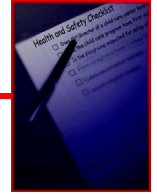


Licensing and Community Action

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This chapter contains recommendations for the responsibilities of agencies, organizations, and society, not for the individual caregiver or child care facility. These recommendations provide the support systems for implementation of the standards in the preceding chapters. Although many of these recommendations are directed to state administrative activity, they define necessary actions to assure the health and safety of children in out-of-home settings

## 9.1 THE REGULATORY AGENCY

### THE REGULATORY POLICY

#### **RECOMMENDATION 9.001 REGULATION OF ALL OUT-OF- HOME CHILD CARE**

Every state should have a statute that identifies the regulatory agency and mandates the licensing and regulation of all full-time and part-time out-of-home care of children, regardless of setting, except care provided by parents or legal guardians, grandparents, siblings, aunts, or uncles or when a family engages an individual to care solely for their children (I).

**DISCUSSION:** A state statute gives government the authority to protect children as vulnerable and dependent citizens and to protect families as consumers of child care service. Licensing must have a statutory basis, because it is unknown to the common law. The statute must address the administration and location of the responsibility. Fifty states have child care regulatory statutes. The laws of some states exempt part day centers, school-age child care, care provided by religious organizations, lessons, summer camps or care provided in small or large family child care homes. These exclusions and gaps in coverage expose children to unacceptable risks.

#### **RECOMMENDATION 9.002 ROLE OF LICENSING AGENCY**

The licensing agency should issue permits of operation to all facilities that comply with standards.

**DISCUSSION:** Every child has a right to protective care that meets the standards, regardless of the child

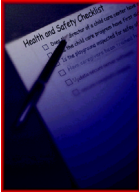
care setting in which the child is enrolled. Public and private schools, nurseries, preschools, centers, child development programs, babysitting centers, early childhood observation centers, small and large family child care homes, and all other settings where young children receive care by individuals who are not close relatives should be regulated. Facilities have been able to circumvent rules and regulations in some states by claiming to be specialized facilities. Nothing in the educational philosophy, religious orientation, or setting of an early childhood program inherently protects children from health and safety risks or provides assurance of quality of child care.

Any exemptions for care provided outside the family may place children at risk. In addition to the basic protection afforded by stipulating requirements and inspecting for licensing, facilities should be required to be authorized for operation. Authorization for operation gives states a mechanism to identify facilities and individuals that are providing child care and authority to monitor compliance. These facilities and individuals may be identified as potential targets for training, technical assistance, and consultation services. Currently, many church run nurseries, nursery schools, group play centers, and home based programs operate incognito in the community because they are not required to notify any centralized agency that they care for children.

The lead agency for licensing of child care in most states is the human services agency. However, the state public health agency can be an appropriate licensing authority for safeguarding children in some states. The education system is increasingly involved in providing services to children in early childhood. The standards should be equally stringent no matter what agency assumes the responsibility for regulating child care.

Home care, which is the care of a child in his/her own home by someone whom the parent has employed, is not care within the family. This type of care should not be licensed as a facility. The relationship between the parent and caregiver is that of employer and employee rather than that of purchaser and provider of care, thus licensing or certification of the individual who provides such care, rather than of the service itself, is desirable and recommended.

A good resource on licensing, regulatory, and enforcement issues is the National Association for Regulatory Administration (NARA), an international professional organization for licensors, dedicated to promoting excellence in human care regulation and licensing through leadership, education, collaboration, and services. Contact information for NARA is located in Appendix BB. In addition, the Position



Statement on Licensing and Public Regulation of Early Childhood Programs published by the National Association for the Education of Young Children (NAEYC) includes rationale for policy decisions related to licensing and regulation (1). See Appendix AA, for the NAEYC position statement on licensing.

### RECOMMENDATION 9.003 CRIMINAL RECORD AND CHILD ABUSE CHECKS

Every state should have a statute which mandates the licensing agency or other authority to obtain a criminal records check and a child abuse registry check on every prospective child care staff person, volunteer, or on a family child care home provider's family member who is over 10 years of age and who comes in contact with children. The expense of criminal records check and child abuse registry checks should be a public responsibility. No staff should be unsupervised with the children until a negative report has been received by the agency. Volunteers should not be unsupervised with the children at any time.

**DISCUSSION:** The cost of criminal records checks, where they have been implemented, has become an additional financial burden on programs, which are forced to pass on the expense to parents or staff. Placing the burden on potential new staff, volunteers, and substitute caregivers themselves proves to be another disincentive to enter this field of work. In many cases juvenile records are sealed and can not be used for the purposes of background checks. Juvenile offender records begin at age 10.

Some states have established definitions for regular volunteers (for whom criminal record and child abuse registry checks should be required) and for short-term visitors, such as entertainers and others, who will not be unsupervised with the children.

## FACILITY LICENSING

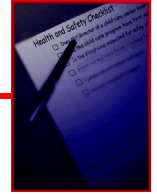
### RECOMMENDATION 9.004 UNIFORM CATEGORIES AND DEFINITIONS

Each state should adopt uniform categories and definitions for its own licensing requirements. While states may use different terms, every state

should have individual standards that are applied to the following types of facilities:

- a) *Small family child care home:* A facility providing care and education of one to six children, including preschool children of the caregiver, in the home of the caregiver;
- b) *Large family child care home:* A facility providing care and education of 7 to 12 children, including preschool children of the caregiver, in the home of the caregiver, with one or more qualified adult assistants to meet child:staff ratio requirements;
- c) *Center:* A facility providing care and education of 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 (for instance, if it is not a drop-in facility);
- d) *Drop-in facility:* A facility providing care that occurs 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;
- e) *School-age child care facility:* A facility offering activities to school-age children before and after school, during vacations, and non-school days set aside for such activities as teachers' in-service programs;
- f) *Facility for children with special needs:* A facility providing specialized care and education in a setting of one or more children who cannot be accommodated in a setting with typically developing children (2). See Children Who are Eligible for Services Under the Individuals with Disabilities Education Act (IDEA), STANDARD 7.001 through STANDARD 7.016;
- g) *Facility for ill children:* A facility providing care of one or more ill children who are temporarily excluded from care in their regular child care setting. See Caring for Ill Children, STANDARD 3.070 through STANDARD 3.080;
  - 1) *Integrated or small group care for ill children:* A facility that has been approved by the licensing agency to care for well children and to include up to six ill children;
  - 2) *Special facility for ill children:* A facility that cares only for ill children, or a facility that cares for more than six ill children at a time;

**DISCUSSION:** Lack of standard terminology hampers the ability of citizens and professionals to compare



rules from state to state or to apply national guidance material to upgrade the quality of care (1). For example, child care for 7 to 12 children in the residence of the caregiver may be referred to as family day care, a group day care home, or a mini-center in different states. While it is not essential that each state use the same terms and some variability in definitions of types of care may occur, terminology should be consistent within the state and as consistent as possible from state to state in the way different types of settings are classified. Child care facilities should be differentiated from community facilities that primarily care for the mentally retarded, the elderly, and other adults and teenagers who need supervised care.

### **RECOMMENDATION 9.005 CARE OF ILL CHILDREN NOT REQUIRING EXCLUSION**

Any facility should be encouraged to care for ill children who do not need to be excluded, as defined in STANDARD 3.068, provided that the licensing authority has approved the facility's written plan describing the symptoms or conditions that the facility is prepared to accommodate and procedures for daily care for such children. Facility types should be specific to the child's developmental level.

**DISCUSSION:** Children enrolled in child care are of an age that places them at increased risk for acquiring infectious diseases. Many children with illness (particularly mild respiratory tract illness without fever) can continue to attend and participate in activities in their usual facility. This perspective is reflected in the standards for excluding children from child care attendance. See Inclusion/Exclusion/Dismissal of Ill Children, STANDARD 3.065 through STANDARD 3.068.

Clearly, when children with possible communicable diseases are present in the alternative care arrangements, emphasis on preventing further spread of disease is as important as in the usual facilities. Prevention of additional cases of communicable disease should be a key objective in these alternative care arrangements for children with minor illness and temporary disability.

Current state regulations concerning exclusion of children from facilities because of illness may be more restrictive than these standards. Some states currently require isolation of a child who becomes ill during the day while attending the facility, and for an ill child who is not expected to return to the facility the

following day (5). The most common alternative care arrangement is for a parent of the ill child to stay home from work and care for the child. Some states have established regulations governing child care for sick children (5).

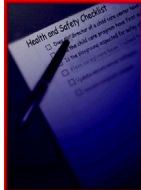
Data are inadequate by which to judge the impact of group care of ill children on their subsequent health and on the health of their families and community. The principles and standards proposed in this manual represent the most current views of pediatric and infectious disease experts on providing this special form of child care. These standards will require revision as new information on disease transmission in these facilities becomes available. The National Association for Sick Child Daycare (NASCD) conducts and sponsors original research on issues related to sick child care and helps establish sick care facilities across the nation. Contact information for the NASCD is located in Appendix BB.

### **INDIVIDUAL CREDENTIALING/ CERTIFICATION**

#### **RECOMMENDATION 9.006 CREDENTIALLING OF INDIVIDUAL CHILD CARE PROVIDERS**

All persons who provide child care or who may be responsible for children or alone with children in a facility should be individually credentialed by a state licensing agency or credentialing body recognized by the state child care regulatory agency. The credential should be granted to individuals who meet age, education, and experience qualifications, whose health status facilitates providing safe and nurturing care, and who have no record of conviction for criminal offenses against persons, especially children, or confirmed act of child abuse. The state should establish qualifications for differentiated roles in child care and a procedure for verifying that the individual who is authorized to perform a specified role meets the qualifications for that role.

**DISCUSSION:** Individual credentialing will enhance child health and development and protect children by ensuring that the staff who care for children are healthy and are qualified for their roles. The current system, in which the details of staff qualifications and ongoing training are checked as part of facility inspection, is cumbersome for child care administrators and



licensing inspectors alike. If staff qualifications were established as part of a separate, more central process, the licensing agency staff could check center records of character references and whether staff members have licenses for the roles for which they are employed.

In a centralized individual credentialing system, successful completion of education should be verified by requiring the individual to submit evidence of completion of credit-bearing courses that have been previously approved as meeting the state's requirements to a central verification office where this transcript should be continually updated. Criminal records and child abuse registries should be checked by state licensing agency staff for evidence of behavior that would disqualify an individual for work in specified child care roles. Evidence of a recent health examination indicating ability to care for children can be submitted at the same time. The center director then knows whether job applicants who have been working in the field previously are qualified at the time they apply for the job, without lengthy waiting for background checks of a prospective employee and without having to hire before background checks have been completed. By this means, children are not exposed to health and safety risks from understaffing, or to care by unqualified or even dangerous individuals employed provisionally because the results of a check are not yet available to the director.

Centralizing individual credentialing, qualifying, or licensing (whichever term is consistent with the state's approach to authorizing legal professional activity) will improve control over quality, encourage a career ladder with increasing qualifications, and reduce the risk of abuse. It will help consumers know that individuals who are caring for their children have met basic requirements for consumer protection. Such a process is analogous to that provided for other education professionals (teachers), and even those service providers with less potential for harm than is involved in caring for children (such as beauticians, barbers, taxi drivers).

The cost of individual certification, credentialing, or licensure will be offset by the benefits to consumers of reliable and consistent qualifications of child care personnel. Program administrators, licensors, and child care personnel, who do not have to undertake the tedious process of verification of each portion of an individual's credentials during all site visits, when sites are licensed, or when individuals change jobs, will experience cost savings and assurance of compliance. Public and private policymakers should use financial and other incentives to help caregivers meet credentialing requirements. They should encourage community colleges to offer courses

appropriate for provider training at times convenient for child care workers to attend.

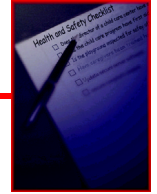
Periodic renewal of the credential should be required, and should be related to requirements for continuing education and the absence of founded claims of child abuse or criminal convictions. The requirement for renewable certification is likely to deter people from applying for work in child care as a way of gaining access to children for sexual purposes since the process would include a check of the child abuse registry (3).

While there is value in checking criminal records, not all criminal records represent hazards for children so serious as to prohibit the individual from working in a child care setting. States should specify which crimes defined in the state's criminal code will prohibit certification and whether any other crimes should limit the ability of the individual to be certified for certain roles. Individuals who have been convicted of violent and/or sexual crimes should not work in child care settings. States should be careful not to rely entirely on criminal record checks to prevent abuse. This method is expensive and does not result in a high number of "hits" as records are checked, because many abusers have not yet been convicted of a crime. In addition, states should rely on other, less costly measures to protect children. The Federal Bureau of Investigation (FBI) maintains a central criminal file. Contact information for the FBI is located in Appendix BB. If all caregivers are certified, and are required to present or post their certificates where they work, their identity, background, and competence can be documented. Checking compliance requires simple inspection of the certificate and verification by contacting the state agency that maintains the computerized registry of qualified individuals. Precautions against forgery should be built into the system.

For information on individual staff qualifications, see Preservice Qualification and Special Training, STANDARD 1.007 through STANDARD 1.022.

### **RECOMMENDATION 9.007 LICENSING AGENCY PRE- LICENSING PROCEDURES**

Before granting a license to a facility, the licensing agency should check as specified below for a record of a physical examination and for educational qualifications, and should check criminal records, juvenile records and the child abuse registry for all adults who are permitted to be alone



with children in a facility. The licensing agency should also check the criminal record files and child abuse registry, as specified below, for all persons over 10 years of age who live in a small or large family child care home where child care is provided.

- a) Staff health appraisals, as specified in Pre-employment Staff Health Appraisal, STANDARD 1.045;
- b) Educational requirements, as specified in STANDARD 1.009, STANDARD 1.014, STANDARD 1.017 through STANDARD 1.019;
- c) Criminal record files, for crimes of violence against persons, especially children, within the state of residence, and for personnel who have moved into the state within the past 5 years, federal or out of state criminal records of the other state(s) where the individual has resided in the past 5 years;
- d) The child abuse registry, for a known history of child abuse or neglect in the state of residence and for personnel who have moved into the state within the past 5 years, the other state(s) where the individual has resided in the past 5 years.

**DISCUSSION:** In many cases juvenile records are sealed and cannot be used for the purposes of background checks. Ten years is the minimum age to be adjudicated a juvenile offender.

## ALTERNATIVE MEANS OF COMPLIANCE

### RECOMMENDATION 9.008 ALTERNATIVE MEANS OF COMPLIANCE

Alternative means of compliance should be granted from state licensing requirements when the intent of the requirement is being met by equivalent means and does not compromise the health, safety or protection of children.

**DISCUSSION:** The ability to grant alternative means of compliance recognizes the variety of settings and services that can effectively and safely meet children's needs. Flexibility in applying licensing regulations should be permitted to the extent that children's need for protection is met.

## THE REGULATION SETTING PROCESS

### RECOMMENDATION 9.009 RATIONAL BASIS OF REGULATIONS

The state child care regulatory agency should formulate, implement, and enforce regulations that reduce risks to children in out-of-home child care.

**DISCUSSION:** Regulations describe the minimum performance required of a facility. Regulations must be:

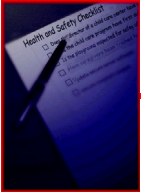
- Understandable to any reasonable citizen;
- Specific enough that any person knows what is to be done and what is not to be done;
- Enforceable, in that they are capable of measurement;
- Consistent with new technical knowledge and changes in public views to offer necessary protection.

### RECOMMENDATION 9.010 COMMUNITY PARTICIPATION IN DEVELOPMENT OF LICENSING RULES

State licensing rules should be developed with active community participation by all interested parties including parents, service providers, advocates, professionals in medical and child development fields, funding and training sources.

Regulations formulated through a representative citizen process should come before the public at well-publicized public hearings held at convenient times and places in different parts of the state. The licensing rules should be re-examined and revised at least every 5 years. The regulatory development process should include many opportunities for public debate and discussion as well as the ability to provide written input.

**DISCUSSION:** The legal principle of broad interest representation has long been applied to the formulation of regulations for child care. Changes in regulation can be implemented only with broad support from the different interests affected. State administrative laws and constitutional principles require public review. The interests of the child must take precedence over all other interests.



## RECOMMENDATION 9.011 COLLABORATIVE DEVELOPMENT OF CHILD CARE REQUIREMENTS AND GUIDELINES

Local and state health departments, child care licensing agencies, health professionals, attorneys, caregivers, parents, and representatives of the business community, including employers, should work together to develop child care licensing requirements and guidelines for ill children.

**DISCUSSION:** Local and state health departments have the legal responsibility to control communicable diseases in their jurisdictions (4). To meet this responsibility, health departments generally have the expertise to provide leadership and technical assistance to licensing authorities, caregivers, parents, and health professionals in the development of licensing requirements and guidelines for the management of ill children. The heavy reliance on the expertise of local and state health departments in the establishment of facilities to care for ill children has fostered a partnership in many states among health departments, licensing authorities, caregivers, and parents for the adequate care of ill children in child care settings. In addition, the business community has a vested interest in assuring that parents have facilities that provide quality care for ill children so parents can be productive in the workplace. This vested interest is likely to produce meaningful contributions from the business community to creative solutions and innovative ideas about how to approach the regulation of facilities for ill children. All stakeholders in the care of ill children should be involved for the solutions that are developed in regulations to be most successful.

See also Caring for Ill Children, STANDARD 3.070 through STANDARD 3.080.

## ADMINISTRATION OF THE LICENSING AGENCY

### GENERAL

## RECOMMENDATION 9.012 ADEQUACY OF STAFF AND FUNDING FOR REGULATORY ENFORCEMENT

All phases of regulatory administration should have authorization, funding, and enough qualified

staff to monitor and enforce the law and regulations of the state.

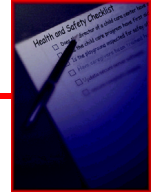
**DISCUSSION:** For regulations to be effective, the regulatory body must formulate, implement, and enforce licensing requirements and assure that licensing inspectors are both sufficient in numbers and capable of fairly and effectively developing and applying the regulations. Funds for all phases of the licensing process should be provided or faulty administrative operations may result, such as inadequate protection of children, formulation of irresponsible standards, inadequate investigations, and insufficient and unfair enforcement.

## STAFF TRAINING

## RECOMMENDATION 9.013 TRAINING AND PERFORMANCE MONITORING OF LICENSING INSPECTORS

Licensing inspectors should receive initial and periodic competency-based training to monitor compliance with licensing standards. Competency should be initially and periodically assessed by simultaneous, independent monitoring by a skilled licensing inspector until the trainee attains the necessary skills.

**DISCUSSION:** Objective assessment of compliance is a learned skill that can be fostered by classroom and self teaching methods but should be mastered through direct practice and apprenticeship. To ensure consistent protection of children, licensing inspectors should undergo periodic retraining and reevaluation to assess their ability to recognize sound and unsound practices. In addition, all staff involved in licensing such as agency directors, attorneys, policy staff, managers, clerical/support personnel and information system staff need periodic training updates. Training for licensors should include best practice and programming, child development theory, and law enforcement.



## STAFFING CAPABILITY

### RECOMMENDATION 9.014 FREQUENCY OF INSPECTIONS OF FACILITIES

Sufficient numbers of licensing inspectors should be hired to provide sufficient time visiting and inspecting facilities to insure compliance with regulations.

**DISCUSSION:** Licensing centers and large family child care homes should require at least one pre-licensing visit, and at least one more visit after granting of the provisional license, and after children are in attendance, to determine that all requirements are being met and that a full license can be granted. In addition, licensing inspectors should follow up promptly, based on priority of severity and on complaints of noncompliance made by parents and the general public. They should make routine unannounced inspections at least annually to determine continued compliance, and they should study compliance at length at the time of re-licensing. The most effective way of ensuring compliance with standards is through the licensors' presence in facilities, identifying deficiencies and giving technical assistance/consultation to bring about compliance. Workloads should be designed so that the licensing inspectors' time is not consumed by in-office tasks.

### RECOMMENDATION 9.015 EDUCATION AND EXPERIENCE OF LICENSING INSPECTORS

Licensing inspectors, and others in licensing positions, should be pre-qualified by education and experience to be knowledgeable about the form of child care they are assigned to inspect. They should receive no less than 40 clock hours of orientation training upon employment. In addition, they should receive no less than 24 clock hours of continuing education each year, covering the following topics and other such topics as necessary based on competency needs:

- a) The licensing statutes and rules for child care;
- b) Other applicable state and federal statutes and regulations;

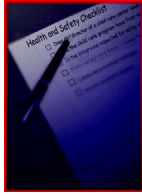
- c) The historical, conceptual and theoretical basis for licensing, investigation, and enforcement;
- d) Technical skills related to the person's duties and responsibilities, such as investigative techniques, interviewing, rule-writing, due process, and data management;
- e) Child development, early childhood education principles, child care programming, scheduling, and design of space;
- f) Law enforcement and the rights of licensees;
- g) Center and large or small family child care home management;
- h) Child and staff health in child care;
- i) Detection, prevention, and management of child abuse;
- j) Practical techniques for inclusion of children with special needs;
- k) Exclusion/inclusion of ill children;
- l) Health, safety, and nutrition;
- m) Recognition of hazards.

**DISCUSSION:** Licensing inspectors are a point of contact and linkage for caregivers and sources of technical information needed to improve the quality of child care. This is particularly true for areas not usually within the network of early childhood professionals, such as health and safety expertise. Unless the licensing inspector is competent and able to recognize areas where facilities need to improve their health and safety provisions, the opportunity for such linkages will be lost.

### RECOMMENDATION 9.016 TRAINING OF LICENSING AGENCY PERSONNEL ABOUT CHILD ABUSE

Staff and administrators in licensing agencies and state supported resource and referral agencies should receive 16 hours of training about child abuse with an emphasis on how child abuse occurs in child care.

**DISCUSSION:** Licensing and resource and referral persons should be as well informed about child abuse issues as caregivers, or better. States should establish inspection procedures to ensure compliance of their agency personnel.



## INSPECTIONS

### RECOMMENDATION 9.017 STATUTORY AUTHORIZATION OF ON-SITE INSPECTIONS

The state statute should authorize the state regulatory agency to conduct on-site inspections.

**DISCUSSION:** The National Association for the Education of Young Children (NAEYC) Position Statement says, “Effective enforcement requires periodic on-site inspections on both an announced and unannounced basis with meaningful sanctions for noncompliance” (1). When unannounced inspections are used, they should be conducted at any hour the facility is in operation, i.e., evenings and nights included if the facility operates at those times. NAEYC recommends that all centers and large and small family child care homes receive at least one site visit per year. Unannounced inspections have been shown to be especially effective when targeted to providers with a history of low compliance. (1)

### RECOMMENDATION 9.018 INITIAL INSPECTION AND AT LEAST ONE ANNUAL INSPECTION

The licensing inspector should make an initial inspection upon receipt of the application for license (either announced or unannounced within a specified time frame), and at least one annual inspection to each center and large and small family child care home thereafter. These inspections may be announced or unannounced.

The schedule of inspections depends upon the quality of the facility as measured by:

- a) The results of an annual inspection by a regulatory inspector;
- b) Concerns raised about compliance with rules by visitors who provide technical assistance and training for the child care providers;
- c) Inspections initiated because of complaints.

The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Parents should be given a summary list of rules and a telephone number for reporting violations and should be encouraged to observe the facility for compliance.

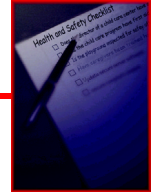
**DISCUSSION:** The initial inspection and consultation often lead to full compliance with health, safety, and program standards, but over time, compliance may slip. Supervision and monitoring of child care facilities are critical to facilitate compliance with the rules in order to prevent or correct problems before they become serious. Technical assistance and consultation on an on-going basis can be very successful in helping programs to achieve compliance with the rules and even to go beyond the basic level of quality. These positive strategies are most effective when they are coupled with the non-regulatory methods used by other parts of the early care and education community to promote quality (such as accreditation, training/education, peer support, and consumer education). All of these methods are most effective when they work together within a coordinated child care system.

Family child care home providers need the same level of support as do larger child care programs. When the licensing agency is not able to make annual inspections, additional contact and support can be provided by other sources, such as the Child and Adult Food Program, a mentor caregiver, or a designated child care health consultant. In these situations, the on-site monitors are encouraged to inspect the facility for basic health and safety hazards and to report to the licensing agency observations of any substantial non-compliance with rules. State statutes and policy differ on the frequency of on-site inspections. Since the average duration of a small family child care home is often less than two years, more frequent visits of licensing inspectors or consultants to these facilities might help keep them in the system and improve the quality of care.

Recent changes in welfare policies have, in some states, supported the growth of “informal” family child care, which is “legally exempt” from regulation. As a consequence, some children who may benefit most from a high quality child care program are in programs that are never visited by a regulator of any kind.

### RECOMMENDATION 9.019 MONITORING STRATEGIES

The licensing agency should adopt monitoring strategies that ensure compliance with licensing requirements. When these strategies do not include a total annual review of all licensing requirements, the agency should review selected policies and performance indicators and/or conduct a random sampling of licensing requirements at least annually. The licensing agency should have



procedures and staffing in place to increase the level of compliance monitoring for any facility found in significant noncompliance.

**DISCUSSION:** Due to an insufficient number of inspectors in licensing agencies across the country, it is important to use various methods in the licensing process to insure quality.

## PROCEDURES FOR COMPLAINTS AND REPORTING

### RECOMMENDATION 9.020 PROCEDURE FOR RECEIVING COMPLAINTS

Each licensing agency should have a procedure for receiving complaints regarding violation of the regulations. Such complaints should be recorded, investigated, and appropriate action, if indicated, should be taken.

**DISCUSSION:** The telephone number for filing complaints should be listed on material about licensing that is given to parents by the state licensing agency or the resource and referral agency. At a minimum, the licensing agency has responsibility for consumer protection. Complaints serve as an early warning before more serious adverse events occur. A fair and equitable process for handling complaints is essential to protect both the person complaining and the target of the complaint from harassment.

### RECOMMENDATION 9.021 WHISTLE-BLOWER PROTECTION UNDER STATE LAW

State law should ensure that caregivers and child care staff who report violation of licensing requirements in the settings where they work are immune from discharge, retaliation, or other disciplinary action for that reason alone, unless it is proven that the report was malicious.

**DISCUSSION:** Staff in child care facilities are in an excellent position to note areas of noncompliance

with licensing requirements in the setting where they work. However, so that they feel safe about reporting these deficiencies, they must be assured immunity from retaliation by the child care facility unless the report is malicious. This immunity is best provided when a state statute mandates it. Individuals who report problems in their own workplace may be known as “whistle-blowers”.

States should recognize and develop a system to deal with complaints against a provider that are retaliatory by disgruntled staff or parents. At times these nuisance complaints serve only to harass the provider and expend valuable licensing resources or unnecessary work.

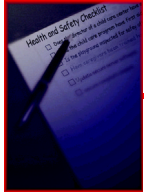
### RECOMMENDATION 9.022 PUBLICITY ABOUT REPORTING SUSPECTED CHILD ABUSE

Licensing agencies should publicize the requirements for reporting and methods of reporting suspected child abuse.

**DISCUSSION:** Child care staff and parents should be aware of the reporting requirements and the procedures for handling reports of child abuse. State requirements may differ, but those for whom reporting suspected abuse is mandatory usually include child care personnel. Information on how to call and how to report should be posted so it is readily available to parents and staff. Emotional abuse can be extremely harmful to children, but unlike physical or sexual abuse, it is not adequately defined in most state child abuse reporting laws. States need to develop procedures for handling allegations of all types of abuse.

Procedures for evaluating allegations of physical and emotional abuse may or may not be the purview of the licensing agency. This responsibility may fall to another agency to which the licensing agency refers child abuse allegations.

For additional information, see Posting Documents, STANDARD 8.077; for training and educational materials, see STANDARD 1.023 and STANDARD 1.036; and Child Abuse and Neglect, STANDARD 3.053 through STANDARD 3.059.



## ENFORCEMENT

### RECOMMENDATION 9.023 STATE STATUTE SUPPORT OF REGULATORY ENFORCEMENT

The state statute should authorize the suppression of illegal operations and enforcement of child care regulations and statutory provisions.

**DISCUSSION:** Without proper enforcement, especially the suppression of illegal operations, licensing could become a ritual and lose its safeguarding intent. Some state laws lack adequate provisions for enforcement.

## ADVISORY GROUP

### RECOMMENDATION 9.024 CHILD CARE ADVISORY BODY

States should have an official broad-based child care advisory body to deal with a wide scope of both regulatory and policy child care related issues. This advisory body should be composed of public and private agency personnel, child development and health professionals, child care providers including caregivers, parents, and citizens.

**DISCUSSION:** A child care advisory board is needed to:

- Review overall rules and regulations for the operation and maintenance of facilities and the granting, suspending, and revoking of both provisional and regular licenses;
- Recommend administrative policy;
- Recommend changes in legislation.

The advisory group may include representatives from the following agencies and groups:

- a) Governor's office;
- b) Legislature;
- c) State agencies with regulatory responsibility or an interest in child care (human services, public health, fire marshal, emergency medical services, education, human resources, attorney general, safety council);
- d) Private organizations with a child care emphasis;
- e) Child care providers including caregivers;

- f) Professionals with expertise in pediatrics, nutrition, mental health, oral health, injury prevention, or early childhood education;
- g) Parents who represent ethnic and cultural diversity;
- h) Citizens.

The advisory group should actively seek citizen participation in the development of child care policy, including parents and child care providers at the level of administration and one-to-one care to children. One method for encouraging citizen participation is through public hearings. In response to specific issues, it is often effective to constitute an ad hoc group to study the questions and provide input to the regulatory agency.

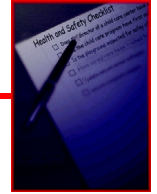
## 9.2 HEALTH DEPARTMENT RESPONSIBILITY

### HEALTH DEPARTMENT ROLE AND PLAN

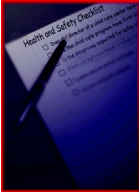
#### RECOMMENDATION 9.025 STATE AND LOCAL HEALTH DEPARTMENT ROLE

State and local health departments should play an important role in the identification, prevention and control of injuries, injury risk, and infectious disease in child care settings as well as in using the child care setting to promote health. This role includes the following activities to be conducted in collaboration with the child care licensing agency:

1. Assisting in the planning of a comprehensive health and safety program for children and child care providers.
2. Monitoring the occurrence of serious injury events and outbreaks involving children or providers.
3. Alerting the responsible child care administrators about identified or potential injury hazards and infectious disease risks in the child care setting.
4. Controlling outbreaks, identifying and reporting communicable diseases in child care settings including:
  - a) Methods for notifying parents, caregivers, and health care providers of the problem.



- b) Providing appropriate actions for the child care provider to take;
  - c) Providing policies for exclusion or isolation of infected children;
  - d) Arranging a source and method for the administration of needed medication.
  - e) Providing a list of reportable diseases, including descriptions of these diseases. The list should specify where diseases are to be reported and what information is to be provided by the child care provider to the health department and to parents;
  - f) Requiring that all facilities, regardless of licensure status, and all health care providers report certain communicable diseases to the responsible local or state public health authority. The child care licensing authority should require such reporting under its regulatory jurisdiction and should collaborate fully with the health department when the latter is engaged in an enforcement action with a licensed facility;
  - g) Determining whether a disease represents a potential health risk to children in out-of-home child care;
  - h) Conducting the epidemiological investigation necessary to initiate public health interventions;
  - i) Recommending a disease prevention or control strategy that is based on sound public health and clinical practices (such as the use of vaccine, immunoglobulin, or antibiotics taken to prevent an infection).
  - j) Verifying reports of communicable diseases received from facilities with the assessment and diagnosis of the disease made by a health care provider and, or the local or state health department.
5. Designing systems and forms for use by facilities for the care of ill children to document the surveillance of cared for illnesses and problems that arise in the care of children in such child care settings.
  6. Assisting in the development of orientation and annual training programs for caregivers. Such training shall include specialized education for staff of facilities that include ill children, as well as those in special facilities that serve only ill children. Specialized training for staff who care for ill children should focus on the recognition and management of childhood illnesses, as well as the care of children with communicable diseases.
  7. Assisting the licensing authority in the periodic review of facility performance related to caring for ill children by:
    - a) Reviewing written policies developed by facilities regarding inclusion, exclusion, dismissal criteria and plans for health care, urgent and emergency care, and reporting and managing children with communicable disease;
    - b) Assisting with periodic compliance reviews for those rules relating to inclusion, exclusion, dismissal, daily health care, urgent and emergency care, and reporting and management of children with communicable disease.
  9. Collaborating in the planning and implementation of appropriate training and educational programs related to health and safety in child care facilities. Such training should include education of parents, physicians, public health workers, licensing inspectors, and employers about how to prevent injury and disease as well as promote health of children and their caregivers.
  10. Ensuring that health care personnel, such as qualified public health nurses, pediatric and family nurse practitioners, and pediatricians serve as child care health consultants as required in STANDARD 1.040 through STANDARD 1.044 and as members of advisory boards for facilities serving ill children.
- DISCUSSION: A number of studies have described the incidence of injuries in the child care settings (23-26). Although the injuries described have not been serious, these occur frequently, and may require medical or emergency attention. Child care programs need the assistance of local and state health agencies in planning of the safety program that will minimize the risk for serious injury(10). This would include planning for such significant emergencies as fire, flood, tornado, or earthquake (27). A community health agency can collect information that can promptly identify an injury risk or hazard and provide an early notice about the risk or hazard (28). An example is the recent identification of un-powered scooters as a significant injury risk for preschool children (29). Once the injury risk is identified, appropriate channels of communication are required to alert the child care administrators and to provide training and educational activities.
- Effective control and prevention of infectious diseases in child care settings depends on affirmative relationships among parents, caregivers, public health



authorities, regulatory agencies, and primary health care providers. The major barriers to productive working relationships between caregivers and health care providers are inadequate channels of communication and uncertainty of role definition. Public health authorities can play a major role in improving the relationship between caregivers and health care providers by disseminating information regarding disease reporting laws, prescribed measures for control and prevention of diseases and injuries, and resources that are available for these activities (9).

State and local health departments are legally required to control certain communicable diseases within their jurisdictions. All states have laws that grant extraordinary powers to public health departments during outbreaks of communicable diseases (4). Since communicable disease is likely to occur in child care settings, a plan for the control of communicable diseases in these settings is essential and often legally required. Early recognition and prompt intervention will reduce the spread of infection. Outbreaks of communicable disease in child care settings can have great implications for the general community (6). Programs administered by local health departments have been more successful in controlling outbreaks of hepatitis A than those that rely primarily on private physicians. Programs coordinated by the local health department also provide reassurance to caregivers, staff, and parents, and thereby promote cooperation with other disease control policies (7). Communicable diseases in child care settings pose new epidemiological considerations. Only in recent decades has it been so common for very young children to spend most of their days together in groups. Public health authorities should expand their role in studying this situation and designing new preventive health measures (8).

Collaboration is necessary to use limited resources most effectively. In small states, a state level task force that includes the Department of Health, might be sufficient. In larger or more populous states, local task forces may be needed. The collaboration should focus on establishing the role of each agency in ensuring that necessary services and systems exist to prevent and control injuries and communicable diseases in facilities.

Health departments generally have or should develop the expertise to provide leadership and technical assistance to licensing authorities, caregivers, parents, and health professionals in the development of licensing requirements and guidelines for the management of ill children. The heavy reliance on the expertise of local and state health departments in the establishment of facilities to care for ill children has fostered a partnership in many states among health depart-

ments, licensing authorities, caregivers, and parents for the adequate care of ill children in child care settings. In addition, the business community has a vested interest in assuring that parents have facilities that provide quality care for ill children so parents can be productive in the workplace.

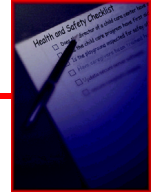
This vested interest is likely to produce meaningful contributions from the business community to creative solutions and innovative ideas about how to approach the regulation of facilities for ill children. All stakeholders in the care of ill children should be involved for the solutions that are developed in regulations to be most successful. For additional information on the training for staff in facilities serving ill children, see STANDARD 3.073; for information regarding health consultants in facilities serving ill children, see STANDARD 3.075.

See also Reporting Illness, STANDARD 3.086 and STANDARD 3.087.

### **RECOMMENDATION 9.026 WRITTEN PLANS FOR THE HEALTH DEPARTMENT ROLE**

The health department's role defined in RECOMMENDATION 9.028 should be described in written plans that assign the responsibilities of community agencies and organizations involved in the prevention and control of injury, injury risk and communicable disease in facilities. The plan should identify child care related risks and diseases as well as provide guidance for risk reduction, disease prevention and control. The health department should develop these written plans in collaboration with the licensing agency (if other than the health department), health care providers, caregivers, and parents to ensure the availability of sufficient community resources for successful implementation. In addition, the health department should provide assistance to the licensing agency (if other than the health department) for the promulgation and enforcement of child care facility standards. These services should be in addition to the health agency's assigned responsibilities for enforcement of the state's immunization and other health laws and regulations.

In addition to *Caring for Our Children* and *Stepping Stones*, the following resources should be consulted in the development of the health department plan:



- a) Guidelines provided by the Centers for Disease Control and Prevention (CDC);
- b) Guidelines from the American Academy of Pediatrics (AAP), including *The Red Book*, the *Report of the Committee on Infectious Diseases: Guidelines for Health Supervision*, and the many other relevant technical manuals on such topics as environment and nutrition;
- c) Guidelines from the American Public Health Association (APHA), including *Control of Communicable Diseases in Man*;
- d) Guidelines from the U.S. Public Health Service's Advisory Committee on Immunization Practices, as reported periodically in *Morbidity and Mortality Weekly Report*;
- e) State and local regulations and guidelines regarding communicable diseases in facilities;
- f) *Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents*;
- g) *Healthy Child Care America Campaign*;
- h) Current early childhood nutrition guidelines such as *Making Food Healthy and Safe for Children*.

DISCUSSION: Written plans help define delegation and accountability, providing the continuity of purpose that helps to institutionalize performance. Contact information for the resources listed above is located in Appendix BB.

### RECOMMENDATION 9.027 REQUIREMENTS FOR FACILITIES TO REPORT TO HEALTH DEPARTMENT

The child care licensing authority should require all facilities under its regulatory jurisdiction to report to the health department and comply with state and local rules and regulations intended to prevent injury and infectious disease that apply to child care facilities.

DISCUSSION: State and local health departments are legally required to control certain communicable diseases within their jurisdictions. Legal requirements for the role of health departments and other government entities in control of injuries vary. States may delegate injury prevention duties to agencies responsible for fire prevention, building inspection, transportation safety, environmental health, agriculture, etc. All states have laws that grant extraordinary powers to public health departments during outbreaks of communicable disease (4). Since communicable disease is likely to occur in child care

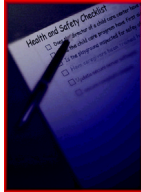
settings, a plan for the control of communicable diseases in these settings is essential and often legally required. Early recognition and prompt intervention will reduce the spread of infection.

Outbreaks of communicable disease in child care settings can have great implications for the general community (6). Programs administered by local health departments have been more successful in controlling outbreaks of hepatitis A than those that rely primarily on private physicians. Programs coordinated by the local health department also provide reassurance to caregivers, staff, and parents, and thereby promote cooperation with other disease control policies (7). Communicable diseases in child care settings pose new epidemiological considerations. Only in recent decades has it been so common for very young children to spend most of their days together in groups. Public health authorities should expand their role in studying this situation and designing new preventive health measures (8).

### RECOMMENDATION 9.028 HEALTH DEPARTMENT ASSISTANCE TO PREPARE PARENT AND STAFF FACT SHEETS

Health departments should help child care providers use prepared prototype parent and staff fact sheets on common illnesses associated with child care. These fact sheets should:

- a) Be provided to parents when their child is first admitted to the facility, to staff at the time of employment and to both parents and staff when communicable disease notification is recommended.
- b) Contain the following information:
  - 1) Disease (case or outbreak) to which the child was exposed;
  - 2) Signs and symptoms of the disease that the parents and caregivers should watch for in the child;
  - 3) Mode of transmission of the disease;
  - 4) Period of communicability;
  - 5) Disease prevention measures recommended by the public health department (if appropriate);
- c) Emphasize modes of transmission of respiratory disease and infections of the intestines (often with diarrhea) and liver, common methods of infection control (such as handwashing). See Hygiene, STANDARD 3.012 through STANDARD 3.027, and Infectious Diseases,



**STANDARD 6.001 through STANDARD 6.039,** for specific diseases that may be asymptomatic in the child but have important consequences for a parent contact (such as hepatitis A virus (HAV) or cytomegalovirus (CMV) including the Centers for Disease Control and Prevention (CDC) guidelines specific to cytomegalovirus (CMV) transmission, exposure, and fetal risk for women providing child care.);

**DISCUSSION:** Education is a primary method for providing information to physicians and parents about the incidence of communicable diseases in child care settings (11). Education of child care staff and parents on the recognition and transmission of various communicable diseases is important to any infection control policy (11). Training of child care staff has improved the quality of their health related behaviors and practices. Training should be available to all parties involved, including caregivers, public health workers, health care providers, parents, and children. Good quality training, with imaginative and accessible methods of presentation supported by well-designed materials, will facilitate learning. The number of studies evaluating the importance of education of child care staff in the prevention of disease is limited. However, data from numerous studies in hospitals illustrate the important role of continuing education in preventing and minimizing the transmission of communicable disease (11). The provision of fact sheets on communicable childhood diseases at the time their child is admitted to a facility helps educate parents as to the early signs and symptoms of these illnesses and the need to inform caregivers of their existence. Illness information sheets can be assembled in a convenient booklet for this purpose. Health departments may consult or use nationally accepted fact sheets on common illnesses available from such agencies as the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the National Association for the Education of Young Children (NAEYC).

For example, CMV is the leading cause of congenital infection in the United States, with approximately 1% of live born infants infected prenatally (12). Fortunately, most infected fetuses escape resulting illness or disability, but 10% to 20% will have hearing loss, mental retardation, cerebral palsy, or vision disturbances. Although it is well known that maternal immunity does not prevent congenital CMV infection, evidence indicates that initial acquisition of CMV during pregnancy (primary maternal infection) carries the greatest risk for resulting illness or disability (12). With current knowledge about the risk of CMV infection in child care staff and the potential consequences of gestational CMV infection, child care staff should

be counseled regarding risks. However, it is unlikely that many facility directors have access to the information needed to counsel employees, and many health care providers may lack sufficient knowledge in the area. Therefore, state and local health departments should distribute the Centers for Disease Control and Prevention (CDC) guidelines on CMV to providers.

For information on Staff Education and Policies on cytomegalovirus (CMV), see STANDARD 6.021. Contact information for CDC, AAP, and NAEYC is located in Appendix BB.

### **RECOMMENDATION 9.029 SOURCES OF TECHNICAL ASSISTANCE TO SUPPORT QUALITY OF CHILD CARE**

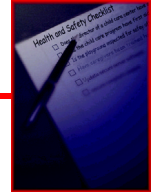
Public authorities, such as licensing agencies, and private agencies, such as resource and referral agencies, should develop systems for technical assistance to states, localities, and child care agencies and providers that address the following:

- a) Meeting licensing and certification requirements. See Individual Credentialing/Certification, RECOMMENDATION 9.006 and RECOMMENDATION 9.007;
- b) Establishing programs that meet the developmental needs of children;
- c) Educating parents on specific health and safety issues through the production and distribution of related material. See Health Education for Parents, STANDARD 2.065 through STANDARD 2.067.

**DISCUSSION:** The administrative practice of developing systems for technical assistance is designed to enhance the overall quality of child care that meets the social and developmental needs of children. The chief sources of technical assistance are:

- a) Licensing agencies (on ways to meet the regulations);
- b) Health departments (on health related matters);
- c) Resource and referral agencies (on ways to achieve quality, how to start a new facility, supply and demand data, how to get licensed, and what parents want).

The state agency has a continuing responsibility to assist an applicant in qualifying for a license and to help licensees improve and maintain the quality of their facility. Regulations should be available to parents and interested citizens upon request.



Licensing inspectors throughout the state should be required to offer assistance and consultation as a regular part of their duties.

Providing centers and networks of small or large family child care homes with guidelines and information on establishing a program of care is intended to promote appropriate programs of activities. Child care staff are rarely trained health professionals. Since staff and time are often limited, caregivers should have access to consultation on available resources in a variety of fields (such as physical and mental health care; nutrition; safety, including fire safety; oral health care; developmental disabilities, and cultural sensitivity) (13).

The public agencies can facilitate access to children and their families by providing useful materials to child care providers.

## TECHNICAL ASSISTANCE FROM THE LICENSING AGENCY

### RECOMMENDATION 9.030 LICENSING AGENCY PROVISION OF CHILD ABUSE PREVENTION MATERIALS

The licensing agency should be a resource for or have knowledge of sources of child abuse prevention materials for child care facilities and parents.

DISCUSSION: Centers and small and large family child care homes are good locations to distribute materials for the prevention of abuse.

### RECOMMENDATION 9.031 LICENSING AGENCY PROVISION OF WRITTEN AGREEMENTS FOR PARENTS AND CAREGIVERS

The licensing agency or a resource and referral agency should provide guidance, technical assistance, and training to support parents and caregivers in developing the written agreements that are required to be available at the time of an inspection visit based on standard language for agreements.

DISCUSSION: The licensing agency can be a resource to parents and caregivers in locating the appropriate materials and tools.

### RECOMMENDATION 9.032 COLLECTION OF DATA ON ILLNESS OR HARM TO CHILDREN IN FACILITIES

The state regulatory agency should have access to an information system for collecting data relative to the incidence of illness, injuries, confirmed child abuse and neglect, and death of children in facilities. This data should be shared with appropriate agencies and the child care health consultant for analysis.

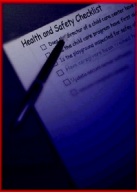
DISCUSSION: Sound public policy planning in respect to health and safety in facilities starts with the collection of epidemiological data.

### RECOMMENDATION 9.033 SUPPORT FOR CONSULTANTS TO PROVIDE TECHNICAL ASSISTANCE TO FACILITIES

State agencies should encourage the arrangement of and the fiscal support for consultants from the local community to provide technical assistance for program development and maintenance. Consultants should have training and experience in early childhood education, issues of health and safety in child care settings, ability to establish collegial relationships with child care providers, adult learning techniques, and ability to help establish links between facilities and community resources.

The state regulatory agency should provide or arrange for other public agencies, private organizations or technical assistance agencies (such as a resource and referral agency) to make the following consultants available to the community of child care providers of all types:

- 1) Program Consultant, to provide technical assistance for program development and maintenance. Consultants should be chosen on the basis of training and experience in early childhood education and ability to help establish links between the facility and community resources;

- 
- 2) Child Health Consultant, who has expertise in child health and child development, is knowledgeable about the special needs of children in out-of-home care settings, and knows the child care licensing requirements and available health resources. A regional plan to make consultants accessible to facilities should be developed;
  - 3) Nutrition Specialist, to be responsible for the development of policies and procedures and for the implementation of nutrition standards to provide high quality meals, nutrition education programs, and appropriately trained personnel, and to provide consultation to agency personnel, including licensing inspectors;
  - 4) Mental Health Consultant, to assist centers, large family child care homes, and networks of small family child care homes in meeting the emotional needs of children and families. The state mental health agency should promote funding through community mental health agencies and child guidance clinics for these services. At the least, such consultants should be available when caregivers identify children whose behaviors are more difficult to manage than typically developing children.

**DISCUSSION:** Securing expertise is acceptable by whatever method is most workable at the state or local level (for example, consultation could be provided from a resource and referral agency). Providers, not the regulatory agency, are responsible for securing the type of consultation that is required by their individual facilities.

The mental health consultant for children younger than school-age is the most difficult of the health consultants to locate. Pediatricians who specialize in developmental pediatrics are most likely to be helpful for this type of consultation. Some, but not all, pediatric psychiatrists and psychologists have the necessary skills to work with behavior problems of this youngest age group. To find such specialists, contact the Department of Pediatrics at academic centers. The faculty at such centers can usually refer child care facilities to individuals with the necessary skills in their area.

The administrative practice of developing systems for technical assistance is designed to enhance the overall quality of child care that meets the social and developmental needs of children. The chief sources of technical assistance are:

- a) Licensing agencies (on ways to meet the regulations);
- b) Health departments (on health related matters);

- c) Resource and referral agencies (on ways to achieve quality, how to start a new facility, supply and demand data, how to get licensed, and what parents want).

Providing centers and networks of small or large family child care homes with guidelines and information on establishing a program of care is intended to promote appropriate programs of activities. Child care staff are rarely trained health professionals. Since staff and time are often limited, caregivers should have access to consultation on available resources in a variety of fields (such as physical and mental health care; nutrition; safety, including fire safety; oral health care; developmental disabilities, and cultural sensitivity) (13).

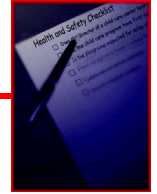
The public agencies can facilitate access to children and their families by providing useful materials to child care providers.

### **RECOMMENDATION 9.034 DEVELOPMENT OF LIST OF PROVIDERS OF SERVICES TO FACILITIES**

The local regulatory agency or resource and referral agency should assist centers and small and large family child care homes to formulate and maintain a list of community professionals and agencies available to provide needed health, dental, and social services to families.

**DISCUSSION:** Families depend on their child care facilities to provide information about obtaining health and dental care and other community services. A number of communities have Family Resource Centers, which are central points for information. It is important that regulatory agencies and resource and referral agencies have knowledge of family resource centers or can provide a directory of community services to child care facilities.

Partnerships among health care professionals and community agencies are necessary to provide a medical home for all children. The American Academy of Pediatrics (AAP) defines the medical home as care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. The medical home is not a building, house, or hospital, but an approach to providing health care services in a high-quality and cost-effective manner (14, 15, 16). Health care professionals and other community service agencies are beginning to recognize that child



care facilities are a logical opportunity to provide health promotion and disease prevention services for children and families.

## CONSULTANTS AND TECHNICAL ASSISTANCE FOR CHILDREN WITH SPECIAL NEEDS

### RECOMMENDATION 9.035 RESOURCES FOR PARENTS OF CHILDREN WITH SPECIAL NEEDS

The state agency or council of agencies responsible for child care services for children with special needs should provide or arrange for the distribution to parents, printed and audiovisual information about assessment of facilities for care of children who are developing differently from typical children.

In addition, the regulatory agency should refer caregivers of children with special needs to community resources for assistance in development and formulation of the written plan of care.

**DISCUSSION:** Parents of children with special needs require support to enable their identification and evaluation of facilities where their children can receive quality child care.

Parents should participate in facility evaluation, both formally and informally. Unless the Interagency Coordinating Council (ICC) or some similar body provides materials to parents, they are unlikely to be able to find and evaluate options for child care for special needs children. While the professionals involved with the family may do this for the family, the parents should have every opportunity to play a significant role in the process.

The state licensing agency as well as the state agencies responsible for implementation of Public Law 105-17, known as the Individuals with Disabilities Education Act (IDEA), should assist child care providers to recognize the opportunity they have to participate in the child's overall care planning and to obtain education they need to provide care to the children.

### RECOMMENDATION 9.036 COMPENSATION FOR PARTICIPATION IN MULTIDISCIPLINARY ASSESSMENTS FOR CHILDREN WITH SPECIAL NEEDS

The agency (or a council of such agencies) within the state responsible for overseeing child care for children with special educational needs should assure that the Individualized Family Service Plan (IFSP) or the Individualized Education Program (IEP) includes compensation for the hours of time spent by members of the multidisciplinary team and the staff from the out-of-home facility in developing the assessment defined in Assessment of Facilities for Children with Special Needs, STANDARD 7.014 through STANDARD 7.016.

**DISCUSSION:** Unless there is a source of compensation for the time spent in planning and completing assessments, these requirements cannot be implemented.

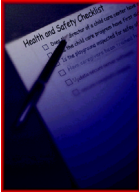
Funding under Individuals with Disabilities Education Act (IDEA) makes it possible for the resources and funding for service to follow the child. Traditionally, these funds have paid for individual therapists, and not for involving others who do not receive compensation for the time they spend in the planning process. Tradition and restrained spending by this practice inhibit effective service delivery for children and families.

## NETWORKING

### RECOMMENDATION 9.037 DEVELOPMENT OF CHILD CARE PROVIDER ORGANIZATIONS AND NETWORKS

State-level agencies and resource and referral agencies should encourage the development of child care provider organizations or networks, to attract, train, support, and encourage participation in facility accreditation, and monitor those caregivers who would like to be part of an organization or system.

**DISCUSSION:** To enhance staff qualifications and a nurturing environment, child care providers need



support (17). This especially applies to family child care home providers who tend to be more isolated than those employed in centers.

In studies of the quality of care in family child care homes, the caregivers who provided better care were those who viewed their role as a profession and acted accordingly, participating in continuous improvement activities (18). Individual caregivers vary widely in educational background and experience. Participation in a network provides access to education and support for individual caregivers. When possible, these networks should include a central facility for enrichment activities for groups of children and support and inservice programs for caregivers.

See Individual Credentialing/Certification, RECOMMENDATION 9.006 and RECOMMENDATION 9.007.

## 9.3 TRAINING

### RECOMMENDATION 9.038 REGULATORY AGENCY PROVISION OF CAREGIVER AND CONSUMER TRAINING AND SUPPORT SERVICES

The regulatory agency should promote participation in a variety of caregiver and consumer training and support services as an integral component of its mission to reduce risks to children in out-of-home child care. Such training should include mechanisms for training of prospective child care staff prior to their assuming responsibility for the care of children.

Persons wanting to enter the child care field should be able to learn from the regulatory agency about training opportunities offered by public and private agencies.

Training programs should address the following:

- a) Child growth and development;
- b) Child care programming and activities;
- c) Discipline and behavior management;
- d) Health and safety practices including injury prevention, infection control and health promotion;
- e) Cultural diversity;
- f) Nutrition and eating habits;

- g) Parent education;
- h) Design and use of physical space;
- i) Care and education of children with special needs.

**DISCUSSION:** Training enhances staff competence (17, 18). In addition to low child:staff ratio, group size, age mix of children, and stability of caregiver, the training/education of caregivers is a specific indicator of child care quality (17, 18). Most states require training for child care staff depending on their functions and responsibilities. Staff members who are better trained are more able to prevent, recognize, and correct health and safety problems. Decisions about management of illness are facilitated by the caregiver's increased skill in assessing a child's behavior that suggests illness (19, 20). Training plans should be based on improving performance rather than on a required number of hours.

The National Resource Center for Health and Safety in Child Care maintains a list of training resources as do Healthy Child Care America (HCCA) grantees within each state.

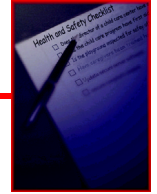
### RECOMMENDATION 9.039 CHILD DEVELOPMENT ASSOCIATE TRAINING

Community colleges, vocational schools, and high schools should make training programs available to all child care providers, regardless of setting, to prepare for the Child Development Associate (CDA) credential.

**DISCUSSION:** CDA training should be offered at times when staff members who are employed fulltime in facilities may attend.

Training of child care staff has improved the quality of their health related behaviors and practices. Training should be available to all parties involved, including caregivers, public health workers, health care providers, parents, and children. Good quality training, with imaginative and accessible methods of presentation supported by well-designed materials, will facilitate learning.

For additional information on training, see also STANDARD 1.023; Continuing Education, STANDARD 1.029 through STANDARD 1.033; and The Health Department's Role, RECOMMENDATION 9.025.



## **RECOMMENDATION 9.040 PROVISION OF TRAINING TO FACILITIES BY HEALTH AGENCIES**

Health departments and Emergency Medical Services (EMS) agencies should provide training, written information, and consultation in coordination with other community resources to facilities, including staff, parents, licensing personnel, and health consultants, in at least the following subject areas:

- a) Immunization;
- b) Reporting of communicable diseases;
- c) Techniques for the prevention and control of communicable diseases;
- d) Exclusion and inclusion guidelines and care of acutely ill children;
- e) General hygiene and sanitation;
- f) Food service and nutrition;
- g) Care of children with special needs (chronic illnesses, developmental disability and behavior problems);
- h) Prevention and management of injury;
- i) Managing emergencies;
- j) Oral health;
- k) Environmental health;
- l) Health promotion, including routine health supervision and the importance of a medical or health home for children and adults;
- m) Health insurance, including Medicaid and the Children's Health Insurance Program (CHIP).

**DISCUSSION:** Training of child care staff has improved the quality of their health related behaviors and practices. Training should be available to all parties involved, including caregivers, public health workers, health care providers, parents, and children. Good quality training, with imaginative and accessible methods of presentation supported by well-designed materials, will facilitate learning.

For additional information on training, see also STANDARD 1.023; Continuing Education, STANDARD 1.029 through STANDARD 1.033; and The Health Department's Role, RECOMMENDATION 9.025.

## **9.4 PROGRAM DEVELOPMENT**

### **RECOMMENDATION 9.041 TECHNICAL ASSISTANCE TO FACILITIES TO ADDRESS DIVERSITY IN THE COMMUNITY**

Technical assistance and incentives should be provided by state, municipal, public, and private agencies to encourage facilities to address within their programs, the cultural and socioeconomic diversity in the broader community, not just in the neighborhood where the child care facility is located.

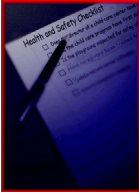
**DISCUSSION:** Children who are exposed to cultural and socioeconomic diversity in early childhood are more likely to value and accept differences between their own backgrounds and those of others as they move through life. This attitude results in improved self-esteem and mental health in children from all backgrounds. Facilities can attract participants from different income and cultural groups by locating in areas convenient to low income families and accessible to middle and upper income parents, and by offering programs that are desirable to a range of parents. Possible locations include:

- a) Sites close to the edge of, rather than deep within, low income housing areas;
- b) Sites near work sites and schools that serve a mix of families;
- c) Sites in mixed income housing areas.

### **RECOMMENDATION 9.042 FOSTERING COLLABORATION TO ESTABLISH PROGRAMS FOR SCHOOL-AGE CHILDREN**

Public and private agencies should foster collaboration among the schools, child care facilities, and resource and referral agencies to establish programs for school-age children, ages 5 to 12 and older. Such care should be designed to meet the social and developmental needs of children who receive care in any setting.

**DISCUSSION:** School-age children who are under-supervised ("latchkey children") are exposed to



considerable health and safety risks. Bringing these children into supervised, quality child care is a societal responsibility.

### **RECOMMENDATION 9.043 PUBLIC-PRIVATE COLLABORATION ON CARE OF MILDLY ILL CHILDREN**

Employers should collaborate with state and regional agencies to facilitate arrangements for the care of mildly ill children in the following settings:

- a) The child's own home, under the supervision of an adult known to the parents and the child;
- b) A separate area in the child's own facility or in a specialized center, where both the caregiver and the facility are familiar to the child;
- c) A child's own small family child care home;
- d) A space within the small family child care home network's central place that serves children from participating small family child care homes, where both the caregiver and the facility are familiar to the child.

**DISCUSSION:** Appropriate care of ill children is preferable to makeshift arrangements that are not in the best interests of the ill child, other children in care, or the family. The most appropriate care of an ill child is at the child's own home by a parent. Businesses should be encouraged to allow the use of sick leave for this purpose. However, when parent care puts the family income or parent employment at risk, the child should receive care that is appropriate for the child. Often, when faced with the pressures of the workplace, parents take ill children to work, leave them in places where either or both the caregiver and place are unfamiliar, or leave them alone. Under the stress of illness, children need familiar caregivers and familiar places where their illnesses and their emotional needs can be managed competently.

See **RECOMMENDATION 9.048**, regarding paid parental leave to care for ill children.

## **9.5 REGULATORY COORDINATION**

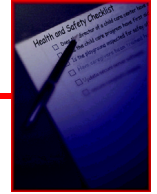
### **RECOMMENDATION 9.044 AGENCY COLLABORATION TO SAFEGUARD CHILDREN IN CHILD CARE**

The state health department, Emergency Medical Services (EMS) agencies, regulatory agencies, funding agencies, child protection agencies, law enforcement agencies, community service agencies, and local government should collaborate to safeguard children in child care. The child care licensing, building, fire safety, and health authorities, as well as any other regulators, should work together as a team. The team should eliminate duplication of inspections to create more efficient regulatory efforts. Examples of activities to be coordinated include:

- a) Inspection;
- b) Reporting and surveillance systems;
- c) Guidance in managing outbreaks of infectious diseases;
- d) Preventing exposure of children to hazards;
- e) Reporting child abuse;
- f) Training and technical consultation.

Agencies should collaborate to educate parents, health care providers, public health workers, licensors, and employers about their roles in ensuring health and safety in child care settings.

**DISCUSSION:** Frequently, caregivers are burdened by complicated procedures and conflicting requirements to obtain clearance from various authorities to operate. To use limited resources, agencies must avoid contradictions in regulatory codes, simplify inspection procedures, and reduce bureaucratic disincentives to the provision of safe and healthy care for children. When regulatory authorities work as a team, collaboration should focus on establishing the role of each agency in ensuring that necessary services and systems exist to prevent and control health and safety problems in facilities. Each member of the team gains opportunities to learn about the responsibilities of other team members so that close working relationships can be established, conflicts can be resolved, and decisions can be reached.



In small states, a state level task force may be sufficient. In larger or more populous states, local task forces may be needed to promote effective use of resources.

## 9.6 PUBLIC POLICY ISSUES AND RESOURCE DEVELOPMENT

### RECOMMENDATION 9.045 STATE-LEVEL COMMISSION ON CHILD CARE

Each state should establish a state-level commission on child care or charge an existing commission with the responsibility for developing a child care plan and facilitating cooperation among government public health, human service, and education departments as well as community-based human services agencies, schools, employers, and caregivers to ensure that the health, safety, and child development needs of children are met by the child care services provided in the state. The commission should include both parents and representatives of agencies and organizations affecting child care. The commission should be mandated by law, and should report to the legislature, to the governor, and to all agencies and organizations represented on the commission no less frequently than once a year. Larger communities should have a local child care advisory body charged with the responsibility of overseeing the development and provision of child care to meet the needs of the particular community with the same broad representation recommended for the state level commission. The state advisory body to the regulatory agency should be a component part of or report to this commission.

**DISCUSSION:** Coordination among public and private sources of health, social service, and education services is essential, especially when young children are in care. Some states have separate groups that advise the health agency, the social service agency, the education agency, the licensing agency, the governor, and the legislature. Other states have some, but not all, of these advisory bodies; each of which has some relevance to child care, but often with a different focus. National initiatives such as the Healthy Child Care America campaign have done much to encourage effective collaboration among agencies and

organizations with the ability to impact child care within states.

Time limited task forces could be created for specific purposes, but there is a need for one standing commission that addresses child care as its primary responsibility. Mandating the commission by law will reduce the likelihood that the commission will be victimized by changes in political leadership or dissolved when its recommendations are not in agreement with a current administration.

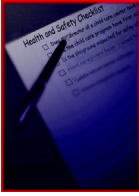
Large municipalities with a similarly diverse group of agencies, authorities, and public and private resources should also have a group to coordinate child care activity. Participation of parent representatives in planning and implementing child care initiatives at the state and local levels promotes effective partnerships between parents and caregivers.

### RECOMMENDATION 9.046 DEVELOPMENT OF RESOURCE AND REFERRAL AGENCIES

States should encourage the use of public and private resources in local communities to develop resource and referral agencies. The functions of these agencies should include the following:

- a) Helping parents find developmentally appropriate child care that protects the health and safety of children;
- b) Giving parents consumer information to enable them to know about, evaluate, and choose among available child care options;
- c) Helping parents maintain a dialogue with their caregivers;
- d) Recruiting new potential caregivers;
- e) Providing training, technical assistance, and consultation to new facilities, and to all caregivers;
- f) Compiling data on supply and demand to identify community needs for child care;
- g) Providing information to employers on options for their involvement in meeting community child care needs.

**DISCUSSION:** Resource and referral agencies provide a locus in the community to assist parents in fulfilling their childrearing responsibilities, a mechanism to coordinate and provide the resources and services that supplement and facilitate the functions of the family, and a mechanism for the coordination of services that helps keep children safe and healthy.



### **RECOMMENDATION 9.047 COORDINATION OF PUBLIC AND PRIVATE POLICYMAKERS TO ENSURE FAMILIES' ACCESS TO QUALITY CHILD CARE**

Public and private policymakers should coordinate public and private resources to ensure that all families have access to affordable, safe, and healthful child care for their children. Stabilizing the child care workforce should be a major goal in improving available child care. To the extent possible, communities should coordinate multiple funding streams to support child care.

**DISCUSSION:** Quality cannot be attained by merely applying standards to caregivers; resources are necessary to meet the cost of quality care at a price that parents can afford. Currently, the low wages and benefits earned by child care staff result in high staff turnover, which adversely affects the health and safety of children. Frequently replaced, untrained, barely oriented, poorly compensated, and overworked staff cannot maintain sanitation routines, be prepared for emergencies, or meet the mental health needs of children for constancy in relationships. Child care is a labor intensive service. Staff wages make up the largest cost in providing care, and caregiver wages in the United States are currently too low to attract and retain qualified staff. Countries that successfully recruit and retain good child care staff pay salaries and benefits equal to those paid to elementary school teachers.

The cost of child care in the United States is currently subsidized by the low wages and benefits of caregivers, who leave their jobs at an astonishingly high rate. Research provides clear evidence that a well qualified and stable staff is essential to the provision of good care for children. Quality care requires not only lower child:staff ratios and smaller group sizes, but also well trained staff to reduce the spread of infectious diseases, provide for safe evacuation and management of emergency situations, and to offer developmentally appropriate program activities. Facilities cannot benefit from training provided to staff if the staff members leave their jobs before the training is implemented (20).

See *The Child Care Bureau's Case Studies of Public-Private Partnerships for Child Care* (21) for examples of successful state-wide collaborative projects.

### **RECOMMENDATION 9.048 ARRANGEMENTS FOR PARENTAL LEAVE**

Arrangements for parental leave should be available to support the ability of parents to take temporary leave from work for up to 3 months after the birth or adoption of a child, or to care for an ill child for whom out-of-home child care is not as safe and healthful as parental care.

**DISCUSSION:** Safe and healthful child care at times when a child is significantly ill or when the child is a newborn or newly adopted child is usually best provided in the child's home by parents. The Family and Medical Leave Act of 1993 provided a minimum of 12 work weeks of unpaid leave during a 12-month period for the birth of a child, adopting or providing foster care, an illness of a close relative, or a disabling health condition of the employee (22). However, effective implementation of the intent of the law requires employer flexibility about the use of vacation, personal and sick leave benefits to protect parent income when using parental leave.

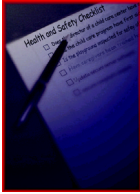
There is no mandate for paid parental leave in the United States. To be a realistic option for parents whose children need them at home, parental leave should be available on short notice, and parent income should be protected by the parents' sick leave, vacation time, personal leave or other benefits. Ready access to paid leave should include all working parents of young children since for many families, the use of unpaid leave is not a realistic option.

Nevertheless, taking parental leave should be a matter of choice. In some families, two parents can combine their leaves to provide extended care at home for a child who is not ready for group care. In other families, the child and family may benefit from the child's entry into a group care setting early in infancy. This is particularly so with difficult infants or stressed parents for whom child care serves as an extended family, providing respite, comfort, advice and support to parents. Parents in nontraditional families should receive the same leave as parents in traditional families.



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