting the ASME/ANSI standard “A112.19.17: Manufactured Safety Vacuum Release Systems for Residential and Commercial Swimming Pool, Spas, Hot Tub and Wading Pool Suction Systems” or ASTM International (ASTM) standard “F2387-04: Standard Specification for Manufactured SVRS for Swimming Pools, Spas, and Hot Tubs” standards, as required by the Virginia Graeme Baker Pool and Spa Safety Act, Section 1404(c)(1)(A)(I) (1,2). | | | |</p>
<table>
<thead>
<tr>
<th>STANDARD 6.3.2.1: Lifesaving Equipment</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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, should be kept in good repair, and should be stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment so that in emergencies, caregivers/teachers will use equipment appropriately. Children should be familiarized with the use of the equipment based on their developmental level.</td>
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<tr>
<td>STANDARD 6.3.5.1: Hot Tubs, Spas, and Saunas</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
<tr>
<td>Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children.</td>
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</tr>
<tr>
<td>STANDARD 6.3.5.2: Water in Containers</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<tr>
<td>Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.</td>
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<tr>
<td>STANDARD 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
<tr>
<td>Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects should not be accessible to children under three years of age:</td>
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<tr>
<td>a) Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches;</td>
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<tr>
<td>b) Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter;</td>
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<td>c) Toys with sharp points and edges;</td>
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<tr>
<td>Topic</td>
<td>290-2.3-.12 Equipment and Supplies</td>
<td>Partially meets.</td>
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<tr>
<td><strong>STANDARD 6.4.1.5: Balloons</strong></td>
<td>Infants, toddlers, and preschool children should not be permitted to inflate balloons, suck on or put balloons in their mouths nor have access to uninflated or underinflated balloons. Children under eight should not have access to latex balloons or inflated latex objects that are treated as balloons and these objects should not be permitted in the child care facility.</td>
<td>290-2.3-.12 Equipment and Supplies</td>
</tr>
<tr>
<td><strong>STANDARD 6.4.2.2: Helmets</strong></td>
<td>All children one year of age and over should wear properly fitted and approved helmets while riding toys with wheels (tricycles, bicycles, etc.) or using any wheeled equipment (rollerblades, skateboards, etc.). Helmets should be removed as soon as children stop riding the wheeled toys or using wheeled equipment. Approved helmets should meet the standards of the U.S. Consumer Product Safety Commission (CPSC) (5). The standards sticker should be located on the bike helmet. Bike helmets should be replaced if they have been involved in a crash, the helmet is cracked, when straps are broken, the helmet can no longer be worn properly, or according to recommendations by the manufacturer (usually after three years).</td>
<td>Not addressed.</td>
</tr>
<tr>
<td><strong>STANDARD 6.5.1.1: Competence and Training of Transportation Staff</strong></td>
<td>At least one adult who accompanies or drives children for</td>
<td>Partially meets.</td>
</tr>
</tbody>
</table>
field trips and out-of-facility activities should receive training by a professional knowledgeable about child development and procedures, to ensure the safety of all children. The caregiver should hold a valid pediatric first aid certificate, including rescue breathing and management of blocked airways. Any emergency medications that a child might require, such as self-injecting epinephrine for life-threatening allergy, should also be available at all times as well as a mobile phone to call for medical assistance. Child:staff ratios should be maintained on field trips and during transport, the driver should not be included in these ratios. No child should ever be left alone in the vehicle.

All drivers, passenger monitors, chaperones, and assistants should receive instructions in safety precautions. Transportation procedures should include:

| a) Use of developmentally appropriate safety restraints; |
| b) Proper placement of the child in the motor vehicle in accordance with state and federal child restraint laws and regulations and recognized best practice; |
| c) Training in handling of emergency medical situations. If a child has a chronic medical condition or special health care needs that could result in an emergency (such as asthma, diabetes, or seizures), the driver or chaperone should have written instructions including parent/guardian emergency contacts, child summary health information, special needs and treatment plans, and should: |
|   1) Recognize the signs of a medical emergency; |
|   2) Know emergency procedures to follow (3); |
|   3) Have on hand any emergency supplies or medications necessary, properly stored out of reach of children; |
|   4) Know specific medication administration (ex. a child who requires EpiPen or diazepam); |
|   5) Know about water safety when field trip is to a location with a body of water. |
| d) Knowledge of appropriate routes to emergency facility; |
| e) Defensive driving; |
| f) Child supervision during transport, including never leaving a child unattended in or around a vehicle; |
| g) Issues that may arise in transporting children with employee, the driver shall have a current driver's license and children shall be restrained by either individual seat belts or appropriate child restraints in accordance with state law. No child shall be left unattended in a motor vehicle. |
| trainings and procedures. |
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<table>
<thead>
<tr>
<th>Standard 6.5.1.2: Qualifications for Drivers</th>
<th>Partially meets.</th>
<th>No mention in the rule about evidence of a safe driving record, no alcohol or other drugs associated with impaired ability to drive within 12 hours prior to transporting children, no criminal record of crimes against or involving children, no medical condition that would compromise driving.</th>
<th>DECAL should consider adding the Stepping Stones standards specific language.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any driver who transports children for a child care program should be at least twenty-one years of age and should have: a) A valid commercial driver’s license that authorizes the driver to operate the vehicle being driven; b) Evidence of a safe driving record for more than five years, with no crashes where a citation was issued; c) No alcohol, prescription or over-the-counter medications, or other drugs associated with impaired ability to drive, within twelve hours prior to transporting children. Drivers should ensure that any prescription or over-the-counter drugs taken will not impair their ability to drive; d) No tobacco, alcohol, or drug use while driving; e) No criminal record of crimes against or involving children, child neglect or abuse, substance abuse, or any crime of violence; f) No medical condition that would compromise driving, supervision, or evacuation capability including fatigue and sleep deprivation; g) Valid pediatric CPR and first aid certificate if transporting children alone.</td>
<td>290-2-3-.11 Health, Safety, and Discipline (j) If children are transported in an automobile by the provider or a home's employee, the driver shall have a current driver's license and children shall be restrained by either individual seat belts or appropriate child restraints in accordance with state law.</td>
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The receipt of such instructions should be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities. Vehicles should be equipped with a first aid kit, fire extinguisher, seat belt cutter, and maps. At least one adult should have a functioning cell phone at hand. Information, names of the children and parent/guardian contact information should be carried in the vehicle along with identifying information (name, address, and telephone number) about the child care center.
other drugs is suspected.

<table>
<thead>
<tr>
<th>STANDARD 6.5.2.2: Child Passenger Safety</th>
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<tbody>
<tr>
<td>When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following should apply:</td>
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<tr>
<td>a) A child should be transported only if the child is restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child’s weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according to the manufacturer’s instructions, in a developmentally appropriate child restraint system.</td>
</tr>
<tr>
<td>b) Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-feet-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance.</td>
</tr>
<tr>
<td>c) For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat’s weight limit or is taller than the height limit. Caregivers/teachers should check the labels on the seat or manufacturer’s instructions if they are unsure of the limits. Manufacturer’s instructions that include these specifications can also be found on the manufacturer’s Website.</td>
</tr>
<tr>
<td>d) Child passenger restraint systems should be installed and used in accordance with the manufacturer’s instructions and should be secured in back seats only.</td>
</tr>
<tr>
<td>e) All children under the age of thirteen should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat), should</td>
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<table>
<thead>
<tr>
<th>290-2-3-.11 Health, Safety, and Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>(j) If children are transported in an automobile by the provider or a home’s employee, the driver shall have a current driver’s license and children shall be restrained by either individual seat belts or appropriate child restraints in accordance with state law. No child shall be left unattended in a motor vehicle</td>
</tr>
</tbody>
</table>

| Partially meets. | Rule has statement about restrained by appropriate child restraints in accordance with state law but does not have any of the specific language of the Stepping Stones standard. | The specifics of the Stepping Stones standard related to child passenger safety should be added to this rule. |
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have an individual lap-and-shoulder seat belt (2).
f) For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer’s instructions (1). Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until reaching the upper height or weight limit of the seat, in accordance with the manufacturer’s instructions (10). Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place.
g) A booster seat should be used when, according to the manufacturer’s instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and twelve years of age) (1).
h) Car safety seats, whether provided by the child’s parents/guardians or the child care program, should be labeled with the child passenger’s name and emergency contact information.
i) 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 (3,11).
j) The temperature of all metal parts of vehicle child restraint systems should be checked before use to prevent burns to child passengers.

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<table>
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<tr>
<th>STANDARD 6.5.2.4: Interior Temperature of Vehicles</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle’s interior temperature exceeds 82°F and providing fresh air through open windows cannot reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.</td>
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</tr>
<tr>
<td>STANDARD 6.5.3.1: Passenger Vans</td>
<td>Not addressed.</td>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
</tr>
<tr>
<td>Child care facilities that provide transportation to children, parents/guardians, staff, and others should avoid the use of fifteen-passenger vans whenever possible. Other vehicles, such as vehicles meeting the definition of a “school bus,” should be used to fulfill transportation of child passengers in particular. Conventional twelve- to fifteen-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration (NHTSA) standards (2,4), and thus cannot be sold or leased, as new vehicles, to carry students on a regular basis. Caregivers/teachers should be knowledgeable about the laws of the state(s) in which their vehicles, including passenger vans, will be registered and used.</td>
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<tr>
<td>STANDARD 7.2.0.2: Unimmunized Children</td>
<td>Meets.</td>
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<tr>
<td>If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child’s primary 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</td>
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290-2-3-.11 Health, Safety, and Discipline.
(b) Age appropriate immunization, or an affidavit or physician’s statement as described in Rule .08(1)(c), shall be required for each preschool age child upon admission to the home or within 30 days thereafter.
or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file (1,2).

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. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011” from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the “Recommended Immunization Schedules” (6).

If a vaccine-preventable disease to which children are susceptible occurs in the facility 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.

<table>
<thead>
<tr>
<th>STANDARD 7.2.0.3: Immunization of Caregivers/Teachers</th>
<th>Not addressed.</th>
<th>DECAL may want to address this specific standard and add it to their rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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” at <a href="http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/">http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/</a>. This schedule is updated annually at the beginning of the calendar year and can be found in Appendix H.</td>
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Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2)
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):
   1) Tdap/Td;
   2) Varicella-zoster;
   3) MMR (measles, mumps, and rubella);
   4) Seasonal influenza;
   5) Human papillomaviruses (HPV) (eleven through twenty-six years of age);
   6) Others as determined by the ACIP and state and local public health authorities.
b) Recommended if a specific risk factor is present:
   1) Pneumococcal;
   2) Hepatitis A;
   3) Hepatitis B;
   4) Meningococcal;
   5) Others as determined by the ACIP and state and local public health authorities.
c) If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason.
d) 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.

**STANDARD 7.3.3.1: Influenza Immunizations for Children and Caregivers/Teachers**
The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized.

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
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Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.

<table>
<thead>
<tr>
<th>STANDARD 7.3.3.2: Influenza Control</th>
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<tbody>
<tr>
<td>When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least twenty-four hours without use of fever reducing medication. Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least twenty-four hours.</td>
</tr>
<tr>
<td>Not addressed.</td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<table>
<thead>
<tr>
<th>STANDARD 7.3.5.1: Recommended Control Measures for Invasive Meningococcal Infection in Child Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of an individual with invasive meningococcal infection in the child care setting should result in the following:</td>
</tr>
<tr>
<td>a) Immediate notification of the local or state health department;</td>
</tr>
<tr>
<td>b) Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection;</td>
</tr>
<tr>
<td>c) Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care contacts;</td>
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<tr>
<td>d) Frequent updates and communication with parents/guardians, health care professionals, and local health authorities.</td>
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<tr>
<td>Not addressed.</td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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<thead>
<tr>
<th>STANDARD 7.3.5.2: Informing Public Health Authorities of Meningococcal Infections</th>
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<tbody>
<tr>
<td>Meningococcal disease is designated as notifiable at the national level, and local and/or state public health department authorities should be notified immediately about the occurrence of invasive meningococcal disease in a child</td>
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<tr>
<td>Not addressed.</td>
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<tr>
<td>DECAL may want to address this specific standard and add it to their rules.</td>
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</table>
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<tr>
<th>Care facility. Timely reporting results in early recognition of outbreaks and prevention of additional infections. Facilities should cooperate with their local or state health department officials in notifying parents/guardians of children who attend the facility about exposures to children with invasive meningococcal infections. Early intervention minimizes anxiety and concern that may result from identification of an attendee with an invasive meningococcal infection. This may include providing local health officials with the names and telephone numbers of parents/guardians of children in involved classrooms or facilities.</th>
</tr>
</thead>
</table>
| **STANDARD 7.3.9.1: Immunization with *Streptococcus Pneumoniae* Conjugate Vaccine (PCV13)**  
*Pneumococcal conjugate (PCV13) vaccine is recommended for all children from two through fifty-nine months of age, including children in child care facilities. The vaccine is recommended to be administered at two, four, six, and twelve through fifteen months of age (1-3,5). Healthy children between twenty-four and fifty-nine months of age who are not immunized completely for their age should be administered one dose of PCV13 (3,5). Children two years of age or older at high risk of invasive disease caused by *Streptococcus pneumoniae* (including sickle cell disease, asplenia, HIV, chronic illness, cochlear implant or immunocompromised) who have received their recommended doses of PCV should receive *S. pneumoniae* polysaccharide vaccine two or more months after receipt of the last dose of PCV (1-3,5). |
| Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
| **STANDARD 7.4.0.1: Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections**  
Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1-3):  
a) Toilet trained children who cannot use a toilet |
| Not addressed. |
| DECAL may want to address this specific standard and add it to their rules. |
for all bowel movements while attending the facility and who develop diarrhea, as defined in Standard 3.6.1.1, should be removed from the facility by their parent/guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This should be accomplished by removing the child who is ill to a separate area of the child care program or, if not possible, to a separate area of the child’s room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as occurs in small family child care homes, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.

b) A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care should be separated from other children and the child’s parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child from the facility.

c) Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for
hepatitis A virus (HAV) should continue for one week after onset of jaundice.

d) Alternate care for children with diarrhea or hepatitis A in special facilities for children who are ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A.

e) Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with Shigella, Shiga toxin-producing E. coli (STEC), or Salmonella enterica serotype Typhi. For Shigella and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For Salmonella serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For Salmonella species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care.

f) The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility.

g) Recommended post-exposure prophylaxis for hepatitis A includes administration of hepatitis A vaccine or immune globulin to all previously unimmunized staff members and attendees of a child care facility in which a person with hepatitis A is identified.

h) If there has been an exposure to a person with hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.

STANDARD 7.5.10.1: Staphylococcus Aureus Skin Infections Including MRSA
The following should be implemented when children or...
staff with lesions suspicious for *Staphylococcus aureus* infections are identified:
   a) Lesions should be covered with a dressing;
   b) Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider;
   c) Exclusion is not warranted unless the individual meets any of the following criteria:
      1) Care for other children would be compromised by care required for the person with the *S. aureus* infection;
      2) The individual with the *S. aureus* infection has fever or a change in behavior;
      3) The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent changing;
      4) A health care professional or health department official recommends exclusion of the person with *S. aureus* infection.

Meticulous hand hygiene following contact with lesions should be practiced. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of *S. aureus* infection and referred for evaluation, if indicated.

A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered. *S. aureus* skin infections initially may appear as red raised areas that may become pus-filled abscesses or “boils,” surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these signs or symptoms occur, the child should be evaluated by his/her primary care provider.

<table>
<thead>
<tr>
<th>STANDARD 7.5.6.1: Immunization for Measles</th>
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</thead>
<tbody>
<tr>
<td>All children in a child care facility should have received</td>
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</table>

| Not addressed. |

| DECAL may want to address this specific standard and add it to their rules. |
age-appropriate immunizations with measles, mumps, and rubella (MMR) vaccine or with measles, mumps, rubella, and varicella (MMRV) vaccine (1). If a case of measles occurs in a child care setting, interrupting subsequent spread depends on prompt immunization of people at risk of exposure or people already exposed who cannot provide documentation of measles immunity, including date of immunization. Children and adults in child care who are not immunized or not age-appropriately immunized against measles should be excluded from care immediately if the child care facility has been notified of a documented case of measles occurring in a child or adult in the center. These children should not be allowed to return to the facility until at least two weeks after the onset of rash in the last case of measles, as determined by health department officials. Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive one or more doses of MMR vaccine unless they have a medical contraindication, documentation of one or more dose of vaccine, history of measles based on primary care provider diagnosis, or laboratory evidence of immunity.

**STANDARD 9.2.3.12: Infant Feeding Policy**

A policy about infant feeding should be developed with the input and approval from the nutritionist/registered dietitian and should include the following:

a) Storage and handling of expressed human milk;

b) Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate;

c) Preparation, storage, and handling of infant formula;

d) Proper handwashing of the caregiver/teacher and the children;

e) Use and proper sanitizing of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers;

f) Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;

Not addressed.

DECAL may want to address this specific standard and add it to their rules.
<table>
<thead>
<tr>
<th>g) Holding infants during bottle-feeding or feeding them sitting up;</th>
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<tr>
<td>h) Prohibiting bottle propping during feeding or prolonging feeding;</td>
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<tr>
<td>i) Responding to infants’ need for food in a flexible fashion to allow cue feedings in a manner that is consistent with the developmental abilities of the child (policy acknowledges that feeding infants on cue rather than on a schedule may help prevent obesity) (1,2);</td>
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<td>j) Introduction and feeding of age-appropriate solid foods (complementary foods);</td>
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<td>k) Specification of the number of children who can be fed by one adult at one time;</td>
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<tr>
<td>l) Handling of food intolerance or allergies (e.g., cow’s milk, peanuts, orange juice, eggs, wheat).</td>
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</table>

Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant’s primary care provider and parents/guardians.

### STANDARD 9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances

Facilities should have written policies addressing the use and possession of tobacco products, alcohol, illegal drugs, prescription medications that have not been prescribed for the user, and unauthorized potentially toxic substances. Policies should include that all of these substances are prohibited inside the facility, on facility grounds, and in any vehicles that transport children at all times. Policies should specify that smoking is prohibited at all times and in all areas used by the children in the program. Smoking is also prohibited in any vehicles that transport children.

Policies must also specify that use and possession of all substances referred to above is prohibited during all times when caregivers/teachers are responsible for the supervision of children, including times when children are transported, when playing in outdoor play areas not attached to the facility, and during field trips.

Child care centers and large family child care homes should provide information to employees about available drug, alcohol, and tobacco counseling and rehabilitation, and any available employee assistance programs.

<p>| 290-2-3-.11 Health, Safety, and Discipline | Partially meets. | Rule addresses the prohibited substances but doesn’t address the policies. | DECAL may or may not want to address the issue of policies. |</p>
<table>
<thead>
<tr>
<th>STANDARD 9.2.3.2: Content and Development of the Plan for Care of Children and Staff Who Are Ill</th>
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<tbody>
<tr>
<td>All child care facilities should have written policies for the management and care of children and staff who are ill. The facility’s plan for the care of children and staff who are ill should be developed in consultation with the facility’s child care health consultant and other health care professionals to address current understanding of the technical issues of contagion and other health risks. This plan should include:</td>
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<tr>
<td>In group care, the facility should address the well-being of all those affected by illness: the child, the staff, parents/guardians of the child, other children in the facility and their parents/guardians, and the community. The priority of the policy should be to meet the needs of the child who is ill and the other children in the facility. The policy should address the circumstances under which separation of the affected individual (child or staff person) from the group is required; the circumstances under which the staff, parents/guardians, or other designated persons need to be informed; and the procedures to be followed in these cases. The policy should take into consideration:</td>
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</table>
| DECAL may want to address this specific standard and add it to their rules.
| a) The physical facility; | b) The number and the qualifications of the facility’s personnel; | c) The fact that children do become ill frequently and at unpredictable times; | d) The fact that adults may be on staff with known health problems or may develop health problems while at work; | e) The fact that working parents/guardians often are not given leave for their children’s illnesses; | f) The amount of care the child who is ill requires if the child remains in the program, can staff devote the time for caring of a child who is ill in the classroom without leaving other children unattended, and can the child participate in any of the classroom activities |

**STANDARD 9.2.3.9: Written Policy on Use of Medications**
The facility should have a written policy for the administration of any prescription or non-prescription (over-the-counter [OTC]) medication. The policy should address at least the following:

- a) The use of written parental/guardian consent forms for each prescription and OTC medication to be administered at the child care facility. The consent form should include:
  1) The child’s name;
  2) The name of the medication;
  3) The date(s) and times the medication is to be given;
  4) The dose or amount of medication to be given;
  5) How the medication is to be administered;
  6) The period of time the consent form is valid, which may not exceed the length of time the medication is prescribed for, the expiration date of the medication or one year, whichever is less.
- b) The use of the prescribing health professional’s authorization forms for each prescription and OTC medication to be administered at the child care facility.
- c) The circumstances under which the facility will agree to administer medication. This may include

**290-2.3-.08 Children’s Records**
(c) The policies and procedures shall also include written procedures for the following:

3. Administering medication and recording noticeable adverse reactions to medication;

**290-2.3-.11 Health, Safety, and Discipline**
(e) Except for first aid, personnel shall not dispense prescription or nonprescription medications to a child without specific written authorization from the child’s physician, parent or guardian. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children. Each dose of medication given to a child shall be documented showing the child’s name, name of medication, date and time given, and the name of the person giving the medication.

| Partially meets. | Rule does not contain all the key elements to be present in the written policy. | DECAL may want to add the specific language from the Stepping Stones standard on written policy regarding the use of medications. |
### Medication Administration

1. **Topical medications** such as non-medicated diaper creams, insect repellants, and sunscreens;
2. **OTC medicines** for fever including acetaminophen and ibuprofen;
3. **Long-term medications** that are administered daily for children with chronic health conditions that are managed with medications;
4. **Controlled substances**, such as psychotropic medications;
5. **Emergency medications** for children with health conditions that may become life-threatening such as asthma, diabetes, and severe allergies;
6. **One-time medications** to prevent conditions such as febrile seizures.

### Administration Conditions

d) The circumstances under which the facility will not administer medication. This should include:
1. No authorization from parent/guardian and/or prescribing health professional;
2. Prohibition of administering OTC cough and cold medication;
3. Not administering a new medication for the first time to a child while he or she is in child care;
4. If the instructions are unclear or the supplies needed to measure doses or administer the medication are not available or not in good working condition;
5. The medication has expired;
6. If a staff person or his/her backup who has been trained to give that particular medication is not present (in the case of training for medications that require specific skills to administer properly, such as inhalers, injections, or feeding tubes/ports).

e) The process of accepting medication from parents/guardians. This should include:
1. Verifying the consent form;
2. Verifying the medication matches what is on the consent form;
3. Accepting authorization for prescription medications from the child’s prescribing health professional only if the medications are in their original container and have the child’s name, the name of the medication, the dose and...
directions for giving the medication, the expiration date of the medication, and a list of warnings and possible side effects;
4) Accepting authorization for OTC medications from the child’s prescribing health professional only if the authorization indicates the purpose of the medication and time intervals of administration, and if the medications are in their original container and include the child’s name, the name of the medication, dose and directions for use, an expiration date for the medication, and a list of warnings and possible side effects;
5) Verifying that a valid Care Plan accompanies all long-term medications (i.e., medications that are to be given routinely or available routinely for chronic conditions such as asthma, allergies, and seizures);
6) Verifying any special storage requirements and any precautions to take while the child is on the prescription or OTC medication.
f) The proper handling and storage of medications, including:
  1) Emergency medications – totally inaccessible to children but readily available to supervising caregivers/teachers trained to give them;
  2) Medications that require refrigeration;
  3) Controlled substances;
  4) Expired medications;
  5) A policy to insure confidentiality;
  6) Storing and preparing distribution in a quiet area completely out of access to children;
  7) Keeping all medication at all times totally inaccessible to children (e.g., locked storage);
  8) Whether to require even short-term medications be kept at the facility overnight.
g) The procedures to follow when administering medications. These should include:
  1) Assigning administration only to an adequately trained, designated staff;
  2) Checking the written consent form;
  3) Adhering to the “six rights” of safe medication administration (child, medication, time/date, dose, route, and documentation) (1);
  4) Documenting and reporting any medication errors;
  5) Documenting and reporting adverse
Validating the Georgia Family Child Care Home Regulations

<table>
<thead>
<tr>
<th>A medication administration record should be maintained on an ongoing basis by designated staff and should include the following:</th>
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<tbody>
<tr>
<td>a) Specific, signed parental/guardian consent for the caregiver/teacher to administer medication including documentation of receiving controlled substances and verification of the amount received;</td>
</tr>
<tr>
<td>b) Specific, signed authorization from the child’s prescribing health professional, prescribing the medication, including medical need, medication, dosage, and length of time to give medication;</td>
</tr>
<tr>
<td>c) Information about the medication including warnings and possible side effects;</td>
</tr>
<tr>
<td>d) Written documentation of administration of medication and any side effects;</td>
</tr>
<tr>
<td>e) Medication errors log.</td>
</tr>
</tbody>
</table>

The facility should consult with the State Board of Nursing, other interested organizations and their child care health consultant about required training and documentation for medication administration. Based on the information, the facility should develop and implement a plan regarding medication administration training.

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

The facility should have a written plan for reporting and managing what they assess to be an incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. The facility should also include procedures of staff training on this plan.

The management, documentation, and reporting of the following:

<table>
<thead>
<tr>
<th>290-2-3-.08 Children’s Records</th>
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<tbody>
<tr>
<td>(d) Written authorization for the child to receive emergency medical treatment when the parent or guardian is not available.</td>
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</table>

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<tr>
<th>Partially meets.</th>
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The rule addresses written authorization but does not address a written plan and what it should contain.

The details of the written plan should be added to this rule.
Following types of incidents, at a minimum, that occur at the child care facility should be addressed in the plan:

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 child care facility;
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 child care facility, even if the death occurred outside of child care hours;
i) The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

The following procedures, at a minimum, should be addressed in the plan for urgent care:

a) Provision for a caregiver/teacher to accompany a child to a source of urgent care and remain with the child until the parent/guardian assumes responsibility for the child;
b) Provision for the caregiver/teacher to provide the medical care personnel with an authorization form signed by the parent/guardian for emergency medical care and a written informed consent form signed by the parent/guardian allowing the facility to share the child’s health records with other service providers;
c) Provision for a backup caregiver/teacher or substitute for large and small family child care homes to make the arrangement for urgent care feasible (child:staff ratios must be maintained at the facility during the emergency);
d) Notification of parent/guardian(s);
e) Pre-planning for the source of urgent medical and dental care (such as a hospital emergency room, medical or dental clinic, or other constantly
Validating the Georgia Family Child Care Home Regulations

| Staffed facility known to caregivers/teachers and acceptable to parents/guardians; | 290-23-.11 Health, Safety, and Discipline | Requirement for a written plan but no details. | Add the details from the Stepping Stones standard. |
| f) Completion of a written incident/injury report and the program’s response; | 290-23-.11 Health, Safety, and Discipline | Requirement for a written plan but no details. | Add the details from the Stepping Stones standard. |
| g) Assurance that the first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a monthly review of the contents; | 290-23-.11 Health, Safety, and Discipline | Requirement for a written plan but no details. | Add the details from the Stepping Stones standard. |
| h) Policy for scheduled reviews of staff members’ ability to perform first aid for averting the need for emergency medical services; | 290-23-.11 Health, Safety, and Discipline | Requirement for a written plan but no details. | Add the details from the Stepping Stones standard. |
| i) Policy for staff supervision following an incident when a child is lost, missing, or seriously injured. | 290-23-.11 Health, Safety, and Discipline | Requirement for a written plan but no details. | Add the details from the Stepping Stones standard. |

STANDARD 9.2.4.3: Disaster Planning, Training, and Communication

Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that may require evacuation, lock-down, or shelter-in-place.

**Written Emergency/Disaster Plan:**

Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include:

- a) Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning;
- b) Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises;
- c) Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or
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posting of flyers at the facility and other community locations; 

d) Mechanisms for notifying and communicating with emergency management public officials; 
e) Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care needs, transporting necessary medical equipment obtaining emergency medical care, responding to an intruder, etc.; 
f) Identification of primary and secondary meeting places and plans for reunification of parents/guardians with their children; 
g) Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services); 
h) Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as paying employees and bills during the aftermath of the disaster; 
i) Contingency plans for various situations that address: 

1) Emergency contact information and procedures; 
2) How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care; 
3) Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required; 
4) Administering medicine and implementing other instructions as described in individual special care plans; 
5) Procedures that might be implemented in the
<table>
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<tr>
<th>Event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;</td>
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<tr>
<td>7) Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).</td>
</tr>
</tbody>
</table>

Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or lessons learned into the document.

Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or disaster situations.

**Training:**

Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address:

<table>
<thead>
<tr>
<th>Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan;</th>
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<tbody>
<tr>
<td>Different types of emergency and disaster situations and when and how they may occur;</td>
</tr>
<tr>
<td>a) Natural Disasters;</td>
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<tr>
<td>b) Terrorism (i.e., biological, chemical, radiological, nuclear);</td>
</tr>
<tr>
<td>c) Outbreaks, epidemics, or other infectious disease emergencies;</td>
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</tbody>
</table>
c) The special and unique needs of children, appropriate response to children’s physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts;
d) Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources;
e) Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations;
f) Developing personal and family preparedness plans;
g) Supporting and communicating with families;
h) Floor plan safety and layout;
i) Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs;
j) Typical community, county, and state emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure);
k) Community resources for post-event support such as mental health consultants, safety consultants;
l) Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur;
m) Insurance and liability issues;
n) New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children’s needs.

**Communicating with Parents/Guardians:**
Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including:

a) Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public;
b) Procedures and instructions for what parents/guardians can expect if something happens at the facility;
c) Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation;
d) Situations that might require parents/guardians to have a contingency plan regarding how their children will
be cared for in the unlikely event of a facility closure. Facilities should conduct an annual drill, test, or “practice use” of the communication options/mechanisms that are selected.

<table>
<thead>
<tr>
<th>STANDARD 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy</th>
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<tbody>
<tr>
<td>The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as:</td>
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<tr>
<td>a) Fire, monthly;</td>
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<td>b) Tornadoes, on a monthly basis in tornado season;</td>
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<td>c) Floods, before the flood season;</td>
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<td>d) Earthquakes, every six months;</td>
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<td>e) Hurricanes, annually;</td>
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<td>f) Threatening person outside or inside the facility;</td>
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<tr>
<td>g) Rabid animal;</td>
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<tr>
<td>h) Toxic chemical spill;</td>
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<tr>
<td>i) Nuclear event.</td>
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<tr>
<td>All drills/exercises should be recorded.</td>
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<tr>
<td>A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards.</td>
</tr>
<tr>
<td>Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice.</td>
</tr>
<tr>
<td>The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel. Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>290-2.3-.11 Health, Safety, and Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>(c) The home shall practice fire drill procedures with children at least monthly. Such drills shall be documented and maintained on file for one year.</td>
</tr>
</tbody>
</table>

| Rule states practicing fire drills but there are no details or procedures to be followed; nor are other emergencies covered. |
| Develop content from the Stepping Stones standard to cover the other emergencies listed and other procedures to be followed. |
STANDARD 9.4.1.10: Documentation of Parent/Guardian Notification of Injury, Illness, or Death in Program
The facility should document that a child’s parent/guardian was notified immediately in the event of a death of their child, of an injury or illness of their child that required professional medical attention, or if their child was lost/missing.
Documentation should also occur noting when law enforcement was notified (immediately) in the event of a death of a child or a lost/missing child.
The facility should document in accordance with state regulations, its response to any of the following events:
- a) Death;
- b) Serious injury or illness that required medical attention;
- c) Reportable infectious disease;
- d) Any other significant event relating to the health and safety of a child (such as a lost child, a fire or other structural damage, work stoppage, or closure of the facility).
The caregiver/teacher should call 9-1-1 to insure immediate emergency medical support for a death or serious injury or illness. They should follow state regulations with regard to when they should notify state agencies such as the licensing agency and the local or state health department about any of the above events.

STANDARD 9.4.1.12: Record of Valid License, Certificate, or Registration of Facility
Every facility should hold a valid license or certificate, or documentation of, registration prior to operation as required by the local and/or state statute.

290-2-3-.11 Health, Safety, and Discipline.
(c) Parent or guardian of any child who becomes ill or is injured while in care shall be notified immediately of any illness or injury requiring professional medical attention, or any illness which may not require professional medical attention but which produces symptoms causing moderate discomfort to the child, such as, but not limited to, any of the following: elevated temperature, vomiting or diarrhea.

290-2-3-.15 Enforcement and Penalties.
No family day care home shall operate in the State without a Certificate of Registration that has been issued by the Department. A registration to operate a family day care home may be denied, revoked, restricted or suspended in accordance with the following:
- a) Refusal of a License, Commission or Registration. The Department shall refuse to
issue a registration upon a showing of:
1. Noncompliance with the Rules and Regulations for Family Day Care Homes which are designated in writing to the facilities as being related to children's health and safety; or
2. Flagrant and continued operation of an unregistered family day care home in contravention of the law; or
3. Prior license, commission or registration denial or revocation within one (1) year of application.

(b) Refusal of a License, Commission or Registration. The Department may refuse to issue a registration upon a showing of:
1. The applicant or the agent of the applicant denies the Department’s representative access to the family day care home for the purposes of determining whether a registration will be granted; or
2. The owner or employees of the family day care home do not undergo the applicable records check and receive satisfactory determinations; or
3. The applicant or agent of the applicant knowingly makes any false statement of material information in connection with the application for registration, or in the alteration or falsification of records maintained by the applicant in connection with the application for registration; or
4. The applicant or alter ego of the applicant has transferred ownership or governing authority of a family day care home, group day care home or a child care learning center within one (1) year of the date of the new application when such transfer was made in order to avert denial, suspension, or revocation of a license, commission or registration; or
5. The applicant or alter ego of the applicant or persons in management or control of the family day care home have
Validating the Georgia Family Child Care Home Regulations

failed to pay a civil penalty or enforcement fine previously imposed by the Department.

(c) Revocation of a License, Commission or Registration. The Department may revoke a registration in the following instances:
1. Where the Department’s representative is refused access to the family day care home for the purpose of determining whether the family day care home is in compliance with these rules; or
2. Where the Department determines that a non-correctable deficiency, abuse or dereliction exists in the operation or management of the family day care home; or
3. Where the Department determines that a correctable abuse, dereliction or deficiency in the operation or management of the family day care home has not been corrected within a reasonable time after:
   (i) having been brought immediately to the attention of the administrator of the family day care home by a Department representative; and
   (ii) having been advised in writing of the deficiencies and setting a time not to exceed ten (10) working days for the filing of an acceptable plan of correction; and
   (iii) the provider fails to submit an acceptable plan of correction to the Department within the specified time limits. In determining whether a plan of correction is acceptable, the Department will consider the extent of the deficiencies, whether the provider has previously been cited for the same deficiencies, the history of compliance including whether the provider has complied with previous plans of correction, and whether the
Validating the Georgia Family Child Care Home Regulations

4. The provider fails to follow the accepted plan of correction; or
5. Where the provider or the provider’s employees do not undergo the applicable records checks and receive satisfactory determinations; or
6. Where there is a flagrant abuse, dereliction or deficiency that constitutes shocking intentional misconduct; or
7. Where the provider knowingly makes any false statement of material information in connection with any statement made or on any documents submitted to the Department as part of an inspection, survey, or investigation, or in the alteration or falsification of records maintained by the provider; or
8. Where the provider or alter ego of the provider fails to pay a civil penalty or enforcement fine imposed by the Department after the time period for requesting an appeal of the notice of imposition of civil penalty or enforcement fine has expired and the provider has not submitted an appeal within required time frame in accordance with these rules and regulations; or
9. Where the provider fails to pay a civil penalty or enforcement fine imposed by the Department after the licensee has submitted a timely appeal of the notice of imposition of civil penalty or enforcement fine and the imposition of the civil penalty or enforcement fine has been affirmed in accordance with the Georgia Administrative Procedure Act, O.C.G.A. Sec. 50-13-1 et seq., and applicable law.

(d) Suspension of a Registration. The Department may suspend the registration to
operate a family day care home in the following instances:
1. Where the provider or employees of a family day care home do not undergo the applicable records checks and receive satisfactory determinations, or
2. Where the Department finds that the public health, safety or welfare imperatively requires emergency action and incorporates a finding to this effect in its order summarily suspending the license pending proceedings for revocation or other action, which proceedings shall be promptly instituted and determined.
(c) **Restriction of a Registration.** The Department may restrict or limit a registration from providing certain kinds of care or services to children or limiting the number and/or age of the children who may be served if the Department determines that the provider either cannot comply with these rules or has not complied with these rules.

<table>
<thead>
<tr>
<th>STANDARD 9.4.2.6: Contents of Medication Record</th>
<th>290-2-3-.11 Health, Safety, and Discipline</th>
<th>Meets.</th>
</tr>
</thead>
</table>
| The file for each child should include a medication record maintained on an ongoing basis by designated staff for all prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. The medication record for prescription and non-prescription medications should include the following:
  a) A separate consent signed by the parent/guardian for each medication the caregiver/teacher has permission to administer to the child; each consent should include the child’s name, medication, time, dose, how to give the medication, and start and end dates when it should be given;
  b) Authorization from the prescribing health professional for each prescription and non-prescription medication; this authorization should also include potential side effects and other warnings about the medication (exception: non-prescription sunscreen and insect repellent always meets). | Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication. | |
| 290-2-3-.08 Children’s Records. | (1) The home shall maintain current and updated individual records on each child in care. The home shall maintain the records outlined herein while the child is in care and for a period of one (1) year after such child is no longer in care at the family day care home. Such records shall include:
  e) Documentation of any medications | |
<p>| | (e) Documentation of any medications | |</p>
<table>
<thead>
<tr>
<th><strong>RESEARCH INSTITUTE FOR KEY INDICATORS (RIKI)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Validating the Georgia Family Child Care Home Regulations</td>
</tr>
</tbody>
</table>

- require parental/guardian consent but do not require instructions from each child’s individual medical provider;
- c) Administration log which includes the child’s name, the medication that was given, the dose, the route of administration, the time and date, and the signature or initials of the person administering the medication. For medications given "as needed," record the reason the medication was given. Space should be available for notations of any side-effects noted after the medication was given or if the dose was not retained because of the child vomiting or spitting out the medication. Documentation should also be made of attempts to give medications that were refused by the child;
- d) Information about prescription medication brought to the facility by the parents/guardians in the original, labeled container with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/ instructions, and relevant warnings. Potential side effects and other warnings about the medication should be listed on the authorization form;
- e) Non prescription medications should be brought to the facility in the original container, labeled with the child’s complete name and administered according to the authorization completed by the person with prescriptive authority;
- f) For medications that are to be given or available to be given for the entire year, a Care Plan should also be in place (for instance, inhalers for asthma or epinephrine for possible allergy);
- g) Side effects.

<table>
<thead>
<tr>
<th><strong>STANDARD 10.4.2.1: Frequency of Inspections for Family Child Care Homes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The licensing inspector should make an onsite inspection to measure compliance with licensing rules prior to issuing an initial license and at least two inspections each year to each center and large and small family child care home thereafter. At least one of the inspections should be unannounced and more if needed for the facility to achieve satisfactory compliance or is closed at any time (1). Sufficient numbers of licensing inspectors should be hired to provide adequate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>290-2.3-.04 Registration Requirements and Applications</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) Pre-Registration Visit. Following receipt and review of the complete application package, the department may conduct an on-site inspection of the potential family day home to assess compliance with these rules. The department may deny the application for registration if conditions are found during the on-site inspection that pose health</td>
</tr>
</tbody>
</table>

Meets.
<table>
<thead>
<tr>
<th>Time visiting and inspecting facilities to insure compliance with regulations</th>
<th>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 are encouraged to post the results of licensing inspections, including complaints, on the Internet for parent and public review. Parents/guardians should be provided easy access to the licensing rules and made aware of how to report complaints to the licensing agency.</th>
<th>and/or safety risks to children.</th>
<th></th>
</tr>
</thead>
</table>
DIFFERENTIAL MONITORING LOGIC MODEL AND ALGORITHM (DMLMA)©: A NEW EARLY CHILDHOOD PROGRAM QUALITY INDICATOR MODEL4 (ECPQIM4©) FOR EARLY CARE AND EDUCATION REGULATORY AGENCIES

Richard Fiene, Ph.D.

This Differential Monitoring Logic Model and Algorithm (DMLMA©) is a 4th generational Early Childhood Program Quality Indicator Model4 (ECPQIM4©) in which the major monitoring systems in early care and education are integrated conceptually so that the overall early care and education system can be assessed and validated. With this new model, it is now possible to compare results obtained from licensing systems, quality rating and improvement systems (QRIS), risk assessment systems, key indicator systems, technical assistance, and child development/early learning outcome systems. The various approaches to validation are interposed within this model and the specific expected correlational thresholds that should be observed amongst the key elements of the model are suggested (see Table 1 and Figures 1 & 2).

The DMLMA© can be used by state agencies (child care, child residential, adult residential (just replace Child Outcomes with Adult Outcomes)), Federal agencies (Head Start, child care, Pre-K), and large provider organizations where an economy of scale is required. This model can be used with state as well as national standards, such as state licensing rules/regulations and Head Start Performance Standards or Caring for Our Children/Stepping Stones. Most states and Federal agencies have either some or all of the key elements of this model in their overall monitoring systems. The purpose of this model is to alter a one-size fits all monitoring system to one that is targeted, spending more time with problem programs who need additional assistance. This is a cost neutral model that is both cost effective and efficient and re-allocates resources from the compliant programs to the non-compliant programs.

Key Elements (see Figures 1 & 2): CI = state or federal standards, usually rules or regulations that measure health and safety - Caring for Our Children or Head Start Performance Standards will be applicable here. PQ = Quality Rating and Improvement Systems (QRIS) standards at the state level; ERS (ECERS, ITERS, FDCRS), CLASS, or CDPES (Fiene, 2007). RA = risk assessment tools/systems in which only the most critical rules/standards are measured. Stepping Stones is an example of this approach. KI = key indicators in which only predictor rules/standards are measured. The Thirteen Indicators of Quality Child Care is an example of this approach. DM = differential monitoring decision making in which it is determined if a program is in compliance or not and the number of visits/the number of rules/standards are ascertained from a scoring protocol. PD = technical assistance/training and/or professional development system which provides targeted assistance to the program based upon the DM results. CO = child outcomes which assesses how well the children are developing which is the ultimate goal of the system.

Once the above key elements are in place, it is then possible to look at the relationships amongst them to determine if the system is operating as it was intended. This is done through a validation (Figure 2) of the overall system and assessing the inter-correlations (Figure 1) to determine that the DM system is improving the health, safety, program quality and ultimately the overall development of the children it serves.

The DMLMA© provides a cross-cutting methodology that can be used in all early care and education delivery systems as well as in other human services. In the past many of these monitoring systems have functioned in silos. The DMLMA© integrates all these various monitoring systems together so that the overall monitoring system can be validated as being cost effective and efficient.
STATE AGENCY PLAN (These Steps can be viewed as an overall plan as outlined in Zellman & Fiene (2012):

The **first step** in utilizing the DMLMA for a state is to take a close look at its Comprehensive Licensing Tool (CI) that it uses to collect violation data on all rules with all facilities in its respective state. If the state does not utilize a tool or checklist or does not review all violation data than it needs to consider these changes because the DMLMA is based upon an Instrument Based Program Monitoring System (IPM) which utilizes tools/checklists to collect data on all rules.

The **second step** for the state is to compare their state’s rules with the National *Health and Safety Performance Standards (Caring for Our Children)* to determine the overlap and coverage between the two. This is the first approach to validation which involves Standards review (Zellman & Fiene, 2012).

The **third step** for the state if it utilizes a Risk Assessment (RA) tool is to assess the relationship between this tool and *Stepping Stones* to determine the overlap and coverage between the two. This is a continuation of the first approach to validation which involves Standards review (Zellman & Fiene, 2012).

The **fourth step** for the state is to compare the results from the CI with the RA tools. This step is the second approach to validation which involves Measures (Zellman & Fiene, 2012). The correlation between CI and RA should be at the .50 level or higher (.50+)(see Table 1).

In the **fifth step**, if a state is fortunate enough to have a QRIS – Quality Rating and Improvement System in place and has sufficient program quality (PQ) data available then they will have the ability to compare results from their CI tool with their PQ tool and validate outputs by determining the relationship between compliance with health and safety rules (CI) and program quality (PQ) measures, such as the ERS’s, CLASS, CDPES, etc… This is a very important step because very few empirical demonstrations appear in the research literature regarding this relationship. This step is the third approach to validation which involves Outputs (Zellman & Fiene, 2012). It would be expected that lower correlations (.30+) would be found between CI and PQ because these tools are measuring different aspects of quality such as health & safety versus caregiver-child interactions or overall classroom quality.

The **sixth step** is for the state to generate a Key Indicator (KI) tool from the CI data base. Please see Fiene & Nixon (1985) and Fiene & Kroh (2000) for a detailed explanation of the methodology for generating a KI tool. This step is also part of the second approach to validation which involves Measures. The correlation between the CI and KI should be very high (.70+) because the KI is a subset of predictor rules taken from the CI data base. If a state did not want to use the KI methodology, a direct comparison could be drawn from The *Thirteen Indicators of Quality Child Care* (Fiene, 2002).

The **seventh step** for the state is to use the RA and KI tools together to determine overall compliance of facilities and how often and which rules will be monitored for future visits. This is the basic component of a Differential Monitoring (DM) approach and continues the second approach to validation (Measures). Also, this step should drive decisions within the technical assistance/training/professional development (PD) system in what resources are allocated to a particular facility. It would be expected that moderate correlations (.50+) would be found amongst RA, KI, DM, and PD.

The **eighth and final step** for the state is to compare the results from the various monitoring tools (CI, PQ, RA, KI) with any child development outcome (CO) data they collect. This is a relatively new area and few, if any, states at this point have this capability on a large scale. However, as Early Learning Networks and Standards are developed, this will become more common place. This step is the forth approach to validation which involves Outcomes (Zellman & Fiene, 2012). The correlations between CI, PQ, RA, KI and CO will be on the lower end (.30+) because there are so many other variables that impact children’s development other than child care facilities.

Validation is a continuous approach and is not a once and done process. States should look at their monitoring systems on an on-going basis and make the necessary adjustments as data are collected and compared in order to keep program monitoring as cost effective and efficient.
Relationship of Key Indicators (Kl), Stepping Stones (RA), and Caring for Our Children (CFOC)(CI)

The above diagram depicts the relationship amongst Kl, RA, and CI in which the full set of rules is represented by CFOC - Caring for Our Children, followed by RA which are the most critical rules represented by Stepping Stones, and finally the predictive rules represented by the 13 Key Quality Indicators.
Table 1: DMLMA® Expected Thresholds

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>PQ</th>
<th>RA</th>
<th>KI</th>
<th>DM</th>
<th>PD</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI</td>
<td>0.3</td>
<td>0.5</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>PQ</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>RA</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>KI</td>
<td>0.5</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>DM</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>PD</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

RELATED PUBLICATIONS:


For additional information, please contact:
Dr Richard Fiene, Director, Research Institute for Key Indicators, DrFiene@gmail.com; ResearchInstituteKeyIndicators@ymail.com
Figure 1: Differential Monitoring Logic Model & Algorithm (DMLMA)\(^\circledast\) Thresholds

**DMLMA\(^\circledast\) Expected Thresholds:**

*High Correlations (.70+) = CI x KI.*

*Moderate Correlations (.50+) = CI x RA; RA x DM; RA x KI; KI x DM; DM x PD.*

*Lower Correlations (.30+) = PQ x CI; PQ x CO; PQ x DM; RA x CO; KI x CO; CI x CO.*

- Licensing System – Health & Safety Rules (CI)
- Risk Assessment Tool (RA)
- Differential Monitoring (DM)
- Technical Assistance (PD)
- Child Outcomes (CO)
- Quality Rating & Improvement (QRIS) (PQ)
- Key Indicator Tool (KI)

CI Visit – less than 100% on KI & RA

KI Visit – 100% on previous KI & RA
Figure 2: Differential Monitoring Logic Model & Algorithm (DMLMA)\(^\circ\) and Validation Approaches (Zellman & Fiene, 2012)

\[
\sum CI \times \sum PQ \Rightarrow \sum RA + \sum KI \Rightarrow \sum DM + \sum PD \Rightarrow CO
\]

- (1) Standards Validation
- (2) Measures Validation
- (3) Output Validation
- (4) Outcome Validation
HUMAN SERVICES LICENSING
MEASUREMENT AND PROGRAM
MONITORING SYSTEMS

Richard Fiene, Ph.D.
Research Psychologist
RIKI/NARA
Methods for Achieving Quality Child Care

Regulatory Paradigms

DMLMA Logic Model & Validation Approaches

DMLMA Expected Thresholds

Licensing/Program Compliance (PC) and Program Quality (PQ)

Risk Assessment (RA) and Key Indicators (KI)

Differential Monitoring (DM)

Professional Development (PD) and Child Outcomes (CO)

Previous Models (ECPQIM 1 – 3)

3 Contents

Methods for Achieving Quality Child Care

GOALS

NONREGULATORY METHODS

Public Education

Training of Caregivers & Directors

Association Membership

Newsletters, Journals & Books

Resource & Referral Centers

REGULATORY METHODS

Accreditation/CFOC

Credentialing

Rate Setting

Fiscal Regulation

Quality Rating & Improvement Systems

Stepping Stones

Environmental Health

Licensing or Registration

Building & Fire Safety

Exempt Programs

Criminal Sanctions

Illegal Unlicensed Operations

Abuse & Neglectful Care

Base line or floor of quality below which no service may legally operate

Revised from YOUNG CHILDREN
Vol. 34 No. 6 Sept. 1979, pp. 22-27
Gwen G Morgan and updated by
Rick Fiene, Dec 2012.
Achieving Quality Child Care

Quality care is achieved by both regulatory and non-regulatory approaches. However, licensing provides the threshold or floor of quality below which no program should be permitted to operate.

Other regulatory approaches toward achieving quality

- **Credentialing**: A formally recognized process of certifying an individual as having fulfilled certain criteria or requisites. (PD)

- **Purchase of service contracts**: Regulation by contract in which performance standards are imposed as a contractual obligation. (PQ - QRIS)

- **Accreditation**: The formal recognition that an agency or organization has compiled with the requisites for accreditation by an accrediting body. Accreditation usually requires the organization seeking this form of recognition to pay for the cost of the process. The organization bestowing the accreditation has no legal authority to compel compliance. It can only remove accreditation. (PQ)

- **Best Practices**: Through affiliation with professional organizations, an agency becomes aware of “best practices” and establishes its own goals to achieve a higher level of care services. (PQ – CFOC)
Non-regulatory approaches to achieving quality care in human services facilities or programs

- Consultation
- Consumer Education
- Peer Support Associations
- Professional Organizations
- Resource and Referral
- Technical Assistance
- Mentoring/Coaching
- Training-Staff Development

Relationship between PC (CI) & PQ

\[ y = 0.0453x + 0.2246 \]

\[ R^2 = 0.8983 \]

PC = % Rule Compliance
Comparing HSPS Violations with CLASS Scores (Fiene, 2013c)

<table>
<thead>
<tr>
<th>HSPS/CM Violations</th>
<th>IS</th>
<th>ES</th>
<th>CO</th>
<th>Number/Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Full Compliance)</td>
<td>3.03</td>
<td>5.99</td>
<td>5.59</td>
<td>75/19%</td>
</tr>
<tr>
<td>1-2 (Substantial Compliance)</td>
<td>3.15</td>
<td>5.93</td>
<td>5.30</td>
<td>135/35%</td>
</tr>
<tr>
<td>3-8 (Mid-Compliance)</td>
<td>2.87</td>
<td>5.85</td>
<td>5.37</td>
<td>143/40%</td>
</tr>
<tr>
<td>9-19 (Lower Compliance)</td>
<td>2.65</td>
<td>5.71</td>
<td>5.32</td>
<td>28/6%</td>
</tr>
<tr>
<td>20-25 (Lowest Compliance)</td>
<td>2.56</td>
<td>5.52</td>
<td>4.93</td>
<td>3/1%</td>
</tr>
</tbody>
</table>

Significance: $F = 4.92; p < .001$  
$F = 4.918; p < .001$  
$F = 4.174; p < .003$

CM Violations = Compliance Measure Violations (lower score = higher compliance)/higher score = lower compliance)  
IS = Average CLASS IS (Instructional Support) Score  
ES = Average CLASS ES (Emotional Support) Score  
CO = Average CLASS CO (Classroom Organisation) Score  
#/% = Number of programs and Percent of programs at each level of compliance

PC & PQ Comparison of CC and PK (Fiene, 2013e)

PC = Child Care Licensing Compliance  
- **Licensing / ECERS-R**  
  - 100 / 3.40 Full Compliance  
  - 99 / 4.35  
  - 98 / 3.89 Substantial Compliance  
  - 97 / 3.15  
  - 96 / 3.16  
  - 95 / 3.53  
  - 90 / 2.56 Medium Compliance  
  - 80 / 2.38 Low Compliance

PQ = Pre-K Program Licensing Compliance  
- **Licensing / ECERS-R**  
  - 100 / 4.88 Full Compliance  
  - 99 / 4.13  
  - 98 / 4.38 Substantial Compliance  
  - 97 / 3.99  
  - 96 / 4.36  
  - 95 / 4.60  
  - 90 / 3.43 Medium Compliance  
  - 80 / 2.56 Low Compliance
Impact of PK on ECERS

Least Squares Means

ECERS PRE-K & Licensing Scores
ECERS Child Care & Licensing Scores

ECERS PRE-K Distribution
ECERS Child Care Distribution

![ECERS Child Care Distribution Graph]

Licensing Scores for PRE-K

![Licensing Scores for PRE-K Graph]
Licensing Scores for Child Care

Impact of Pre-K & Higher Standards

- Pre-K only ECERS average = 4.15
  - These are classrooms funded by Pre-K.
- Pre-K’s impact on child care, ECERS average = 3.60
  - These are classrooms not funded by Pre-K but in the same building as a Pre-K funded classroom.
- Child care only ECERS average = 3.26
  - These are classrooms in programs that are not funded by Pre-K.
Impact of Pre-K on ECERS Scores

CC w/ & w/o Pre-K with ECERS Scores

Two-sample t-test
PQ = \frac{ERS}{CLASS}

PC = \% Rule Compliance

Relationship between PC (CI) & PQ

(Fiene & Nixon, 1985) (Fiene, 1985) (Fiene, 2013e)

Eliminate the Plateau Effect

PC = \% Rule Compliance

Regulatory Paradigms

Absolute (Class, 1957)

- All rules are created equal.
- 100\% Compliance = Full License.
- PC + PQ = Linear.
- All rules are reviewed all the time.

Relative/Differential (Fiene, 1985)

- All rules are not created equal.
- Substantial Compliance = Full License.
- PC + PQ = Not Linear.
- Selected key rules are reviewed all the time.
**DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM (DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model**

CI x PQ => RA + KI => DM + PD => CO

Definitions of Key Elements:
- CI = Comprehensive Licensing Tool (Health and Safety) [Caring for Our Children]
- PQ = ECERS-R, FDCRS-R, CLASS, CDPES (Caregiver/Child Interactions/Classroom Environment)
- RA = Risk Assessment, (High Risk Rules) [Stepping Stones]
- KI = Key Indicators (Predictor Rules) [13 Key Indicators of Quality Child Care]
- DM = Differential Monitoring, (How often to visit and what to review)
- PD = Professional Development/Technical Assistance/Training
- CO = Child Outcomes (See next slide for PD and CO key elements)

\[
CI \times PQ \Rightarrow RA + KI \Rightarrow DM + PD \Rightarrow CO
\]

Definitions of Key Elements:

- **CI** = Comprehensive Licensing Tool (Health and Safety) (Caring for Our Children) (Structural Quality)
- **PQ** = Program Quality Initiatives (ECERS-R, FDCRS-R, CLASS, CSRELS, QRIS, Accreditation) (Process Quality)
- **PD** = Program Quality Initiatives (cont) - Professional Development/Technical Assistance/Training
- **RA** = Risk Assessment, (High Risk Rules/Standards) (Stepping Stones)
- **KI** = Key Indicators (Predictor Rules/Standards) (13 Key Indicators of Quality Child Care)
- **DM** = Differential Monitoring, (How often to visit and what to review)
- **CO** = Child Outcomes (Developmental, Health, & Safety Outcomes)
**Early Childhood Program Quality Indicator Model (ECPQIM4©):**

Differential Monitoring Logic Model (DMLM©)(Fiene, 2014)

- **Program Compliance (PC)**
  - Full Licensing Visit
  - Comprehensive Instrument (CI)
  - Health & Safety
  - Structural Quality
  - Eg: Caring for Our Children (CFOC)

- **Program Quality (PQ) Initiatives:**
  - Quality Rating & Improvement (QRIS)
  - Professional Development (PD)
  - Early Learning System (ELS)
  - Process Quality
  - Eg: CLASS/ERS’s (ECERS, FDCRS)

- **Key Indicators (KI) – Abbreviated Visit**
  - Statistical predictor rules/standards that predict overall compliance with rules or standards.
  - Eg: 13 Indicators of Quality Child Care

- **Risk Assessment (RA) – Abbreviated Visit**
  - Weighting of Rules or Standards
  - Places children at greatest risk of mortality or morbidity if non-compliance found.
  - Eg: Stepping Stones to CFOC

- **Differential Monitoring (DM):** How often to visit – More or Less? And what is reviewed – More or Less? Time saved on the compliant programs can be used with the non-compliant programs. This should create a more cost effective and efficient program monitoring system with targeted reviews which should ultimately lead to better outcomes (CO) for the children and their families served in the programs.

---

**Differential Monitoring Scoring Protocol (DMSP)©**

<table>
<thead>
<tr>
<th>Score</th>
<th>Systems Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systems in place.</td>
</tr>
<tr>
<td>2</td>
<td>KI or RA in place and not linked.</td>
</tr>
<tr>
<td>4</td>
<td>(KI &amp; RA in place but not linked) or (PC + PQ are linked).</td>
</tr>
<tr>
<td>6</td>
<td>(KI &amp; RA in place) &amp; (KI + RA are linked).</td>
</tr>
<tr>
<td>8</td>
<td>(KI &amp; RA in place but not linked) &amp; ((PC + PQ) are linked).</td>
</tr>
<tr>
<td>10</td>
<td>All systems in place and linked.</td>
</tr>
</tbody>
</table>
### Differential Monitoring Scoring Protocol (DMSP)©

**Point Assignment**

<table>
<thead>
<tr>
<th>Score</th>
<th>Systems Present and Point Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systems in place.</td>
</tr>
<tr>
<td>2</td>
<td>(KI (1)) &amp; (KI -&gt; DM (1)) or ((RA (1)) &amp; (RA -&gt; DM (1)))</td>
</tr>
<tr>
<td>4</td>
<td>(PC + PQ (4)) or (KI (1) &amp; (KI -&gt; DM (1)) &amp; (RA (1) &amp; (RA -&gt; DM (1)))</td>
</tr>
<tr>
<td>6</td>
<td>(KI + RA -&gt; DM (4)) &amp; (KI (1)) &amp; (RA (1))</td>
</tr>
<tr>
<td>8</td>
<td>(KI (2) &amp; RA (2)) &amp; (PC + PQ (4)).</td>
</tr>
<tr>
<td>10</td>
<td>(KI + RA -&gt; DM (4)) &amp; (KI (1)) &amp; (RA (1)) &amp; (PC + PQ (4))</td>
</tr>
</tbody>
</table>

KI (Key Indicators); RA (Risk Assessment); PC (Program Compliance/Licensing); PQ (Program Quality Initiatives; DM (Differential Monitoring).
### Program Monitoring

**Effectiveness/Efficiency Relationship**

<table>
<thead>
<tr>
<th>SYSTEMS (pts)</th>
<th>MODEL</th>
<th>GA</th>
<th>NY</th>
<th>HS</th>
<th>IL</th>
<th>KS</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>KI (1)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RA (1)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>KI + RA -&gt; DM (4)</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KI + RA (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC + PQ (4)</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KI -&gt; DM (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RA -&gt; DM (1)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL (10)</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

- **Effectiveness (blue)/Efficiency (gold)**

![Graph showing the relationship between effectiveness and efficiency](image)

**How Important** vs **How Much in Resources**

- Effectiveness generally decreases as the amount of resources increases.
- The graph illustrates the trade-off between the two metrics.
The Licensing Law:
All Rules that are promulgated based upon the Law

Compliance Decision:
100% compliance with all rules all the time.

Compliance Decision:
Substantial (96-99%) but not 100% compliance with all rules all the time.

Key Indicators are ok to use.
Risk Assessment cannot be used.
Key Indicators are ok to use.
Risk Assessment ok to use.

The above diagram depicts the relationship amongst KI, RA, and CI in which the full set of rules is represented by CFOC - Caring for Our Children, followed by RA which are the most critical rules represented by Stepping Stones, and finally the predictive rules represented by the 13 Key Quality Indicators.
Relationship of Health and Safety Rules/Regulations, Standards, and Guidelines in Early Care and Education

Validation Approaches (Zellman & Fiene, 2012)

- **First Approach (Standards)**
  - CI \times Caring for Our Children/Stepping Stones/13 Key Indicators of Quality Child Care

- **Second Approach (Measures)**
  - CI \times RA + KI \times DM

- **Third Approach (Outputs)**
  - PQ \times CI

- **Fourth Approach (Outcomes)**
  - CO = PD + PQ + CI + RA + KI
## DMLMA© Expected Thresholds

### Key Elements Examples
- CI x KI
- RA x CI; RA x DM; RA x KI; DM x KI; DM x PD
- PQ x CI; PQ x CO; RA x CO; KI x CO; CI x CO

### DMLMA Expected Thresholds Matrix*

<table>
<thead>
<tr>
<th></th>
<th>PQ</th>
<th>RA</th>
<th>KI</th>
<th>DM</th>
<th>PD</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI</td>
<td>0.3</td>
<td>0.5</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
<td>NS</td>
</tr>
<tr>
<td>PQ</td>
<td></td>
<td></td>
<td></td>
<td>0.3</td>
<td>0.3</td>
<td>NS</td>
</tr>
<tr>
<td>RA</td>
<td></td>
<td></td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>KI</td>
<td></td>
<td></td>
<td></td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>DM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.4</td>
</tr>
</tbody>
</table>
Interpretation of Inter-Correlations

- Based upon recent research, the relationships between H&S (CI)(PC) and QRIS (PQ) standards and Child Outcomes (CO) is difficult to find significance.

- The relationship between Professional Development (PD) and staff interactions with Child Outcomes (CO) appear to be the significant relationship that should be explored as a Quality Intervention.

- If we want to explore H&S and QRIS standards significant relationships we may need to look at children's health & safety outcomes.

A Validation Study: State Example (Fiene, 2013e)

<table>
<thead>
<tr>
<th>Validation Approach/Research Question</th>
<th>CCC Actual (Expected*)</th>
<th>FCC Actual (Expected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 STANDARDS/Key Indicators</td>
<td>VALIDATED</td>
<td>VALIDATED</td>
</tr>
<tr>
<td>KI x CR</td>
<td>.49 (.50+)</td>
<td>.57 (.50+)</td>
</tr>
<tr>
<td>KI x LS</td>
<td>.78 (.70+)</td>
<td>.87 (.70+)</td>
</tr>
<tr>
<td>2 MEASURES/Core Rules/ACDW</td>
<td>VALIDATED</td>
<td>VALIDATED</td>
</tr>
<tr>
<td>CR x LS</td>
<td>.69 (.50+)</td>
<td>.74 (.50+)</td>
</tr>
<tr>
<td>CR x ACDW</td>
<td>.76 (.50+)</td>
<td>.70 (.50+)</td>
</tr>
<tr>
<td>3 OUTPUTS/Program Quality</td>
<td>VALIDATED</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>ECERS-R/PS x LS</td>
<td>.37 (.30+)</td>
<td>FDCRS x LS</td>
</tr>
<tr>
<td>ECERS-R/PS x LS</td>
<td>.29 (.30+)</td>
<td>FDCRS x CR</td>
</tr>
<tr>
<td>ECERS-R/PS x CR</td>
<td>.33 (.30+)</td>
<td>---</td>
</tr>
<tr>
<td>ECERS-R/PS x CR</td>
<td>.34 (.30+)</td>
<td>---</td>
</tr>
</tbody>
</table>

*See below for the expected r values for the DMLMA© thresholds which indicate the desired correlations between the various tools.

**DMLMA© Thresholds**
- High correlations (.70+) = LS x KI.
- Moderate correlation (.50+) = LS x CR; CR x ACDW; CR x KI; KI x ACDW.
- Lower correlation (.30+) = PQ x LS; PQ x CR; PQ x KI.
## Validation of Key Indicator Systems

### Figure 1

<table>
<thead>
<tr>
<th></th>
<th>Providers who fail the Key Indicator review</th>
<th>Providers who pass the Key Indicator review</th>
<th>Raw Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers who fail the Comprehensive review</td>
<td>W</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Providers who pass the Comprehensive Review</td>
<td>Y</td>
<td>Z</td>
<td></td>
</tr>
<tr>
<td>Column Totals</td>
<td></td>
<td></td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

### Annotations for Figure 1

- A couple of annotations regarding Figure 1.
- **W + Z** = the number of agreements in which the provider passed the Key Indicator review and also passed the Comprehensive review.
- **X** = the number of providers who passed the Key Indicator review but failed the Comprehensive review. This is something that should not happen, but there is always the possibility this could occur because the Key Indicator Methodology is based on statistical methods and probabilities. We will call these False Negatives (FN).
- **Y** = the number of providers who failed the Key Indicator review but passed the Comprehensive review. Again, this can happen but is not as much of a concern as with “**X**”. We will call these False Positives (FP).
National Validation Data

Figure 2

<table>
<thead>
<tr>
<th></th>
<th>Providers who fail the Key Indicator review</th>
<th>Providers who pass the Key Indicator review</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers who fail the Comprehensive review</td>
<td>25</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Providers who pass the Comprehensive Review</td>
<td>7</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>Column Total</td>
<td>32</td>
<td>18</td>
<td>50</td>
</tr>
</tbody>
</table>

Formula for Agreement Ratio

To determine the agreement ratio, we use the following formula:

\[ \frac{A}{A + D} \]

Where \( A \) = Agreements and \( D \) = Disagreements.

Based upon Figure 2, \( A + D = 42 \) which is the number of agreements; while the number of disagreements is represented by \( B = 1 \) and \( C = 7 \) for a total of 8 disagreements. Putting the numbers into the above formula:

\[ \frac{42}{42 + 8} \]

Or

\[ .84 = \text{Agreement Ratio} \]

The False Positives (FP) ratio is .14 and the False Negatives (FN) ratio is .02. Once we have all the ratios we can use the ranges in Figure 3 to determine if we can validate the Key Indicator System. The FP ratio is not used in Figure 3 but is part of the Agreement Ratio.
Thresholds for Validating Key Indicators for Licensing Rules

- **Agreement Ratio Range**  |  **False Negative Range**  |  **Decision**  
- (1.00) – (.90)  |  .05+  |  Validated  
- (.89) – (.85)  |  .10 - .06  |  Borderline  
- (.84) – (.00)  |  .11 or more  |  Not Validated  

Differential Monitoring Model

- **Key Elements**
  - **Program Compliance (PC)** generally represented by a state’s child care licensing health & safety system or at the national level by *Caring for Our Children*.
  - **Program Quality (PQ)** generally represented by a state’s QRIS, or at the national level by Accreditation (*NAEYC, NECPA*), *Head Start Performance Standards, Environmental Rating Scales, CLASS*, etc..
  - **Risk Assessment (RA)** generally represented by a state’s most critical rules in which children are at risk of mortality or morbidity, or at the national level by *Stepping Stones*. 
Differential Monitoring Model (cont)

- **Key elements (continued)**
  - **Key Indicators (KI)** generally represented by a state’s abbreviated tool of statistically predictive rules or at the national level by *13 Indicators of Quality Child Care* and NACCRRA’s *We CAN Do Better Reports*.
  - **Professional Development (PD)** generally represented by a state’s technical assistance/training/professional development system for staff.
  - **Child Outcomes (CO)** generally represented by a state’s *Early Learning Network Standards*.

Differential Monitoring Benefits

- **Differential Monitoring (DM)** benefits to the state are the following:
  - Systematic way of tying distinct state systems together into a cost effective & efficient unified valid & reliable logic model and algorithm.
  - Empirical way of reallocating limited monitoring resources to those providers who need it most.
  - Data driven to determine how often to visit programs and what to review, in other words, should a comprehensive or abbreviated review be completed.
Program Compliance/Licensing (CI)(PC)

- These are the comprehensive set of rules, regulations or standards for a specific service type.
  - Caring for Our Children (CFOC) is an example.
  - Head Start Performance Standards is an example.
- Program meets national child care benchmarks from NACCRA’s We CAN Do Better Report.
- No complaints registered with program.
- Substantial to full compliance with all rules.

Advantages of Instrument Based Program Monitoring (IPM)

- Cost Savings
- Improved Program Performance
- Improved Regulatory Climate
- Improved Information for Policy and Financial Decisions
- Quantitative Approach
- State Comparisons
## State Example of Violation Data (Fiene, 2013d)

### Violation Data in Centers and Homes by Regional Location

<table>
<thead>
<tr>
<th>Region</th>
<th>Centers</th>
<th>Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Violations*</td>
<td>Number</td>
</tr>
<tr>
<td>1</td>
<td>9.30</td>
<td>109</td>
</tr>
<tr>
<td>2</td>
<td>8.32</td>
<td>191</td>
</tr>
<tr>
<td>3</td>
<td>5.31</td>
<td>121</td>
</tr>
<tr>
<td>4</td>
<td>3.57</td>
<td>61</td>
</tr>
</tbody>
</table>

* = Average (Means)

### Violation Data in Centers and Homes by Type of Licensing Inspection

<table>
<thead>
<tr>
<th>License Type</th>
<th>Centers</th>
<th>Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Violations*</td>
<td>Number</td>
</tr>
<tr>
<td>Initial</td>
<td>7.44</td>
<td>36</td>
</tr>
<tr>
<td>Renewal</td>
<td>7.07</td>
<td>368</td>
</tr>
<tr>
<td>Amendment</td>
<td>9.51</td>
<td>55</td>
</tr>
<tr>
<td>Correction</td>
<td>6.71</td>
<td>14</td>
</tr>
<tr>
<td>Temporary</td>
<td>11.22</td>
<td>9</td>
</tr>
</tbody>
</table>

* = Average (Means)

## Head Start: Content Area Correlations (Fiene, 2013c)

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th>ERSEA</th>
<th>FCE</th>
<th>FIS</th>
<th>GOV</th>
<th>SYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDE</td>
<td>.33**</td>
<td>.26**</td>
<td>.06ns</td>
<td>.14**</td>
<td>.13*</td>
<td>.33**</td>
</tr>
<tr>
<td>CHS</td>
<td>.29**</td>
<td>.18**</td>
<td>.09ns</td>
<td>.25**</td>
<td>.51**</td>
<td></td>
</tr>
<tr>
<td>ERSEA</td>
<td>.15**</td>
<td>.10*</td>
<td>.27**</td>
<td>.38**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCE</td>
<td>.01ns</td>
<td>.17**</td>
<td>.23**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIS</td>
<td></td>
<td>.13*</td>
<td>.23**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOV</td>
<td></td>
<td></td>
<td>.38**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
International Study of Child Care Rules (Fiene, 2013a)

USA vs World

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Countries</th>
<th>USA</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACR (R1)</td>
<td>1.1220</td>
<td>0.8462</td>
<td>not significant</td>
</tr>
<tr>
<td>GS (R2)</td>
<td>0.4063</td>
<td>0.5865</td>
<td>not significant</td>
</tr>
<tr>
<td>Director (R3)</td>
<td>1.5655</td>
<td>0.0000</td>
<td>t = 7.100, p &lt; .0001</td>
</tr>
<tr>
<td>Teacher (R4)</td>
<td>1.6563</td>
<td>0.0000</td>
<td>t = 7.632, p &lt; .0001</td>
</tr>
<tr>
<td>Preservice (R5)</td>
<td>0.9375</td>
<td>1.6731</td>
<td>t = 4.989, p &lt; .001</td>
</tr>
<tr>
<td>Inservice (R6)</td>
<td>0.6563</td>
<td>1.0481</td>
<td>t = 2.534, p &lt; .02</td>
</tr>
<tr>
<td>Clearances (R7)</td>
<td>0.6094</td>
<td>1.2404</td>
<td>t = 3.705, p &lt; .01</td>
</tr>
<tr>
<td>Development (R8)</td>
<td>1.6406</td>
<td>1.4519</td>
<td>not significant</td>
</tr>
<tr>
<td>Health (R9)</td>
<td>0.9844</td>
<td>1.7404</td>
<td>t = 6.157, p &lt; .0001</td>
</tr>
<tr>
<td>Parent (R10)</td>
<td>1.6020</td>
<td>1.2085</td>
<td>not significant</td>
</tr>
</tbody>
</table>

Parent = Parent involvement (R10)
Health = Health and safety recommendations (R9)
Development = Six developmental domains (R8)
Clearances = Background checks (R7)
Inservice = 24 hours of ongoing training (R6)
Preservice = Initial orientation training (R5)
Teacher = Lead teacher has CDA or Associate degree (R4)
Director = Directors have bachelor's degree (R3)
GS = Group size NAEYC Accreditation Standards met (R2)
ACR = Staff/child ratios NAEYC Accreditation Standards met (R1)
Program Quality (PQ)

- Generally Quality Rating and Improvement Systems (QRIS) and/or Accreditation systems either used separately or together.
- Program has attained at least a 5 on the various ERS’s or an equivalent score on the CLASS.
- Program has moved through all the star levels within a five year timeframe.
- Percent of programs that participate.
- Generally PQ builds upon PC/Licensing system.

Keystone STARS ECERS Comparisons to Previous Early Childhood Quality Studies (Barnard, Smith, Fiene & Swanson (2006))
### ECERS/FDCRS By Type of Setting (Fiene, et al. 2002)

- **Head Start**: 4.9
- **Preschool**: 4.3
- **Child Care Centers**: 3.9
- **Group Child Care Homes**: 4.1
- **Family Child Care Homes**: 3.9
- **Relative/Neighbor Care**: 3.7

### ECERS Distribution By Type of Service—Head Start (HS), Child Care Center (CC), Preschool (PS)

<table>
<thead>
<tr>
<th></th>
<th>HS</th>
<th>CC</th>
<th>PS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>8%</td>
<td>62%</td>
<td>35%</td>
</tr>
<tr>
<td>(3.99 or less)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>46%</td>
<td>23%</td>
<td>44%</td>
</tr>
<tr>
<td>(4.00–4.99)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>46%</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>(5.00 or higher)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ECERS/FDCRS and Education of the Provider

- High School Diploma (24%) 3.8
- Some College (24%) 4.1
- Associate’s Degree (17%) 4.2
- Bachelor’s Degree (31%) 4.3
- Master’s Degree (4%) 4.7

NECPA/ERS’s/QRIS (Fiene, 1996)

<table>
<thead>
<tr>
<th>STAR 1</th>
<th>STAR 2</th>
<th>STAR 1 and 2 Combined</th>
<th>STAR 3</th>
<th>STAR 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>NECPA Score (without Infant/Toddler Section)</td>
<td>n = 21</td>
<td>Mean = 647.04 Range: 408.99 to 887.54 s.d.: 163.79</td>
<td>n = 25</td>
<td>Mean = 647.21 Range: 365.84 to 887.54 s.d.: 168.69</td>
</tr>
<tr>
<td>ECERS-R Score</td>
<td>n = 20</td>
<td>Mean = 3.92 Range: 2.40 to 5.68 s.d.: .97</td>
<td>n = 24</td>
<td>Mean = 3.86 Range: 2.40 to 5.68 s.d.: .869</td>
</tr>
<tr>
<td>NECPA Score (Infant/Toddler Only)</td>
<td>n = 9</td>
<td>Mean = 83.50 Range: 59 to 138 s.d.: 30.81</td>
<td>n = 1</td>
<td>Mean = 79.0</td>
</tr>
<tr>
<td>ITERS-R</td>
<td>n = 9</td>
<td>Mean = 3.72 Range: 2.81 to 5.22 s.d.: .706</td>
<td>n = 1</td>
<td>Mean = 5.01</td>
</tr>
</tbody>
</table>
PC/PQ Conceptual Similarities

- 100% Compliance with child care health & safety rules = QRIS Block System.
- Substantial but not 100% Compliance with child care health & safety rules = QRIS Point.
- Both Licensing (PC) and QRIS (PQ) use rules/standards to measure compliance. Licensing rules are more structural quality while QRIS standards have a balance between structural and process quality.

Determining Compliance

- Risk assessment
  - Identify requirements where violations pose a greater risk to children, e.g., serious or critical standards
  - Distinguish levels of regulatory compliance
  - Determine enforcement actions based on categories of violation
  - Stepping Stones to Caring for Our Children is an example of risk assessment (AAP/APHA/NRC, 2013)
- Key indicators
  - Identify a subset of regulations from an existing set of regulations that statistically predict compliance with the entire set of regulations
  - Based on work of Dr. Richard Fiene (2002) – 13 indicators of quality
  - “Predictor rules”

National Center on Child Care Quality Improvement, Office of Child Care
**Risk Assessment (RA)**

- Risk Assessment (RA) are those rules which place children at greatest risk of mortality or morbidity.
- *Stepping Stones* is an example of Risk Assessment Tool and Approach.
- When Risk Assessment (RA) and Key Indicators (KI) described in the next slide are used together, most cost effective and efficient approach to program monitoring.
- 100% compliance with RA rules.

---

**State Example of Risk Assessment Tool**

<table>
<thead>
<tr>
<th>Core Rules</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diapering</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discipline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant Sleep Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Plant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playgrounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff:Child Ratios</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swimming</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field Trips</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS**

- **TOTAL LOW:**
- **TOTAL MEDIUM:**
- **TOTAL HIGH:**

**ANNUAL COMPLIANCE DETERMINATION**

*Compliance:* 0 or 1 core rule category of Low risk, and/or No more than 2 core rule categories of Medium risk, or 1 Medium and 1 High risk

*Not Compliant:* 6 or more core rule categories of Low and/or 3 or more Medium risk, and/or 2 or more core rule categories of High risk
RA Example = Stepping Stones

13 Key Indicators/Stepping Stones
Crosswalk with State Rules Template

<table>
<thead>
<tr>
<th>13 Indicators/Stepping Stones Standard</th>
<th>State Licensing Rule Analysis</th>
<th>Analysis Clarification</th>
<th>Recommendation</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key Indicators (KI) (Fiene & Nixon, 1985)

- Key Indicators are predictor rules that statistically predict overall compliance with all rules.
- *13 Indicators of Quality Child Care* is an example of this approach.
- Most effective if KI are used with the Risk Assessment (RA) approach described on the previous slide.
- Must be 100% compliance with key indicator rules.

Advantages of Key Indicators

- Quality of Licensing is maintained.
- Balance between program compliance and quality.
- Cost savings.
- Predictor rules can be tied to child outcomes.
Pre-Requisites for Key Indicators

- Licensing rules must be well written, comprehensive, and measureable.
- There must be a measurement tool in place to standardize the application and interpretation of the rules.
- At least one year’s data should be collected.

How to Develop Key Indicators

- Collect data from 100-200 providers that represent the overall delivery system in the state.
- Collect violation data from this sample and sort into high (top 25%) and low (bottom 25%) compliant groups.
- Statistical predictor rules based upon individual compliance.
- Add additional rules.
- Add random rules.
Criteria for Using Key Indicators

- The facility had:
  - A regular license for the previous two years
  - The same director for the last 18 months
  - No verified complaints within the past 12 months
  - The operator has corrected all regulatory violations cited within 12 months prior to inspection
  - A full inspection must be conducted at least every third year
  - Not had a capacity increase of more than 10 percent since last full inspection
  - A profile that does not reveal a pattern of repeated or cyclical violations
  - No negative sanction issued within the past 3 years

Key Indicator Systems Summary

1980 - 2010
- Time savings only.
- Child care mostly.
- Child care benchmarking.
- Substantial compliance.
- Safeguards.
- Tied to outcomes study.
- Adult residential – PA.
- Child residential – PA.
- Risk assessment/weighting.

2011+
- Time and cost savings.
- All services.
- Benchmarks in all services.
- CC national benchmarks.
- Safeguards.
- Tied to outcomes study.
- National benchmarks.
- Inter-National benchmarks.
- Risk assessment/DMLMA.
Key Indicator/Non-Compliance Relationship

Key Indicator (blue)/Non-Compliance (gold)

Effective Efficient

Providers In Compliance with specific standard | Programs Out Of Compliance with specific standard | Row Total
--- | --- | ---
High Group = top 25% | A | B | Y
Low Group = bottom 25% | C | D | Z
Column Total | W | X | Grand Total

Use data from this matrix in the formula on the next slide in order to determine the phi coefficients.
Key Indicator Matrix Expectations

- $A + D > B + C$
- $A + D = 100\%$ is the best expectation possible.
- If $C$ has a large percentage of hits, it increases the chances of other areas of non-compliance (False positives).
- If $B$ has a large percentage of hits, the predictive validity drops off considerably (False negatives).

Key Indicator Statistical Methodology

$$\phi = \frac{(A)(D)-(B)(C)}{\sqrt{(W)(X)(Y)(Z)}}$$

$A$ = High Group + Programs in Compliance on Specific Compliance Measure.
$B$ = High Group + Programs out of Compliance on Specific Compliance Measure.
$C$ = Low Group + Programs in Compliance on Specific Compliance Measure.
$D$ = Low Group + Programs out of Compliance on Specific Compliance Measure.

$W$ = Total Number of Programs in Compliance on Specific Compliance Measure.
$X$ = Total Number of Programs out of Compliance on Specific Compliance Measure.
$Y$ = Total Number of Programs in High Group.
$Z$ = Total Number of Programs in Low Group.
### Key Indicator Coefficient Ranges

<table>
<thead>
<tr>
<th>KI Coefficient Range</th>
<th>Characteristic of Indicator</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+1.00) – (+.26)</td>
<td>Good Predictor - Licensing</td>
<td>Include</td>
</tr>
<tr>
<td>(+1.00) – (+.76)</td>
<td>Good Predictor – QRIS</td>
<td>Include</td>
</tr>
<tr>
<td>(+.25) – (-.25)</td>
<td>Unpredictable – Licensing</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(+.75) – (-.25)</td>
<td>Unpredictable – QRIS</td>
<td>Do not Include</td>
</tr>
<tr>
<td>(-.26) – (-1.00)</td>
<td>Terrible Predictor</td>
<td>Do not Include</td>
</tr>
</tbody>
</table>

### Examples of Key Indicator Applications

- Health and Safety Licensing Key Indicators.
- Stepping Stones Key Indicators
- Office of Head Start Key Indicators.
- Accreditation Key Indicators – NECPA – National Early Childhood Program Accreditation.
- Environmental Rating Scale Key Indicators – Centers.
- Environmental Rating Scale Key Indicators – Homes.
- Caregiver Interaction Scale Key Indicators.
- Quality Rating & Improvement System Key Indicators – QualiStar.
- Footnote: Child & Adult Residential Care Key Indicators.
- Footnote: Cruising Industry in general and Royal Caribbean in particular.
Examples of Health & Safety Key Indicators

- Program is hazard free in-door and out-doors.
- Adequate supervision of children is present.
- Qualified staff.
- CPR/First Aid training for staff.
- Hazardous materials are inaccessible to children.
- Staff orientation and training.
- Criminal Record Checks.
- Ongoing monitoring of program
- Child immunizations

Caring for Our Children Basics (2015)

- Stepping Stones 3 (2013)
- Senate Bill 1086 (2014)
- Notice for Proposed Rule Making to Amend CCDF Regulations (2013)
- 27 Indicators from Head Start Program Standards (2014)
- 15 Key Indicators from Stepping Stones 3 (Fiene)(2013)
- 77 Observable Health and Safety Standards for Early Care and Education Providers from Caring for Our Children (Alkon)(2014)
Federal Legislation

- In the House of Representatives, U. S., September 15, 2014. Resolved, That the bill from the Senate (S. 1086) entitled “An Act to reauthorize and improve the Child Care and Development Block Grant Act of 1990, and for other purposes.”, do pass with the following

- SECTION 1. SHORT TITLE. 1 This Act may be cited as the “Child Care and Development Block Grant Act of 2014”.

QRIS Key Indicators – CO. QualiStar

- The program provides opportunities for staff and families to get to know one another.
- Families receive information on their child’s progress on a regular basis, using a formal mechanism such as a report or parent conference.
- Families are included in planning and decision making for the program.
The Key Indicators from *Stepping Stones* (3rd Edition)

- 1.1.1.2 - Ratios for Large Family Child Care Homes and Centers
- 1.3.1.1 - General Qualifications of Directors
- 1.3.2.2 - Qualifications of Lead Teachers and Teachers
- 1.4.3.1 - First Aid and CPR Training for Staff
- 1.4.5.2 - Child Abuse and Neglect Education
- 2.2.0.1 - Methods of Supervision of Children
- 3.2.1.4 - Diaper Changing Procedure
- 3.2.2.2 - Handwashing Procedure
- 3.4.3.1 - Emergency Procedures
- 3.4.4.1 - Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
- 3.6.3.1 - Medication Administration
- 5.2.7.6 - Storage and Disposal of Infectious and Toxic Wastes
- 6.2.3.1 - Prohibited Surfaces for Placing Climbing Equipment
- 7.2.0.2 - Unimmunized Children
- 9.2.4.5 - Emergency and Evacuation Drills/Exercises Policy

Development of Head Start Key Indicators

- Interest in streamlining the monitoring protocol – Tri-Annual Reviews.
- Selected a representative sample from the overall Head Start data base.
- The Head Start monitoring system is an excellent candidate for developing key indicators and differential monitoring system:
  - Highly developed data system to track provider compliance history.
  - Well written, comprehensive standards.
  - Monitoring Protocols in place for collecting data.
  - Risk assessment system in use.
  - Program quality (CLASS) data collected.
- Example of a national system using key indicators.
- Head Start has all the key elements present from the Differential Monitoring Model as presented earlier.
**Head Start Key Indicators (Fiene, 2013c)**

<table>
<thead>
<tr>
<th>CM</th>
<th>Phi</th>
<th>ES</th>
<th>CO</th>
<th>IS</th>
<th>Total Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDP4.1</td>
<td>.28***</td>
<td>.10*</td>
<td>ns</td>
<td>ns</td>
<td>.30***</td>
</tr>
<tr>
<td>CHS1.1</td>
<td>.39***</td>
<td>.15**</td>
<td>.16**</td>
<td>ns</td>
<td>.39***</td>
</tr>
<tr>
<td>CHS1.2</td>
<td>.33***</td>
<td>.18**</td>
<td>.15**</td>
<td>.10*</td>
<td>.36***</td>
</tr>
<tr>
<td>CHS2.1</td>
<td>.49***</td>
<td>.18**</td>
<td>.15**</td>
<td>ns</td>
<td>.54***</td>
</tr>
<tr>
<td>CHS3.10</td>
<td>.39***</td>
<td>.11*</td>
<td>.11*</td>
<td>ns</td>
<td>.24***</td>
</tr>
<tr>
<td>PRG2.1</td>
<td>.31***</td>
<td>.11*</td>
<td>ns</td>
<td>ns</td>
<td>.46***</td>
</tr>
<tr>
<td>SYS2.1</td>
<td>.47***</td>
<td>.15**</td>
<td>.16**</td>
<td>.14**</td>
<td>.55***</td>
</tr>
<tr>
<td>SYS3.4</td>
<td>.58***</td>
<td>.13*</td>
<td>.10*</td>
<td>ns</td>
<td>.36***</td>
</tr>
</tbody>
</table>

* P < .05  
** p < .01  
*** p< .001

**Head Start Key Indicators Sample Content**

<table>
<thead>
<tr>
<th>CD64.1</th>
<th>The program hires teachers who have the required qualifications, training, and experience. 1304.33(f), 644A(h)(1), 644A(h)(3)(A), 644A(h)(3)(B), 644A(h)(3)(C), 644A(h)(3)(D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS1.1</td>
<td>The program engages parents in obtaining from a health care professional a determination of whether each child is up to date on a schedule of primary and preventive health care (including dental) and assists parents in bringing their children up to date when necessary and keeping them up to date as required. 1304.20(a)(1)(ii), 1304.20(a)(1)(ii)(A), 1304.20(a)(1)(ii)(B)</td>
</tr>
<tr>
<td>CHS1.3</td>
<td>The program ensures that each child with a known, observable, or suspected health, oral health, or developmental problem receives follow-up and further testing, examinations, and treatment from a licensed or certified health care professional. 1304.20(a)(1)(iii), 1304.20(a)(1)(iv), 1304.20(c)(3)(ii)</td>
</tr>
<tr>
<td>CHS1.9</td>
<td>The program, in collaboration with each child's parent, performs or obtains the required linguistically and age-appropriate screenings to identify concerns regarding children within 45 calendar days of entry into the program, obtains guidance on how to use the screening results, and uses multiple sources of information to make appropriate referrals. 1304.20(a)(2), 1304.20(b)(1), 1304.20(b)(2), 1304.20(b)(3)</td>
</tr>
<tr>
<td>CHS1.10</td>
<td>Maintenance, repair, safety of facility and equipment 1304.33(a)(7)</td>
</tr>
<tr>
<td>POS.1</td>
<td>Members of the governing body and the Policy Council receive appropriate training and technical assistance to ensure that members understand information they receive and can provide effective oversight of, make appropriate decisions for, and participate in programs of the Head Start agency. 6402(d)(3)</td>
</tr>
<tr>
<td>SYS2.1</td>
<td>The program establishes and regularly implements a process of ongoing monitoring of its operations and services, including delegate agencies, in order to ensure compliance with Federal regulations, adherence to its own program procedures, and progress towards the goals developed through its Self-Assessment process. 1304.51(i)(2), 641A(g)(3)</td>
</tr>
<tr>
<td>SYS3.4</td>
<td>Prior to employing an individual, the program obtains from Federal, State, or Tribal criminal record checks covering all jurisdictions where the program provides Head Start services to children; Federal, State, or Tribal criminal record checks as required by the law of the jurisdiction where the program provides Head Start services; Criminal record checks as otherwise required by Federal law 648A(g)(2)(A), 648A(g)(2)(B), 648A(g)(2)(C)</td>
</tr>
</tbody>
</table>
HSKI-C Monitoring Protocol

- Administration for Children and Families
- U. S. Department of Health and Human Services
- Office of Head Start
- September 8, 2014

Conceptual Similarities Between Licensing & QRIS and Key Indicator Methodology

- 100% Compliance with child care health & safety rules = QRIS Block System. Cannot use Key Indicators.
- Substantial but not 100% Compliance with child care health & safety rules = QRIS Point. Can use Key Indicators.
- Both Licensing and QRIS use rules/standards to measure compliance. Licensing rules are more structural quality while QRIS standards have a balance between structural and process quality. Both rules and standards can be used within the Key Indicator methodology.
Other Examples of Key Indicators

- **CIS**
  - Item 5 – Excited about Teaching
  - Item 7 – Enjoys Children
  - Item 12 – Enthusiastic

- **FDCRS**
  - Item 4 – Indoor Space Arrangement
  - Items 14b, 15b, 16 – Language
  - Item 18 – Eye hand Coordination

- **ECERS**
  - Item 16 – Children Communicating
  - Item 31 – Discipline

---

Key Indicator (KI) Formula Matrix for ECERS

Item 16 – Children Communicating

<table>
<thead>
<tr>
<th></th>
<th>Providers with a 5 or higher on Item 16</th>
<th>Programs with a 3 or less on Item 16</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Group – 5.00+</td>
<td>117</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td>Low Group – 3.00 or less</td>
<td>0</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>117</strong></td>
<td><strong>35</strong></td>
<td><strong>152</strong></td>
</tr>
</tbody>
</table>

These data are taken from a 2002 Program Quality Study (Fiene, et al) completed in Pennsylvania. The phi coefficient was 1.00. The first time this has occurred in generating key indicators. It was replicated in a 2006 QRIS – Keystone STARS Evaluation.
Box Plot of ECERS Item 16

Box Plot of ECERS Item 39
Normal & Skewed Data

ECERS Total Scores
State’s Family CC Home Licensing

![Histogram of GALS/CC Frequency]

- Mean = 5.85
- Std. Dev. = 5.78
- N = 144

Head Start Performance Standards

![Histogram of CI Total Violations Frequency]

- Mean = 3.33
- Std. Dev. = 3.79
- N = 412
Dichotomization & Skewed Data

- When data are extremely skewed as is the case with licensing data, dichotomization of data is warranted.

- Skewed licensing data has a strong possibility of introducing very mediocre programs into the high group which will make it difficult to always identify the best programs.

- It is much easier to identify problem programs in a skewed data distribution.
Differential Monitoring Options

- Reward good compliance:
  - Abbreviated inspection – if no serious violations, for a period of time
  - Fewer full compliance reviews if compliance record is strong
- Response to non-compliance:
  - Additional monitoring visits
  - Technical assistance

- The number of core rule categories cited and the assigned risk level determines the annual compliance level. (Georgia)

- Determine how often particular rules are included in inspections. Rules that pose the most risk of harm to children if violated are reviewed during all inspections. (Virginia)

National Center on Child Care Quality Improvement, Office of Child Care

Provider Outcomes to Determine Differential Monitoring (DM)

- Fully licensed – substantial/full compliance.
- Potentially accredited (NAEYC/NECPA).
- Highest star rating.
- Cost effective and efficient delivery system.
- Little turnover of staff and director.
- Fully enrolled.
- Fund surplus.

The above results determine the number of times to visit & what to review and resources allocated.
Differential Monitoring (DM) Allocation: An Example

- **Absolute System – One size fits all.**
  - 25% of providers need additional assistance & resources.
  - Other 75% receive the same level of monitoring services without differential monitoring based upon past compliance history. No additional services available.

- **Relative System – Differential Monitoring.**
  - 25% of providers need additional assistance & resources.
  - 25% have a history of high compliance and are eligible for Key Indicator/Abbreviated Monitoring visit. Time saved here is reallocated to the 25% who need the additional assistance & resources.
  - 50% receive the same level of monitoring services because they are not eligible for Key Indicators nor are they considered problem providers.

**Monitoring Tools**

- **26 States use differential monitoring**
- Increased from 11 States in 2005
- **Most States report using abbreviated compliance forms**
- **Nearly all States provide technical assistance during monitoring activities**
- 45 percent report assisting facilities to improve quality beyond licensing regulations

*National Center on Child Care Quality Improvement, Office of Child Care*
Program Monitoring Questions?

- Generalist versus Specialists Assessors.
- General (SS3) versus Special Standards (Licensing, QRIS, HSPS).
- How Key Indicators can be used?
  - KI = Generalists.
  - CI = Specialists.
- Based upon approach from previous slide, discussion should be generalist + specialist rather than generalist or specialist.

**Differential Monitoring (DM) Example (Fiene, 2013e)**

```
Core Indicators Screener = CR + KI

Compliance Decisions:
Core Indicators = Core Rules + Key Indicators. This determines if a program receives a CI or MV visit;
Core Indicators (100%) = the next visit is a Licensing Study. Every 3-4 years a full Licensing Study is conducted.
Core Indicators (not 100%) = The next visit is a Licensing Study where all rules are reviewed.
Compliance = 96%+ with all rules which indicates substantial to full compliance with all rules and 100% with Core Indicators. The next visit is a Monitoring Visit.
Non-compliance = less than 96% with all rules which indicates lower compliance with all rules. The next visit is a Licensing Study.
```
Professional Development (PD)

- All staff have CDA or degrees in ECE.
- Director has BA in ECE.
- All staff take 24 hours of in-service training/yr.
- Mentoring of staff occurs.
- Training/PD fund for all staff.
- Professional development/training/technical assistance (PD) linked to Differential Monitoring (DM) results.

Mentoring

Individualized, on-site support to help child care staff implement the knowledge and skills they are receiving in classroom instruction.

Benefits:

- Building relationships.
- Effecting long term change in best practices.
- Providing a support system.
Relationship between Child Care Income and Quality Measures (Fiene, 2002b)

### Correlations

<table>
<thead>
<tr>
<th></th>
<th>ITERS</th>
<th>ARNETT</th>
<th>KIDI</th>
<th>BLOOM</th>
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<tr>
<td><strong>Pearson Correlation</strong></td>
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<td>ITERS</td>
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<td>.599**</td>
<td>.107</td>
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<td>.661**</td>
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<td>.568</td>
<td>.038</td>
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** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Infant-Toddler Teacher Mentoring
ITERS/HOME Post-Test Scores

Child Outcomes (CO)

- **Health and safety:**
  - Immunizations (95%+).
  - Child well-being (90% of key indicators).

- **Developmental Outcomes:**
  - Social (90% meeting developmental benchmarks).
  - Emotional (90% meeting developmental benchmarks).
  - Cognitive (90% meeting developmental benchmarks).
  - Gross and fine motor (90% meeting developmental benchmarks).
Correlation of Accreditation, Licensing, & Training with Child Outcomes

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- *p < .05
- Kontos & Fiene (1997).

Key Element Publication Summary

- **PC =** Caring for Our Children *(AAP/APHA/NRC, 2012).*
- **PQ =** National Early Childhood Program Accreditation *(NECPA)(Fiene, 1996).*
- **RA =** Stepping Stones *(NRC, 2013).*
- **KI = 13** Indicators of Quality Child Care *(Fiene, 2002a).*
- **DM =** International Child Care & Education Policy *(Fiene, 2013a).*
- **PD =** Infant Caregiver Mentoring *(Fiene, 2002b).*
- **CO =** Quality in Child Care: The Pennsylvania Study *(Kontos & Fiene, 1997).*
Outstanding Issues

- Process versus Structural Quality Indicators
- Input/Processes versus Output/Outcomes
- Impact of Pre-K and QRIS on Licensing

Core Indicators – Final Thoughts

- Childhood Immunizations (PC)
- Director & Teacher Qualifications (PC, PQ)
- Mentoring/Coaching (PQ/PD)
- Family Engagement (PQ)
- Social-Emotional & Language Learning/Competencies (ELS, PD)
Early Childhood Program Quality Indicator Model (ECPQIM) Evolution

- Nixon Veto of Comprehensive Child Development Bill 1971. (ECPQIM1)
- FIDCR Moratorium 1981. (ECPQIM1)
- Reagan Block Grant Formula 1983. (ECPQIM1)
- CCDBG enacted 1991. (ECPQIM2)
- Caring for Our Children (CFOC) 1st Edition 1993. (ECPQIM2)
- Stepping Stones 1st Edition 1995. (ECPQIM2)
- Child Care Development Fund (CCDF) enacted 2001. (ECPQIM3)
- Child Care Aware First Report Card 2007. (ECPQIM3)
- OPRE/ACF Validation Brief 2012. (ECPQIM4)
- Differential Monitoring Logic Model (DMLMA) 2012-13. (ECPQIM4)
- CCDBG Bill, CCDF Rule, CFOC-Basics, OCC Brief 2013-14. (ECPQIM4)
The following graphics represent the previous generations of ECPQIM 1-4 beginning in 1975 up to the present model (DMLMA, 2013).
**Inputs**
- Agency Rule Making Authority
- Regulations, Requirements, Codes, Funding Rules
- Monitoring System
  - Surveillance
  - Licensing
  - Registration
  - Certification
- CCR&R
  - Local CC Programs
  - CC Organizations
  - Consumers
  - Monitors

**Processes**
- Interagency Review
- Compliance Study
  - Change/Clarification
  - Guidance Material
    - Training & TA
    - Consumer Materials
- Weighted Indicator Checklist
- Field Survey
  - Focus Groups
  - Public Hearings

**Outcomes**
- Consistent Data Collection
  - Combined/Cost-Effective Use of Resources to Meet State Priorities
- Strength/Clarity of Rules Reduced
- Duplication of Rules Consistency Across Agencies
- Monitoring Efficiency Program
  - Compliance Targeting Resources to Areas of Need
- Consensus-Building Increased State-Local Cooperation

---


\[ CO + PO = (PD + PC + PQ)/PM \]

Where:
- \( CO \) = Child Outcomes
- \( PO \) = Provider Outcomes
- \( PD \) = Professional Development
- \( PC \) = Program Compliance/Licensing
- \( PQ \) = Program Quality/QRIS
- \( PM \) = Program Monitoring
DIFFERENTIAL MONITORING LOGIC MODEL & ALGORITHM
(DMLMA©) (Fiene, 2012): A 4th Generation ECPQIM – Early Childhood Program Quality Indicator Model

Cl x PQ => RA + KI => DM + PD => CO

Definitions of Key Elements:
Cl = Comprehensive Licensing Tool (Health and Safety) (Caring for Our Children)
PQ = ECERS-R, FDCRS-R, CLASS, COPIES (Caregiver/Child Interactions/Classroom Environment)
RA = Risk Assessment, (High Risk Rules) (Stepping Stones)
KI = Key Indicators (Predictor Rules) (13 Key Indicators of Quality Child Care)
DM = Differential Monitoring, (How often to visit and what to review)
PD = Professional Development/Technical Assistance/Training
CO = Child Outcomes (See Next Slide for PD and CO Key Elements)

Early Childhood Program Quality Improvement and Indicator Models (ECPQI2M0–4©)

ECPQI2M1©: 1975 – 1994. Qualitative to Quantitative; focus on reliability; data utilization; distinctions between program monitoring and evaluation; Key Indicators, Weighted Rules, & principles of licensing instrument design introduced. (Fiene, 1981; Fiene & Nixon, 1985).
RELATED PUBLICATIONS AND REPORTS


Fiene (2013d). Kansas Child Care Key Indicators. Middletown: Pennsylvania, Research Institute for Key Indicators.


Fiene (2002b). Improving child care quality through an infant caregiver mentoring project, Child and Youth Care Forum, 31(2), 75-83.


Fiene, Greenberg, Bergsten, Carl, Fegley, & Gibbons (2002). The Pennsylvania early childhood quality settings study, Harrisburg, Pennsylvania: Governor’s Task Force on Early Care and Education.


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National Association for Regulatory Administration (NARA)

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http://RIKIInstitute.wikispaces.com  www.naralicensing.org
RELATIONSHIP OF KEY INDICATORS/RISK ASSESSMENT TOOLS AND CARING FOR OUR CHILDREN BASICS (2015)*

Legend:
NRC = National Resource Center for Health and Safety in Child Care
AAP = American Academy of Pediatrics
APHA = American Public Health Association
OHS = Office of Head Start
ACF = Administration for Children and Families
OCC = Office of Child Care
ASPE = Assistant Secretary’s Office for Planning and Evaluation
13I = Thirteen Indicators of Quality Child Care (2002), ASPE
HSKI-C = Head Start Key Indicators (2013)
Stepping Stones = Stepping Stones to Caring for Our Children (2013), NRC, AAP, APHA
* Other tools, standards and legislation comprise CFOCB (2015); this graphic only shows the relationship between CFOCB and Key Indicators and Risk Assessment Tools
Relationship of Comprehensive Reviews (CR) to Key Indicator (KI) or Risk Assessment (RA) Rule Non-Compliance

Key Indicator Rule | Both | Risk Assessment Rule

**Prediction**

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ECELS Infant Toddler Program Quality Improvement Project (ITQIP)  
Report of Pre-Test Data Collection  
Richard Fiene, Ph.D.  
August 1, 2014

ABSTRACT

This brief report will provide an analysis of the sites selected as part of the Infant Toddler Program Quality Improvement Project (ITQIP) in the Pre-Test data collection phase.

INTRODUCTION

This report is the initial analysis looking at the pre-test scores between the 16 intervention sites and the 16 control sites. This will be a descriptive report demonstrating the likenesses and differences between the two groups.

The evaluation plan (see Figure 1 for the Logic Model Display) is a classic randomly assigned clinical trial in which a group of child care programs will be randomly assigned to the intervention group in receiving the specific training and technical assistance specific to the selected CFOC3 standards. A comparison group also randomly assigned will receive the typical training and technical assistance that is available through the state training system. These two groups will be compared on the pre-test for equivalency and then one year later in a post-test format. At this point the intervention group will be switched to a comparison format and the comparison group will become the intervention group. If funding can be found to pay for it, a second post-test would be performed at this data point to determine the latent effects of the training/technical assistance.
**RESULTS of Pre-Test**

**Intervention Group**
The range in scores was 175 to 267 with an average score of 208 out of a possible 322 points (65%).

**Control Group**
The range in scores was 164 to 271 with an average score of 219 out of a possible 322 points (68%).

The results clearly demonstrate that there are no significant differences between the two groups on the pre-test scores with the exception of three items (SS 240, CA310, CA42).
## Intervention and Control Group Comparisons

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ns = not significant.
ECELS Infant Toddler Program Quality Improvement Project (ITQIP)

Richard Fiene, Ph.D.

August 25, 2015

ABSTRACT

This brief report provides an analysis of the sites selected as part of the Infant Toddler Program Quality Improvement Project (ITQIP) in comparing data from the pre-test to post-test for both the Intervention and Control Groups. It is clearly demonstrated in the results that the Intervention Group was very effective in producing change in making sure children were being immunized; received training on proper medication administration; received and reviewed safe sleep policies and have been trained; were provided the necessary education, policies, and procedures for child abuse and prevention; followed proper adult hygiene and proper diapering protocols; and ensured infants and toddlers had adequate activities and outdoor play.

INTRODUCTION

This report compares pre-test and post-test scores between the 13 intervention sites (3 sites did not follow through with their Child Care Health Consultant (CCHC) and were dropped from the intervention group) and the 16 control sites of the Infant Toddler Program Quality Improvement Project. This will be a descriptive report demonstrating the similarities and differences between the two groups.

The evaluation plan (see Figure 1 for the Logic Model Display) is a classic randomly assigned clinical trial in which a group of child care programs were randomly assigned to the intervention group in receiving the specific training and technical assistance specific to the selected Caring for Our Children (3rd Edition) CFOC3 standards. A comparison group also randomly assigned received the typical training and technical assistance that is available through the state training system in Pennsylvania. These two groups were compared on the pre-test for equivalency and then one year later in a post-test format. At this point the intervention group will be switched to a comparison format and the comparison group will become the intervention group. If funding
can be found to pay for it, a second post-test would be performed at this data point to determine the latent effects of the training/technical assistance.

Figure 1: EVALUATION PLAN LOGIC MODEL

RESULTS of Pre-Test to Post-Test (Summary and Detailed Item Results)

**Intervention Group**
The range in scores was 175 to 267 with an average score of 212 out of a possible 322 points (66%) on the pre-test. The range in scores was 213 to 297 with an average score of 255 out of a possible 322 points (79%) on the post-test. This change from pre-test to post-test was statistically significant (t = -4.62; p < .0001).

**Control/Comparison Group**
The range in scores was 164 to 271 with an average score of 218 out of a possible 322 points (68%) on the pre-Test. The range in scores was 149 to 257 with an average score of 221 out of a possible 322 points (69%) on the post-test. All these changes from pre- to post-test were non-significant.

**Intervention – Control/Comparison Groups**
The average scores between the Intervention (212) and Control (218) groups on the pre-test were non-significant. The average scores between the Intervention (255) and Control (221) groups on the post-test were statistically significant (t = -3.46; p < .002).
## Intervention (I) and Control (C) Group Comparisons from Pre-Test to Post-Test

Significant Changes Based Upon t-test Analyses and Comparisons of Intervention & Control Groups at Post-Test for Each Item (NS = Not Significant; S = Significant)

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IM412 | S* | NS | NS  
IM413 | NS | NS | S*  
SN414 | NS | NS | S*  

* p < .05  
** p < .01  
*** p < .001

DISCUSSION

It is clear from the results that the intervention of the Child Care Health Consultants (CCHC) was very effective in the pre to post-test scores on a number of items (N = 17) that showed a statistically significant change from pre- to post-test for the Intervention Group and 14 items in comparing the Intervention Group to the Control/Comparison Group showed a statistically significant change. At the same time there was only one item in the Control/Comparison Group that showed a statistically significant change from pre- to post-test. As a footnote, there were also only 3 items that showed a statistically significant difference between the Intervention and Control Groups on the pre-test (Fiene, 2014).

These results are rather robust given the small sample size (N = 13 for the Intervention Group and N = 16 for the Control Group). This specific intervention utilizing CCHCs is a viable coaching/mentoring intervention that needs additional exploration in replication studies. At least when it comes to Caring for Our Children standards this is a first demonstration of an effective training/technical assistance/coaching/mentoring intervention.
In summary, the intervention appeared to be most effective in making improvements in the following areas:

- Children being immunized,
- Received training on proper medication administration,
- Received and reviewed safe sleep policies and have been trained,
- Were provided the necessary education, policies, and procedures for child abuse and prevention,
- Following proper adult hygiene and proper diapering protocols,
- Every Care Plan for children with special needs has the required elements,
- Making sure that infants and toddlers had adequate activities and outdoor play.

Reference