DEFINITIONS

We have defined many terms in the Glossary found on page 479. Some of these are so important to the user that we are emphasizing them here as well.

Types of requirements: Three terms describe different types of requirements have been carried forward from the 1992 edition:

- A ***standard*** is a statement that defines a goal of practice. It differs from a recommendation or a guideline in that it carries great incentive for universal compliance. It differs from a regulation in that compliance is not necessarily required for legal operation. It usually is legitimized or validated based on scientific or epidemiological data, or when this evidence is lacking, it represents the widely agreed upon, state-of-the-art, high-quality level of practice.

  The agency, program, or health practitioner that does not meet the standard may incur disapproval or sanctions from within or outside the organization. Thus, a standard is the strongest criteria for practice set by a health organization or association. For example, many manufacturers advertise that their products meet ASTM standards as evidence to the consumer of safety, while those products that cannot meet the standards are sold without such labeling to undiscerning purchasers. In *Caring for Our Children,* specific standards define the frequency of visits to child care facilities and qualifications of health consultants to such facilities. Some states have adopted or even exceeded parts of these standards in their regulations, but many more have not done so. Facilities that use a health consultant, as specified in Standards 1.040 through 1.044, could be expected to be of higher quality than those that do not.

- A ***recommendation*** is a statement of practice that potentially provides a health benefit to the population served. An organization or a group of individuals with expertise or broad experience in the subject matter usually initiates it. It may originate within the group or be solicited by individuals outside the organization. A recommendation is not binding on the practitioner; that is, there is no obligation to carry it out. A statement may be issued as recommendation because it addresses a fairly new topic or issue, because scientific supporting evidence may not yet exist, or because the practice may not yet enjoy widespread acceptance by the members of the organization or by the intended audience for the recommendation.

  For example, in Chapter 9 of *Caring for Our Children*, Recommendation 9.004 suggests that States should adopt uniform categories and definitions for use in their own licensing that cover the types of facilities addressed by the standards. While it is recognized that each State might differ in the specific definitions of services they choose to use, the recommendation says that each State should be sure that the sum of their licensing effort should address all the types of service specified in the standards.

- A ***guideline*** is a statement of advice or instruction pertaining to practice. Like a recommendation, it originates in an organization with acknowledged professional standing. Although it may be unsolicited, a guideline is developed in response to a stated request or perceived need for such advice or instruction. For example, the American Academy of Pediatrics (AAP) has a guideline for the elements required to make the diagnosis of Attention-Deficit/Hyperactivity Disorder.

- A ***regulation*** takes a previous recommendation or guideline and makes it a requirement for legal operation. A regulation originates in an agency with either governmental or official authority and has the power of law. Such authority is usually accompanied by an enforcement activity. Examples of regulations are: State regulations pertaining to health and safety requirements for caregivers and children in a licensed child care center, and immunizations required for participation in group care. The components of the regulation, of course, will vary by topic addressed as well as by area of jurisdiction (e.g., municipality or state). Because a regulation

prescribes a practice that every agency or program must comply with, it usually is the minimum or the floor below which no agency or program should operate.

Types of facilities: Child care offers developmental care and education for children who live at home with their families. Several types of facilities are covered by the general definition of child care. Although States vary greatly in their legal definitions, overall, there is a generally understood definition for child care facilities. Much overlap and confusion of terms still exists in defining child care facilities. Although the needs of children do not differ from one setting to another, the declared intent of different types of facilities may differ. Thus, facilities that operate part-day, in the evening, during the traditional work day and work week, or during a specific part of the year may call themselves by different names. These standards recognize that while children's needs do not differ in any of these settings, the way children's needs are met may differ by whether the facility is in a residence or a non-residence and whether the child is expected to have a longer or only a very short-term arrangement for care. Thus, we have designated the type of facility to which each standard applies using the following definitions:

- A ***Small Family Child Care Home*** provides care and education for up to six children at one time, including the preschool children of the caregiver, in a residence that is usually, but not necessarily, the home of the caregiver. The key elements are that this type of care takes place in a setting that is used both for child care and as a residence (often simultaneously) and that the total number of children is limited to a maximum of six at any one time. Family members or other helpers may be involved in assisting the caregiver, but often, there is only one caregiver present at any one time.

- A ***Large Family Child Care Home*** provides care and education for between 7 and 12 children at a time, including the preschool children of the caregiver, in a residence that is usually, but not necessarily, the home of one of the caregivers. Staffing of this facility involves one or more qualified adult assistants so that the requirements specified in the child:staff ratio and group size standard are met. The key element that distinguishes this type of facility is the combined use of the premises as a residence and for child care (often simultaneously) and that the number of children in care requires more than one caregiver present at any one time.

- A ***Center*** is a facility that provides care and education to any number of children in a nonresidential setting, or 13 or more children in any setting, if the facility is open on a regular basis. To distinguish a child care center from drop-in facility, a center usually provides care for some children for more than 30 days per year per child. In many cases, summer camps operate for more 30 days per year per child and, in fact, provide center-based child care.

- A ***Drop-in-Facility*** provides care for fewer than 30 days per year per child either on a consecutive or intermittent basis or on a regular basis, but for a series of different children.

- A ***School-Age Child Care Facility*** offers activities to children before and after school, during vacations, and on non-school days set aside for such activities as teachers' in-service programs.

- A ***Facility for Children with Special Needs*** provides specialized care and education for children who cannot be accommodated in a setting with typically developing children.

- A ***Facility for Ill Children*** provides care for one or more children who are temporarily excluded from care in their regular child care setting. Their condition does not require parental care but they cannot participate in the regular program at their usual source of child care, require more staff time than can be offered in their usual setting without putting the other children at risk, or have a condition that poses a risk for the adults or children in their usual child care facility. Such facilities for ill children are of two types:

- An ***Integrated or Small Group Care Facility for Ill Children*** provides care that has been approved by the licensing agency in a facility that cares for well children and is authorized to include up to six ill children.

- A ***Special Facility for Ill Children*** cares only for ill children or cares for more than six ill children at a time.

Age groups: Although we recognize that designated age groups and developmental levels must be used flexibly to meet the needs of individual children, many of the standards are applicable to specific age and developmental categories. The following categories are used in *Caring for Our Children*.

Developmental Stage	Age	Functional Definition (By Developmental Level)
Infant	0-12 months	Birth to ambulation
Toddler	13-35 months	Ambulation to accomplishment of self-care routines such as use of the toilet
Preschooler	36-50 months	From achievement of self-care routines to entry into regular school
School-Age Child	5-12 years	Entry into regular school, including kindergarten through 6th grade

Format and Language Level

In Chapters 1 through 8, the reader will find the scientific reference and/or epidemiological evidence for the standard in the rationale section of each standard. The rationale explains the intent of and the need for the standard. Where no scientific evidence for a standard is available, the standard is based on the best available professional consensus. If such a professional consensus has been published elsewhere, that reference is cited. References for the rationales are at the end of each chapter. Thus, the rationales both justify the standard and serve as an educational tool. The Comments section includes other explanatory information relevant to the standard, such as applicability of the standard and, in some cases, suggested ways to measure compliance with the standard. Although this document reflects the best information available at the time of publication, like the first edition, this second edition will need updating from time to time to reflect changes in knowledge affecting child care.

Because the standards have many users with differing backgrounds and need for reference material, we ask readers of *Caring for Our Children* to accept some inconvenience when their purpose might be better met by a different format. The electronic version will help users to search for key words and concepts that might be addressed in a variety of places in the document. Although the standards have not been written from the perspective of a single use, we expect that many of the standards will be used as licensing requirements. Therefore, to the extent possible, the wording of the standards has been written to be measurable and enforceable. Also, measurability is important for performance standards in a contractual relationship between a provider of service and a funding source. Concrete and specific language helps caregivers and facilities put the standards into practice. Where a standard is difficult to measure, we have provided guidance to make the requirement as specific as possible. For some readers, the wording of some standards may seem highly technical; they will need to have that standard interpreted by specialists. Whenever feasible, we have written the standards to be understood by readers from a wide variety of backgrounds.

Users of the Standards

The intended users of the standards include many who contribute to the well-being of children. Each has a unique viewpoint. For many of the users, access to the Internet version of the publication will be useful. For those who need a full print

document, the hard copy will be preferable. Many will want to use both versions for different purposes. For example, the electronic search of the Internet version helps identify all points in the standards that address a particular topic. The hard copy is easily used where Internet access is unavailable. The intended users include:

- Health professionals
- Trainers
- Regulators
- Child Care Providers
- Academics and Researchers

All of the standards are attainable. Some may have already been attained in individual settings; others can be implemented over time. For example, any organization that funds child care should, in our opinion, adopt these standards as funding requirements and should set a payment rate that covers the cost of meeting them.

The following are some of the ways in which *Caring for Our Children* may be used:

1. ***As guidance material for administrators and caregivers:*** Anyone operating a child care facility on any level needs information on good practice. These standards will inform:
   - Administrators at all levels, from those who operate a chain of centers to caregivers in small family child care homes
   - Caregivers
   - Those who teach courses to caregivers.

2. ***As a reference for consultants:*** Public health professionals, pediatricians, and others provide consultation to caregivers. This role requires knowledge that goes beyond traditional patient-centered pediatrics or public health approaches. Many local and state health departments have developed child care guidance material that public health nurses, sanitarians, and nutritionists, among others, use in consulting with caregivers. This document will help support and update such guidance material.

3. ***As guidance to citizens' groups in states revising their licensing requirements:*** Because licensing has the force of law, caregivers and facilities must meet any requirements set by licensing agencies. Resource limitations may delay full implementation of some of the standards. To address such limitations, the Maternal and Child Health Bureau funded a project to set priorities among the standards based on their association with the prevention of disease, disability and death (morbidity and mortality). The publication of this subset of the first edition of *Caring for Our Children* was called *Stepping Stones to Using Caring for Our Children*. Where resource constraints require focused implementation, the updated standards that correspond with *Stepping Stones* should be the first implemented. A similar process must be used to look at the new standards that first appear in the second edition.

4. ***As guidance material to State Departments of Education (DOEs) and local school administration:*** Some public schools and private schools offer programs for 4-year-olds and even younger children. A few schools provide infant programs. Licensing requirements for child care seldom cover public and private school systems. Few States have written standards for such programs when they are operated by schools. Many school codes fail to adequately address child handwashing, location of bathrooms, child:staff ratios and group size, teacher qualifications for working with preschool children, and injury prevention. As state DOEs begin to write standards for school-operated child care and preschool facilities, and as principals begin to implement good practice in early childhood and child care facilities, this guidance material will help.

5. ***As guidance material for funding of subsidized facilities:*** Most States and localities provide child care services for income-eligible families through purchase-of-service contracts and individual vendor/voucher mechanisms. Public interest in purchasing child development services for at-risk children has increased, largely due to dissemination of research about the key role played by early childhood experience in the development of the brain. Welfare-to-work policies have increased attention to the use of non-parental child care by the poor that parallels increased interest in child care for middle and upper class families as more women in all groups are participating in the labor force.

   Many communities offer subsidized child care/developmental services for children with special needs. Schools and other agencies are setting up specialized arrangements to serve children with special needs, sometimes paying for children with special needs to be included in local community child care settings with typically developing children. When States and localities purchase child care services, the standards offer guidance not only on the level of service to expect, but also a way to estimate the corresponding level of funding to meet such requirements for children with special needs.

6. ***As guidance material to other national private organizations that write standards:*** Several other national organizations have expressed their strong interest in child care by writing standards for accreditation or guidance for the field. Both the first and second editions of *Caring for Our Children* draw on the expertise of these other organizations in developing the standards. Reciprocally, the work done on these standards should be equally useful to other organizations.

7. ***As guidance material for parents and the general public:*** Parents need consumer information to choose quality child care for their children. By drawing on the standards, organizations that serve parents can train their staff and develop educational materials that provide credentialed advice for parents. For example, resource and referral counselors, community health professionals, and social workers will be able to use *Caring for Our Children* as a reference for their work with parents, the general public, and the media.

Relationship of the Standards to Laws, Ordinances, and Regulations

The members of the technical panels could not annotate the standards to address local laws, ordinances, and regulations. Many of these legal requirements are out-of-date or have a different intent from that addressed by the standards. Users of this document should check legal requirements that may apply to facilities in particular locales. Where conflicts are noted, we recommend further work at the local level to resolve such conflicts.

In general, child care is regulated by at least three different legal entities or jurisdictions. The first is the building code jurisdiction. Building inspectors enforce building codes to protect life and property in all buildings, not just child care facilities. Some of the recommended standards should be written into state or local building codes, rather than into the licensing requirements.

The second major legal entity that regulates child care is the health system. A number of different codes are intended to prevent the spread of disease in restaurants, hospitals, and other institutions where hazards and risky practices might exist. Many of these health codes are not specific to child care; however, specific provisions for child

care might be found in a health code. Some of the provisions in the recommended standards might be appropriate for incorporation into a health code.

The third legal jurisdiction applied to child care is child care licensing. Usually, before a child care operator receives a license, the operator must obtain approvals from health and building safety authorities. Sometimes a standard is not included as a child care licensing requirement because it is covered in another code. Sometimes, however, it is not covered in any code. Since children need full protection, the issues addressed in this document should be addressed in some aspect of public policy, and consistently addressed within a community. In an effective regulatory system, different inspectors do not try to regulate the same thing. Advocates should decide which codes to review in making sure that these standards are addressed appropriately in their regulatory systems. Although the licensing requirements are most usually affected, it may be more appropriate to revise the health or building codes to include certain standards and it may be necessary to negotiate conflicts among applicable codes.