



Innovation in monitoring in early care and education

Options for states

**An ASPE White Paper,
in partnership with ACF**



U.S. Department of Health and Human Services

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

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April 2015

Pamala A. Trivedi

Office of the Assistant Secretary for Planning and Evaluation (ASPE),
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Suggested citation: Trivedi, P. A. (2015). *Innovation in monitoring in early care and education: Options for states*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of health and Human Services.

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Acknowledgments

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

Executive Summary

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

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

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

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

Options for states that could improve monitoring practice:

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

Background, Issues and Challenges

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

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

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

- What is the current purpose of monitoring in ECE?
- What federal regulations for ECE monitoring currently exist?
- What is the evidence base for effective monitoring strategies in ECE or analogous sectors?

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

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

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

Table 1: Types of Child Care and Early Care and Education (ECE) Settings¹	
Child care center	Services offered to children in a non-residential setting; usually include full- and part-time group options. Examples are nursery and preschool programs. Centers can be commercial, non-profit, recreational, or can be run by religious institutions, and local, state, or federal government.
Family child care home (FCC)	One individual who provides child care services for fewer than 24 hours per day, as the sole caregiver, in a private residence other than the child's residence.
Group child care home	Two or more individuals who provide child care services in a private residence other than the child's home.
Relative care ²	An individual related to the child other than parents, providing care in any setting, typically the relative's home.
In-home care	Care provided in the child's home. Examples include an <i>au pair</i> , nanny, or nanny share.
Head Start/Early Head Start (HS/EHS)	Promote the school readiness of young children from low-income families through the mental, social, and emotional development of children birth – aged 5. Programs are offered as part- or full-day, and some programs offer a combination of home- and center-based services.
Pre-Kindergarten (Pre-K)	Part- or full-day classroom-based programs that are usually within one year of starting elementary school.

¹ Many of these definitions are according to the Child Care and Development Fund (CCDF) Final Rule (1998). Care is usually specified as fewer than 24 hours per day per child, unless care in excess of 24 hours is due to the nature of parent(s)' work.

² Relative and in-home care are usually excluded from state regulations.

Licensing, monitoring, accreditation, and national standards: The need for reform

Licensing, accreditation, and monitoring systems have been independently designed and implemented. Licensing in ECE settings is under the provision of the state and subject to local statutes. In contrast, ECE providers may choose to seek accreditation by a private organization. The National Association for the Education of Young Children (NAEYC) and the National

Association for Family Child Care Homes (NAFCC) are two of the major national professional organizations that provide accreditation. Accreditation typically involves a provider self-study followed by an onsite review by trained professionals associated with accrediting bodies.

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

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

A lack of coordination across systems. Federal and state governments have implemented systems for monitoring in response to national and local statutes in different ECE sectors. These sectors range from the state-administered Child Care and

National Health and Safety

Standards. Ensuring the health and safety of children across ECE settings is a foundational element of quality care, a major concern of families, and a top federal priority. The National Resource Center for Health and Safety in Child Care and Early Education ([NRC](#)) partnered with the American Academy of Pediatrics ([AAP](#)) and the American Public Health Association ([APHA](#)) to develop a set of recommended national health and safety standards with the publication of [Caring for Our Children](#) and [Stepping Stones](#) (3rd edition, 2011) with funding from the HHS' Health Resource Services Administration (HRSA), Maternal Child Health Bureau (MCHB). These standards are not required but provide research-based best practices that minimize adverse incidents for children in ECE settings. Although the licensing administration field has embraced these two documents, the guidance is not regulatory and may be more aspirational than immediately practical in some early care and education settings. The Administration for Children and Families (ACF) and HRSA have also created an additional companion document to *Caring for our Children* called *Caring for Our Children Basics* that will serve as a voluntary tool for states to create a floor of minimum health and safety standards across Head Start and child care settings. This document was released for public comment in 2014.

Development Fund (CCDF), Head Start and Early Head Start (HS/EHS) grantees that receive federal funds, the expanding state-administered Pre-Kindergarten programs, state-administered Early Intervention and Special Education, the federally funded Child and Adult Care Food Program (CACFP), and the federally administered Department of Defense (DOD) child care programs on military installations. A common result of varying statutes is inefficiency and a high administrative burden for grantees and programs that are subject to different monitoring requirements due to support from multiple funding streams.

For example, a large number of private and public ECE providers—including many HS/EHS grantees—participate in CACFP, a federal program administered by the U.S. Department of Agriculture (USDA) that offers assistance to ECE centers and family child care homes in providing nutritious foods. Many children who participate in ECE with the assistance of federal subsidies attend programs that are part of the CACFP program. Additionally, the training and inspection requirements for CCDF across states and CACFP are very similar. Program and monitoring requirements are also similar across CACFP and CCDF, and USDA has issued guidance³ encouraging streamlining of these requirements. However, a lack of coordination among state agencies that administer these programs often results in duplicative inspections across these federal programs, and results of monitoring visits are not shared or used in concert in efficient ways.

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

The program that I run, it's a licensed child care facility, so it's inspected by child care licensing, it's inspected by the food program, it's inspected actually by the local arm of the State health department, it's inspected by Head Start, and it's inspected separately by Early Head Start...and it's inspected by the HIPPY USA⁴ because we use the HIPPY curriculum, and it's inspected by Denver Public Schools because we are a Denver Public Schools Colorado preschool program provider, and now we're being also inspected by the Denver Preschool Program. So we are inspected by funding stream, if you will. We are an incredibly high-quality program. We have all the stars you can get. We'd have more stars if there were more stars in Colorado's QRIS⁵. We have incredibly clean [monitoring reports] every 3 years Head Start and Early Head Start. There are never any findings in this program, and yet I am monitored by everybody and their brother.⁶

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

³ United States Department of Agriculture (USDA). (2013). Monitoring of Licensing Requirements in the Child and Adult Care Food Program, Guidance to Regional Directors, Special Nutrition Programs. Washington, DC: USDA. Retrieved from <http://www.fns.usda.gov/sites/default/files/CACFP14-2013.pdf>

⁴ Home Instruction for Parents of Preschool Youngsters

⁵ Quality Rating and Improvement Systems

⁶ Brantley, C. M. Testimony of Charlotte M. Brantley, Child Care and Development Block Grant Reauthorization: Hearing Before US Senate Subcommittee on Children and Families, Committee on Health, Education, Labor and Pensions, § HELP (2011). Washington, DC. Retrieved from <http://www.gpo.gov/fdsys/pkg/CHRG-112shrg87199/html/CHRG-112shrg87199.htm>

enforcement from different federal and state regulatory agencies, concerns and non-compliances may be handled differently by each entity. Current monitoring practices often overlap in ways that are not efficient and are potentially burdensome to ECE programs subject to multiple and duplicative regulations.^{7,8} The inefficiencies and increased costs are passed along to taxpayers, monitors, and regulators.

The need for more effective oversight. Unfortunately, while there are cases of high-quality programs that are frequently monitored by parallel systems, there are also egregious instances of serious injury or deaths in ECE programs. In part, these instances can be attributed to a lack of effective oversight or resources needed to meet regulatory requirements. In 2011, the U.S. Department of Health and Human Services' Office of the Inspector General (OIG)⁹ reviewed open-source information from the previous decade and found several cases across states of individuals convicted of serious sexual offense who gained access to child care facilities as maintenance workers, cooks, or spouses or friends of providers. OIG found that providers either knowingly hired these offenders or did not perform the necessary pre-employment background checks intended to detect such convictions.

To further identify health and safety risks at child care providers receiving federal funds, in 2014 OIG¹⁰ audited licensed child care centers and family child care homes across states. OIG found that although states were largely conducting inspections that their licensing rules mandated, the monitoring did not ensure that providers complied with state health and safety licensing requirements. Noted violations existed that were often related to physical conditions of the center or family home, and required criminal background and child protection checks. To ensure more adequate state oversight, OIG recommended that monitoring staff have smaller caseloads. States also provided feedback about undertaking analyses of inspection protocols in order to increase efficiency for existing monitoring staff. Recently, Crowley¹¹ and her colleagues undertook an analysis of routine, unannounced reports of child care centers collected by the Connecticut Department of Public Health. The study found that outdoor safety was the largest area of non-compliance. Notably, there was a positive association between compliance with health and safety regulations and continuing professional development and education for staff, another Connecticut requirement. Inconsistency in reporting among inspection staff also threatened to undermine a standardized and fair licensing experience for

7 American Academy of Pediatrics (AAP), American Public Health Association (APHA), & National Resource Center for Health and Safety in Child Care and Early Education. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*, 3rd edition. Retrieved from <http://nrckids.org/CFOC3/index.html>

8 Brantley, C.M. Testimony of Charlotte M. Brantley, President and CEO, Clayton Early Learning, Child Care and Development Block Grant Reauthorization: Hearing Before US Senate Subcommittee on Children and Families, Committee on Health, Education, Labor and Pensions (2011).

9 US Government Accountability Office (GAO). (2011). *Child Care: Overview of relevant employment laws and cases of sex offenders at child care facilities* (No. GAO-11-757). Washington, DC: US Government Accountability Office. 441 G Street NW; Washington, DC 20548. Retrieved from <http://www.gao.gov/new.items/d11757.pdf>

10 US Department of Health and Human Services, Office of the Inspector General (HHS/OIG). (2014). *Some Connecticut child care centers did not always comply with state health and safety licensing requirements* (No. A-01-13-02506). Washington, DC: US Department of Health and Human Services, Office of the Inspector General. Retrieved from <https://oig.hhs.gov/reports-and-publications/oas/acf.asp> Please see this report and a series of similar audits about Michigan, Maine and Louisiana published between April-August, 2014

11 Crowley, A. A., Sangchoon J., & Rosenthal, M. S. (2013). *Health and Safety of Child Care Centers: An Analysis of Licensing Specialists' Reports of Routine, Unannounced Inspections*. *American Journal of Public Health*, 103(10), e52–e58.

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

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

Monitoring in Child Care Settings

Current regulations, variations in state practice, and upcoming reforms

The Administration for Children and Families (ACF) administers the Child Care and Development Fund (CCDF), providing child care subsidies for 1.5 million children every month.¹² Based on data reported to ACF by States, in fiscal year 2012, an estimated that 89 percent of children who received CCDF subsidies were served in either family homes or centers.¹³ Prior to the passage of the Child Care and Development Block Grant Act of 2014 (CCDBG), there were no specific federal health and safety requirements defined in statute. Current federal regulations require states to certify that procedures are in place to ensure compliance with all applicable state and local health and safety requirements. Some states allow providers to self-certify, yet current CCDF regulations do not require monitoring. States are required¹⁴ to have health and safety regulations related to 1) preventing and controlling infectious disease; 2) building and physical premises safety; and 3) minimum health and safety training. However, states have considerable flexibility in how they meet these requirements. For example, because it had not been in federal statute or regulation, not all states have requirements for criminal background checks, training on first aid and CPR, or safe sleep.¹⁵

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

12 Administration for Children and Families, Office of Child Care (ACF/OCC). (2014, January 27). FY 2012 Preliminary Data Table 1 - Average Monthly Adjusted Number of Families and Children Served. Retrieved from <http://www.acf.hhs.gov/programs/occ/resource/fy-2012-ccdf-data-tables-preliminary-table-1>

13 Administration for Children and Families, Office of Child Care (ACF/OCC). (2014, January 27). FY 2012 Preliminary Data Table 3 - Average Monthly Percentages of Children Served by Types of Care. Retrieved from <http://www.acf.hhs.gov/programs/occ/resource/fy-2012-ccdf-data-tables-preliminary-table-3>

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

15 Smith, L. K. Testimony of Linda K. Smith, Deputy Assistant Secretary and inter-Departmental Liaison for Early Childhood Development, ACF, Child Care and Development Block Grant Reauthorization: Hearing Before US Senate Subcommittee on Children and Families, Committee on Health, Education, Labor and Pensions (2012). Washington, DC. Retrieved from <http://www.help.senate.gov/imo/media/doc/Smith7.pdf>

tremendously. As mentioned previously, most states have exemptions for licensing, including facilities with parents on the premises; facilities operated by religious organizations; recreational programs or instructional classes; facilities with a small number of hours per day or week; and before- and after- school programs. Family child care providers are often excluded from licensing in some states and not regulated by other public agencies. Reports of child injury and death occur most frequently in homes and facilities that are not monitored by states.

In one of the few national studies of child mortality rates in early care and education, Dreby¹⁶ and colleagues documented variation in fatality rates by the strength of licensing requirements. This study also suggested that licensing serves as an important mechanism for identifying high-risk facilities that pose the greatest threats to child safety. It is important to note that there is a lack of comprehensive, national data on deaths and injuries in child care, and many states do not require reporting on deaths or serious injuries. In FY 2012, ACF began requiring states to include a Quality Performance Report (QPR) as an appendix to biannual State Plan submissions, and currently, states have the option to list and describe the annual number of injuries and fatalities in child care. However, not all states review the context and circumstances of injuries and fatalities in child care in ways that provide opportunities to improve regulations and enforcement. The discussion below delves further into variations in state practices of implementing health and safety standards. Following this discussion, prominent case studies are presented of states mobilizing efforts across public and private sectors to learn from tragedies in child care by putting in place safeguards to prevent children from being harmed. Recent state data and examples from the media underscore the need for more uniform requirements across states.

State licensing thresholds. Using data collected in 2011, the Office of Child Care's National Center on Child Care Quality Improvement (NCCCQI) in conjunction with the National Association for Regulatory Administration (NARA) analyzed child care licensing and monitoring practices in states.^{17,18,19} All states regulate child care centers. However, state variation is even more pronounced among family child care homes, group child care homes, and certain types of religiously affiliated child care facilities. Forty-two states license family child care homes, and nine of these states (21 percent) require licensure when there is even one unrelated child in care (AL, CT, DE, DC, MA, MD, MI, OK and WA). Most other States set their licensing threshold to three children (19 percent) or four children (26 percent). Thirty-eight states license group child care homes, which are defined as two or more adults taking care of a group of children, with states (42 percent) most frequently setting the threshold at seven

16 Wrigley, J., & Dreby, J. (2005). Fatalities and the organization of child care in the United States, 1985-2003. *American Sociological Review*, 70(5), 729-757.

17 National Center on Child Care Quality Improvement (, & National Association for Regulatory Administration (NARA). (2012). *Trends in Child Care Center Licensing Regulations and Policies for 2011* (Policy Brief No. 999). Washington, DC: US Department of Health and Human Services, Office of Child Care. Retrieved from http://www.qrisnetwork.org/sites/all/files/resources/Debi%20Mathias/2012-12-01%2007:08/999_1208_Center_Licensing_Trends_Brief_FINAL.pdf

18 National Center on Child Care Quality Improvement (NCCCQI), & National Association for Regulatory Administration (NARA). (2013). *Research Brief #2: Trends in Family Child Care Home Licensing Requirements and Policies for 2011* (Policy Brief). Washington, DC: US Department of Health and Human Services, Office of Child Care. Retrieved from <https://childcare.gov/resource/research-brief-2-trends-family-child-care-home-licensing-requirements-and-policies-2011>

19 National Center on Child Care Quality Improvement (NCCCQI), & National Association for Regulatory Administration (NARA). (2013). *Research Brief #3: Trends in Group Child Care home Licensing Regulations and Policies for 2011*. Washington, DC: US Department of Health and Human Services, Office of Child Care. Retrieved from <https://childcare.gov/resource/research-brief-3-trends-group-child-care-home-licensing-regulations-and-policies-2011>

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

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

Table 2: Frequency of Licensing Inspections in States in 2011*			
	Child Care Centers (N=50 states)**	Family Child Care Homes*** (N=42 states)	Group Child Care Homes (N=38 states)****
More than three times per year	4	4	3
Three times per year	3	2	1
Twice a year	14	9	13
Once a year	24	14	14
Once every two years	3	5	2
Once every three years	0	2	1
Less than once every three years	1	1	1
No inspection	0	3	0
Other frequency**	1	3	3
Note 1* Please see footnotes 10-12 for the National Center on Child Care Quality Improvement (NCCCQI) Research Briefs that are the source of data for this table Note 2**For the purposes of this study, DC was treated as a state. ID has child care licensing at the city/county level and was not included in this study. Note 3***Not all states license family child care homes or group child care homes Note 4**** Other frequencies could be based on compliance history or facility size			

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

20 Administration for Children and Families (ACF). Guidance Released to States by the Office of Child Care Related to Criminal Background Checks. Information Memorandum. Washington, DC: Administration for Children and Families (ACF), September 20, 2011. http://www.acf.hhs.gov/sites/default/files/occ/im2011_05.pdf.

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

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

Although all states and territories require some type of background check for ECE providers, the types of providers and staff members who must undergo background checks vary, as does the kind of background check that is required, which combination of state and federal databases are used, and whether fingerprinting is involved. An organization focused on research, advocacy, and resources for families and practitioners, Child Care Aware of America described background checks that are not based on fingerprints as “of limited value²¹,” presumably because a name search alone can be misleading. NCCQI-NARA found that in 2011, 12 states required comprehensive checks of federal and state criminal history checks for both center-based staff and family child care home staff; the process used fingerprinting and checks of child abuse and neglect registries. Many of the states that have implemented comprehensive background checks are also working on other aspects of health and safety. Table 3 below summarizes state practices on different aspects of criminal background checks.

Table 3: Comprehensiveness of Background Checks in States in 2011*			
	Child Care Centers (N=50 states)	Family Child Care Homes (N=42 states)	Group Child Care Homes (N=38 states)
Criminal history records	48	41	35
Federal fingerprints	32	20	26
State fingerprints	26	17	21
Child abuse and neglect registry	44	38	34
Sex offender registry	24	13	20

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

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

21 Child Care Aware of America (formerly NACCRRA). (2012). Background checks: It is time to protect children in child care. Arlington, Virginia: Child Care Aware of America. Retrieved from <http://www.naccrra.org/publications/naccrra-publications/2012/7/background-checks-it-is-time-to-protect-children-in-child-c>

22 NACCRRA (Now Child Care Aware of America, CCA). (2011). National parent polling results: The economy's impact on parent's choice and perceptions about child care. Arlington, Virginia: NACCRAA, now CCA. Retrieved from http://www.naccrra.org/sites/default/files/default_site_pages/2011/parent_polling_one_pager_healthsaf_sept_2011_0.pdf

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

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

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

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

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

Health and Safety Provisions of the CCDBG Act of 2014

The CCDBG Act includes the following provisions:

- States must provide pre-service and ongoing health and safety training to all CCDF providers. Topic areas include: 1) prevention of shaken baby syndrome and abusive head trauma; 2) prevention and control of infectious diseases, including immunization; 3) hand washing and self-care; 4) medication administration; 5) management of food allergies; 6) safe sleep and prevention of Sudden Infant Death Syndrome (SIDS); 7) sanitary food handling; 8) building and physical premises safety; 9) emergency preparedness; 10) handling of hazardous materials; and 11) first aid and CPR.
- Trainings on social-emotional development, positive behavioral support, and other strategies to prevent preschool expulsion were suggested as activities associated with improving quality.
- States must establish age-appropriate child-to-staff ratios.
- States must develop health and safety standards related to first aid and CPR, prevention of Sudden Infant Death Syndrome (SIDS), and child abuse prevention.
- States can no longer rely solely on provider self-certification of health and safety requirements.
- States must perform at least one annual inspection and at least one pre-licensure inspection of CCDF providers and one annual fire, health, and safety inspection of license-exempt CCDF providers.
- All individuals who provide care for children and accept CCDF subsidies must undergo comprehensive background checks.

Case Study: The experience of reform in Georgia

Georgia has been reforming its ECE licensing administration, housed in Bright from the Start: The Department of Early Care and Learning (DECAL). Bobby Cagle led these efforts as DECAL commissioner from 2011-2014. In 2013, researchers at the Frank Porter Graham Institute conducted an evaluation of the state's licensing and monitoring practices in overseeing 6,000 providers.²³ Prior to Commissioner Cagle's tenure, health and safety violations were predominately handled through technical assistance (TA), though the infrastructure and staffing were not in place to follow-up

with ECE providers on their areas of non-compliance. Cagle's approach, which garnered public support, combined increased enforcement action with TA.

Public and legislative support. Reform was facilitated in part through public outcry, after a series of articles in the local paper, *The Atlanta-Journal Constitution* on the safety of children in child care. One of DECAL's first responses to the increased scrutiny was commissioned studies investigating the statewide prevalence of serious injuries in child care.^{24,25}

23 Bryant, D. M., & Maxwell, K. (2013). Georgia Child Care Licensing and Monitoring Study: Final Report. The University of North Carolina at Chapel Hill: FPG Child Development Institute.

24 Carter, J. (2012). Infant and Child Injuries in Georgia: A Study Comparing Injuries in Child Care Facilities with Infant and Child Injuries in the General Population (Using Emergency Room and Hospital Data). Atlanta, GA.

An analysis of state administrative data indicated that young children were much safer in center-based care than other ECE settings. The study also highlighted concerns over safe sleep practices. As is the case in a select number of other states,²⁶ public attention and advocacy involving the families of young children who died in child care was crucial in enacting legislative changes to support health and safety. Following the death of a four month old child placed on his stomach to sleep, Jace's Law was passed unanimously by the Georgia legislature, granting DECAL the authority to immediately close a family child care home in which a minor dies. In 2011, the legislature further granted DECAL emergency closure authority when there is any immediate risk to children—a significant improvement from the 90-day formal revocation process.

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

DECAL's overall goal is to visit each facility twice a year, a goal they met in 80 percent of family child care homes and 67 percent of child care centers in 2012.²⁷

To address the number of children in unregulated care in Georgia, DECAL is advocating for a legislative change that

would require regulation of family child care homes to begin when a provider cares for two, rather than three unrelated children.

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

Change in staffing practices. Many states struggle with a high turnover rate for regulatory and support staff.²⁸ This problem is compounded in Georgia because in the rural parts of the state, travel times are extensive for child care consultants who conduct monitoring visits. Since DECAL increased its enforcement authority in terms of the number of follow-up visits required when there is an adverse event at a facility, more demands have been placed on staff. DECAL has tried to address turnover and the additional burden it places on remaining staff by significantly expanding the number of child care consultants on staff. To address vacancies with minimal burden, new staff members are also cross-trained to handle “blended caseloads” that include different types of ECE facilities, and initial licensing visits as well as complaints. The DECAL management team considers reallocating staff resources an integral part of building a more sustainable infrastructure.

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

25 Carter, J. (2012). An Assessment of the Risk of Preventable Deaths Among Children in Child Care in Georgia (2007-2009). Atlanta, GA.

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

27 Bryant & Kelly, 2013

28 Bryant & Kelly, 2013

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

DECAL has developed an inter-rater reliability process in which multiple child care consultants conduct monitoring visits to the same facilities, and results of compliance determinations are compared by DECAL's in-house research staff. DECAL also focuses monitoring visits around a set of 74 "core rules" that were deemed the most crucial to ensuring children's health and safety. In 2014, Richard Fiene, a university-based investigator, determined that Georgia's core rules moderately correlated with key indicators of compliance that emerged from licensing data from 2008-2012.²⁹ Based on these findings, DECAL is considering changes to its compliance determination protocol to more closely align the core rules with compliance indicators.

Interagency communication and collaboration. Effective communication between the divisions within DECAL that handle child care regulation and Pre-K was reported, particularly about child care centers that are applying for a grant to house Georgia's Pre-K classes. In these

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

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



DECAL's Mission and Vision Statements

Case Study: The experience of reform in Kansas

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

The trend for infant mortality in Kansas was also higher than other states at the time, with Kansas ranked 40th out of all states in 2011.³⁰ The Governor's Blue Ribbon Panel on Infant Mortality highlighted these statistics, as well as the need to collect more robust and geographically specific data. In addition, in 2010, Kansas was ranked 46 out of all states in the annual report by Child Care Aware³¹ on state standards and oversight for family child care homes. At the time, one third of all child care providers were 'registered family day care homes,' which could serve up to six children without being subject to pre-inspection, or any ongoing monitoring or regulation, except in the event of a complaint.



Lexie Engelman:
July 6, 2003 - August 10, 2004

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

30 Kansas Blue Ribbon Panel on Infant Mortality. (2011). Road Map for Preventing Infant Mortality in Kansas. Topeka, KS: Kansas Health Institute. Retrieved from <http://www.khi.org/documents/2011/apr/18/road-map-preventing-infant-mortality-kansas/>

31 Child Care Aware of America (formerly NACCRRA). (2010). Leaving Children to Chance: NACCRRA's Ranking of state standards and oversight for small family child care homes, 2010 update. Arlington, Virginia: Child Care Aware of America. Retrieved from <http://www.naccrra.org/node/1745>

Lexie's Law required that by the end of June, 2011, all registered providers transition to licensed providers. New health and safety regulations were effective by February 2012 that included regular inspection, training for providers, and the minimum requirement that new providers applying for a license have at least a high school diploma. New rules for the competent supervision of children in child care came into effect, as well as additional requirements for the protection of children. Lexie's Law also established an online database with information about complaints and violations that families can access. The implementation of Lexie's Law has boosted Kansas from 46th, to 3rd in Child Care Aware's³² annual ranking, and state officials have used new data collected electronically from providers to target regulatory action and provide information to the public in a much more timely way. State officials report that more stringent regulations have greatly enhanced state capacity to protect children, in part by supporting providers.

Lessons learned from reform efforts in states

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

32 Child Care Aware of America (formerly NACCRRRA). (2012). Leaving Children to Chance: NACCRRRA's Ranking of state standards and oversight for small family child care homes, 2012 update

Monitoring across ECE sectors

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

Head Start/Early Head Start. A federal program established in 1965, Head Start (HS) promotes school readiness for children from low-income families by offering comprehensive services. Early Head Start has served infants, toddlers, young children, and expectant parents since 1994. In fiscal year 2013, HS/EHS was funded to serve nearly one million children³³. Currently, the Office of Head Start (OHS) uses the Office of Head Start Monitoring System, which is aligned with five-year grant oversight to assess program services and quality.

The Designation Renewal System (DRS), which went into effect in 2011,³⁴ introduced major changes to the Head Start monitoring system. The DRS uses monitoring outcomes to make designation determinations that increased accountability by specifying conditions about whether high-quality, comprehensive services are being offered to children and families. The new system informs decisions about whether a grantee needs to re-apply for funding, and effectively transformed all HS grants from indefinite funding to five-year grant periods. To date, four cohorts of Head Start grantees—including nearly 400 individual grantees—have been designated to compete for continued funding.

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

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

³³ Office of Head Start. (2014). Head Start Program Facts Fiscal Year 2013. Washington, DC: US Department of Health and Human Services. Retrieved from <http://eclkc.ohs.acf.hhs.gov/hslc/mr/factsheets/docs/hs-program-fact-sheet-2013.pdf>

³⁴ Section 641(c)(1) of the Head Start Act, 45 CFR (2011). Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements/1307/Part%201307-FRNotice_2011-28880.pdf

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

State funded Pre-Kindergarten Programs. State-funded prekindergarten programs have grown in recent years and are an important part of the President’s Early Learning Initiative.³⁵ However, systematic implementation or monitoring of these programs by the states that operate them is currently limited. To date, there are more than 54 different public Pre-K initiatives in 40 states and territories which serve more than one million children.^{36,37} In most states, Pre-K is a mixed delivery system. Some providers are part of the K-12 public school system, monitored by State Departments of Education. Others are HS grantees subject to federal monitoring. Still others are private entities that receive state grants to administer services and are subject to regulation by state licensing agencies.

Monitoring often consists of evaluating or tracking the implementation of early learning standards for Pre-K, yet in many states that offer these services, programs are not required to adhere to standards. The frequency of monitoring visits to state Pre-K programs varies widely across states, and Pre-K stakeholders—including philanthropists, advocates, business leaders, and elected officials—may not be well versed in assessment methods or health and safety standards.³⁸ Monitoring data may include classroom quality, teacher efforts to support student learning, information about the quality of teacher-child interactions, and facility and safety practices.

Documenting children’s learning outcomes is an increasingly common way to assess State Pre-K providers and make determinations about funding.³⁹ As states curtailed their budgets during from 2008-2012, they eliminated monitoring requirements that were put in place in the early 2000s. Tension remains between the number of slots available for students and the budget for monitoring and quality improvement. The Preschool Development Grant⁴⁰ funding opportunities first made available in 2014, required states to describe the system they intended to put in place for monitoring subgrantees that will be providing high-quality Pre-K services. This requirement was put in place despite a lack of standardization and mandate for monitoring protocols in existing Pre-K systems. It is likely that states that receive this funding either through a development or expansion track will put in place more sophisticated monitoring and evaluation systems, and are offered flexibility in designing these systems.

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

35 <http://www.whitehouse.gov/issues/education/early-childhood>

36 Ackerman, D. J., & Coley, R. J. (2014). State Pre-K Assessment Policies: Issues and Status. Princeton, NJ: Educational Testing Service (ETS). Retrieved from <http://www.ets.org/Media/Research/pdf/PIC-PRE-K.pdf>

37 Barnett, S. W., Carolan, M., Fitzgerald, J., & Squires, J. H. (2012). The State of Preschool 2012: State Preschool Yearbook. Rutgers Graduate School of Education: National Institute for Early Childhood Research (NIEER). Retrieved from <http://nieer.org/publications/state-preschool-2012>

38 Ackerman & Coley, 2014.

39 Barnett et al., 2012.

40 <http://www2.ed.gov/programs/preschooldevelopmentgrants/index.html>

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

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

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

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

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

41 Office of Special Education and Rehabilitative Services (OSSERS) (2012). Office of Special Education Program's Results Driven Accountability Home Page. Retrieved May 5, 2014, from <http://www2.ed.gov/about/offices/list/osers/osep/rda/index.html>

42 Office of Special Education and Rehabilitative Services (OSERS). (2014). New accountability framework raises the bar for state special education programs. Washington, DC: US Department of Education. Retrieved from <http://www.ed.gov/news/press-releases/new-accountability-framework-raises-bar-state-special-education-programs>

43 Smith, L., & Smith, M. R. (2011). Child Care: Like the military, is it time for shared responsibility. Arlington, Virginia: National Association of Child Care Resource & Referral Agencies (NACCRRA, now Child Care Aware).

44 Floyd, L., & Phillips, D. (2013). Child care and other support programs. *The Future of Children*, 23(2), 73–97.

As is the case in other ECE sectors, the DOD programs are currently in the midst of reform. For the first time since 1996, the DOD in August of 2014 issued new guidance and instructions⁴⁵ for providing care. Some of these reforms were to standardize inspections across branches of the military. The service branches have reached consensus on a common framework for inspection criteria that groups them into three main categories of 1) general management; 2) facility, health, safety and risk management; and 3) programming. Each service branch compared current criteria to ensure they inspect the same items. Further standardization is currently underway that will involve the number of classrooms observed and the number of files reviewed during inspections. Software is being developed to support the inspection visit and report writing. These efforts will ensure that regardless of how a military family enters the child care system, the family has access to the same high level of quality.

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

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

Quality in ECE settings has multiple dimensions. It has been defined as the aspects of the environment and children's experiences that nurture child development.⁴⁶ High-quality ECE settings have been associated with better language development, math, and reading skills at kindergarten entry.^{47,48} Burchinal and colleagues⁴⁹ identified structural components of quality as class size, teacher-child ratios, staff turnover, salaries, training, and curriculum. These structural components of quality are related to what has been identified as process-level components, including teacher beliefs, and teacher-child interactions.⁵⁰ There is no single method of evaluating quality, and the definitions of quality could vary from different stakeholder perspectives.⁵¹ Some states have additional goals for their regulatory systems, including using licensing as a foundation for building quality improvement systems.

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

45 US Department of Defense, Office of Family Policy. Department of Defense Instruction, Number 6060.02 (2014). Retrieved from <http://www.dtic.mil/whs/directives/corres/pdf/606002p.pdf>

46 Layzer, J. I., & Goodson, B. D. (2006). The quality of early care and education settings: definitional and measurement issues. *Evaluation Review*, 30(5), 556–576.

47 Burchinal, M., Peisner-Feinberg, E., Bryant, D. M., & Clifford, R. (2000). Children's social and cognitive development and child care quality: Testing for different associations related to poverty, gender, or ethnicity. *Applied Developmental Science*, 4(3), 149–165.

48 Pianta, R. C., La Paro, K., Payne, C., & Bradley, R. (2002). The relation of kindergarten classroom environment to teacher, family, and school characteristics and child outcomes. *The Elementary School Journal*, 102(3), 225–238.

49 Burchinal, M., Roberts, J. E., Nabors, L. A., & Bryant, D. M. (1996). Quality of Center Child Care and Infant Cognitive and Language Development. *Child Development*, 67(2), 606–620.

50 Howes, C., & Smith, E. W. (1995). Relations among child care quality, teacher behavior, children's play activities, emotional security, and cognitive activity in child care. *Early Childhood Research Quarterly*, 10, 381–404.

51 Winterbottom, C., & Jones, I. (2014). National Accreditation and its role in early education: An analysis of Florida's Gold Seal Quality Child-Care program and licensing standards. *Journal of Early Childhood Research*, 12(1), 64–76.

of quality. A widely promoted strategy to improve quality in ECE is voluntary accreditation through a national organization, such as NAEYC and NAFCC. NAEYC offers a five-year accreditation to school and center-based providers and NAFCC offers a three-year accreditation to family child care providers. Both organizations begin the accreditation process with a self-study. In addition to an on-site observation, accreditation by both organizations involves a commitment to upholding research-based standards, meeting credential and training requirements for providers, program administrators, and teaching staff, and meeting the requirements for the highest level of regulation to operate a facility by the authorized regulatory agency—the state licensing agency, state board of education, or military. Maintaining each kind of accreditation involves annual reporting, updates and agreeing to announced and/or unannounced (in the case of NAEYC) visits before each renewal. Whitebook⁵² noted that public funds, including CCDF funds, are increasingly directed to accredited programs as a way to supplement what is sometimes limited quality assurance provided by compliance with state licensing systems.

Health and safety in accredited programs. Research is limited on the relationship between state child care regulations and accreditation. However, the presumption in the field is that accredited programs exceed the floor of minimum health and safety standards regulated by state licensing agencies. Apple⁵³ used descriptive statistics to examine the relation between quality indicators found in state regulations and the number of NAEYC accredited programs in states. Apple found that as maximum staff-child ratios decrease and minimum pre-service teacher education qualifications increase in state child care regulations, the number of ECE programs that have obtained or are seeking accreditation increases. Winterbottom and Jones⁵⁴ studied the relationship between accreditation and licensing violations in the state of Florida. Comparing licensing data on the 23 percent of ECE centers that were accredited from 2007-2010 with non-accredited child care centers, Winterbottom and Jones determined that children were more at-risk for both imminent and less serious health and safety violations if they attended a non-accredited ECE center. Although the number of statewide health and safety violations increased over time among all facilities, presumably because of increased enforcement, accredited facilities experienced a lower rate of increase.

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

52 Whitebook, M., Sakai, L., & Howes, C. (1997). NAEYC Accreditation as a strategy for improving child care quality. Washington, DC: National Center for Early Childhood Work Force (NCECW). Retrieved from <http://www.ccw.org/storage/ccworkforce/documents/publications/naeyc.pdf>

53 Apple, P. L. (2006). A developmental approach to early childhood program quality improvement: The relation between state regulation and NAEYC accreditation. *Early Education and Development*, 17(4), 535–552.

54 Winterbottom & Jones, 2014

Lessons learned from the Race to the Top—Early Learning Challenge (RTT—ELC)

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

The five key areas of reform are:⁵⁶

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

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

55 Early Learning | The White House. (2014). Retrieved April 30, 2014, from <http://www.whitehouse.gov/issues/education/early-childhood>

56 The Early Learning Challenge Technical Assistance Program (ELC TA). (2013). Race to the Top-Early Learning Challenge Brochure. Washington, DC: US Department of Education. Retrieved from <http://www2.ed.gov/programs/racetothetop-earlylearningchallenge/2013-early-learning-challenge-flyer.pdf>

57 Quality Rating & Improvement Systems — Alliance for Early Childhood Finance. (2014). Retrieved April 30, 2014, from <http://www.earlychildhoodfinance.org/qrisk>

traditionally offered a pathway for credentialed programs to enter at a higher quality level, in part through a policy strategy that has become increasingly common in states known as tiered reimbursement. Through tiered reimbursement, child care providers that are offering higher quality care are eligible to receive a reimbursement rate that is higher than the maximum rate set by the state when they care for a child who is receiving CCDF subsidies. NAEYC noted in 2012 that 27 states and the District of Columbia had tiered CCDF reimbursement rates for center and family and group child care homes linked to accreditation.⁵⁸

QRIS systems had not been traditionally designed to include funding streams, standards, or requirements for ECE providers who were Head Start grantees, state Pre-K, or special education providers. However, RTT—ELC encouraged states to include all ECE programs, and grantees had to re-conceptualize their approach in order to create an integrated QRIS. In 2012, ECE financing and policy expert Louise Stoney⁵⁹ reviewed the QRIS sections of the first round of applications to the program, which consisted of 35 states and the District of Columbia. Stoney noted that several states also envisioned QRIS as an opportunity to align monitoring and technical assistance. North Carolina and Oregon made this the cornerstone of their ECE reform plan. Illinois, Kentucky, and New Mexico also focused on creating an integrated process so ECE providers with different funding streams only have to be monitored once.

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

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

58 National Association for the Education of Young Children (NAEYC). (2012). NAEYC Chart: States with tiered reimbursement programs. Washington, DC: National Association for the Education of Young Children (NAEYC). Retrieved from <http://www.naeyc.org/policy/tieredprograms>

59 Stoney, L. (2012). Unlocking the potential of QRIS: Trends and opportunities in the Race to the Top-Early Learning Challenge Applications (Policy Brief). QRIS National Learning Network. Retrieved from <http://qrisnetwork.org/sites/all/files/resources/gscobb/2012-03-07%2008:29/LouiseStoneyMemo.pdf>

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

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

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

Some RTT—ELC states have mandated that participation of Universal Pre-K programs be included in QRIS. In other states, Pre-K participation is voluntary. However, even in states with mandatory participation, it has been difficult to apply all the QRIS standards, particularly to Pre-K programs in K-12 facilities. Many of the RTT—ELC teams include state Pre-K directors in efforts to address these issues. Just as there is collaboration and cross-training between QRIS and state licensing staff, there are opportunities to work closely together and conduct joint monitoring visits with education staff. For example, Ohio and Georgia reported a high level of collaboration.

In summary, the lessons learned from the QRIS features in RTT—ELC are instructive in thinking about larger ECE policy about the layering of funding streams, collaboration between agencies, and how to develop early learning standards of quality that are applicable to different kinds of ECE providers. As the RTT—ELC states continue to grapple with reducing the burden of licensing, quality, monitoring, and federal visits, the solutions and compromises they arrive at by engaging stakeholders throughout ECE systems will undoubtedly be instructive to all states.

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

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

Monitoring and reform in the child welfare systems

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

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

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

60 For a historical overview of federal child care policy, please see Courtney, M. E., Needell, B., & Wulczyn, F. (2004). Unintended consequences of the push for accountability: the case of national child welfare performance standards. *Children and Youth Services Review*, 26, 1141–1154.

61 Children's Bureau. (2012). Child and Family Services Review Fact Sheet. Washington, DC: US Department of Health and Human Services. 200 Independence Avenue SW; Washington, DC 20201. Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/cfsr-fact-sheet>

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

The first round of CFSRs took place between 2000 and 2004, and the second round was from 2007 to 2010. The Children’s Bureau set very high standards of performance for the CFSR,⁶² and no states achieved substantial conformity on child and family outcomes. Therefore, the Children’s Bureau took a step back to consider how to improve the CFSR process, and in the summer of 2014 issued new guidance⁶³ for states on the next rounds of CFSRs, to be conducted between 2015-2018. The Children’s Bureau is also currently encouraging States to strengthen their own self-monitoring tools using the principles of continuous quality improvement (CQI).

Despite performance gaps, there are instances of states engaging in the CSFR and PIP process to move forward on self-evaluation and quality improvement. The National Conference of State Legislatures documented several instances of child welfare administrators partnering with state legislators and other community stakeholders over CFSR results in ways that were productive in moving state systems reform efforts forward, as well as building the infrastructure to finance these changes.^{64,65} In the recent history of child welfare reform, states have expressed concerns about being held accountable for child well-being largely because child outcomes are dependent on other, related systems. Although state officials, advocates, and researchers have been critical about the measures used in the reviews, there is consensus among stakeholders that the focus on child and family outcomes is appropriate and constituted a much-needed shift in child welfare monitoring. As the capacity of states to routinely collect and use data to examine their work and make data-driven decisions is built through CQI frameworks, the role of federal monitoring is being re-configured.

Monitoring of patient safety and quality in health care delivery settings

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

62 Children’s Bureau. (2011). Federal child and family services reviews: Aggregate report, round 2 fiscal years 2007-2010. Washington, DC: US Department of Health and Human Services, Administration on Children, Youth & Families. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/fcfsr_report.pdf

63 <http://www.acf.hhs.gov/programs/cb/monitoring/child-family-services-reviews/round3>

64 National Conference of State Legislatures (NCSL). (2005). Focusing on child welfare systems: Collaborating with state legislators on reform. Denver, CO: National Conference of State Legislatures. Retrieved from <http://www.ncsl.org/print/cyf/collaborate.pdf>

65 National Conference of State Legislatures (NCSL). (2010). State progress toward child welfare improvement: Findings from fiscal years 2007 and 2008 of the Child and Family Service Reviews. Denver, CO: National Conference of State Legislatures (NCSL). Retrieved from http://www.ncsl.org/documents/cyf/progress_cw_improvement.pdf

The modern culture of patient safety in U.S. hospitals coalesced after the Institute of Medicine (IOM) released a report in 1999 entitled, *To Err is Human: Building a Safer Health System*.⁶⁶ The report highlighted the tens of thousands of deaths each year attributable to preventable medical errors, and called for comprehensive efforts across sectors to improve patient safety. Problematic areas cited by the report include: a fragmented health care delivery system, a lack of attention to preventable medical errors in the systems that license health care providers, flaws in the medical liability system, and the lack of financial incentive for health care organizations to improve safety and quality of care.

Regulatory groups have instituted major patient-safety initiatives that have been undertaken in the years since the IOM report, through professional organizations, and private, for-profit companies.⁶⁷ The IOM report noted that licensing and accreditation standards were the main accountability drivers for health care organizations and professionals; yet, at the time, neither focused on patient health and safety. An influential party in health and safety monitoring of health care organizations is the third party credentialing organization, the Joint Commission (TJC), formerly known as the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The Joint Commission has been classified as a quasi-regulatory entity, and it is an independent, not-for-profit organization that accredits and certifies more than 20,000 hospitals across the country. Hospitals that participate in Medicare and Medicaid are required to undergo a regulatory review by the Centers for Medicare & Medicaid Services (CMS), or alternatively, CMS enables hospital participation if they are accredited by a private body, such as The Joint Commission, and a select few other organizations that have been recently granted deeming authority.

The Joint Commission operates on a three-year accreditation cycle, and transitioned from pre-announced, to unannounced, full-survey visits in 2008. Beginning in 2001, the Joint Commission adapted some of the recommendations in the IOM report and introduced new standards that focused directly on patient safety and quality.⁶⁸ Surveys are conducted every 18-39 months after each unannounced visit. Surveyors currently talk to patients and caregivers whereas prior to 1999, the focus of surveys was a records and policies review. Surveys are performed to verify compliance with standards that encompass performance expectations, structures, and processes in place for quality health care. Survey reports include Requirements for Improvement (RFI), and organizations have 45-60 days to respond to these reports before accreditation decisions are made. Beginning in 2002, accredited hospitals began collecting data on core performance measures and their outcomes. Indicator scores are public, and comparisons can be made between hospitals. Provider participation in this data collection and reporting is linked to CMS reimbursements.⁶⁹

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

66 Institute of Medicine. (1999). *To err is human: Building a safer health system*. National Academies Press, Washington, DC.

67 Devers, K. J., Pham, H. H., & Liu, G. (2004). What Is Driving Hospitals' Patient-Safety Efforts? *Health Affairs*, 23(2), 103–115.

68 The Joint Commission. (2014). *The Joint Commission History*. Retrieved from http://www.jointcommission.org/assets/1/6/Joint_Commission_History.pdf

69 The Joint Commission. (2014, January 10). *Facts about the Patient Safety Advisory Group*. Retrieved from http://www.jointcommission.org/assets/1/6/Patient_Safety_Advisory_Group_1_19_13.pdf

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

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

TJC is the main source of health care organization credentialing, but appears to have limited effectiveness in improving patient safety outcomes, and has been the subject of more than one Government Accountability Office study about conflict of interest.⁷⁶ Keenan⁷⁷ recently documented private sector alternatives to TJC that have recently been granted deeming authority by CMS and appear to be engaging in promising practices that address some of the concerns that have plagued TJC. The Health Care Facilities Accreditation Program (HFAP) offers accreditation standards that are closely aligned with CMS, and also integrates information from recent, successful public health campaigns. Other newly granted credentialing organizations engage in more outcome-based, rather than inspection-focused, surveys.

70 Wachter, R. M. (2010). Unmistakable Progress, Troubling Gaps. *Health Affairs*, 29(1), 165–173.

71 Weinstein, R. A., Edmond, M., & Eickhoff, T. C. (2008). Who Is Steering the Ship? External Influences on Infection Control Programs. *Clinical Infectious Diseases*, 46(11), 1746–1750.

72 US Government Accountability Office. (2004). CMS needs additional authority to adequately oversee patient safety in hospitals (No. 04-850). Washington, DC: US Government Accountability Office. 441 G Street NW; Washington, DC 20548. Retrieved from <http://www.gao.gov/new.items/d04850.pdf>

73 Kenniston, E. (2011, February). Have accreditor policies improved patient safety? California Western Law School. Retrieved from http://hlaw.ucsd.edu/prospectivestudents/documents/Kenniston_HavePoliciesImprovedPatientSafety.pdf

74 Agency for health care research and quality (AHRQ). (2009). 10 Patient Safety Tips for Hospitals (No. 10-M008). Washington, DC: Agency for Health care Research and Quality (AHRQ).

75 Medical Liability Reform & Patient Safety Initiative | Agency for Healthcare Research & Quality (AHRQ). (2014.). Retrieved April 21, 2015, from <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/liability/> For more historical information, please also see: Wachter, R. M. (2004). The end of the beginning: Patient safety five years after “to Err is Human.” *Health Affairs*, 23(4), 534–545, and Wachter, 2009.

76 US Government Accountability Office. (2006). Hospital accreditation: Joint commission on accreditation of health care organization's relationship with its affiliate (No. 07-79). Washington, DC: US Government Accountability Office. 441 G Street NW; Washington, DC 20548. Retrieved from <http://www.gao.gov/new.items/d0779.pdf>

77 Kenniston, E. 2011

Lessons learned from child welfare and health care monitoring

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

The Differential Monitoring Model and Statistical/Risk-Based Approaches

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

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

Maintain a research-based risk-assessment method whereby industry-wide and facility-specific risks, including both immediate and cumulative risks, are identified and prioritized; focuses inspections and technical assistance accordingly; and, applies the agency’s enforcement continuum systematically to avert or abate priority risks, to build consistent compliance, and to improve overall consumer protection across all relevant domains.⁷⁸

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

⁷⁸ NARA, 2009

decisions.⁷⁹ Although Fiene’s work is extensive and well documented, it has not been extensively subjected to peer-review.

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

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

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

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

⁷⁹ Fiene, R. (2012, 2013, 2014) Differential Monitoring Logic Model and Algorithm (DMLMA)©: A New Early Childhood Program Quality Indicator Model (ECPQIM)©.

Case Study: The Head Start Key Indicator (HSKI) Pilot Study.

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

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

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

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

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

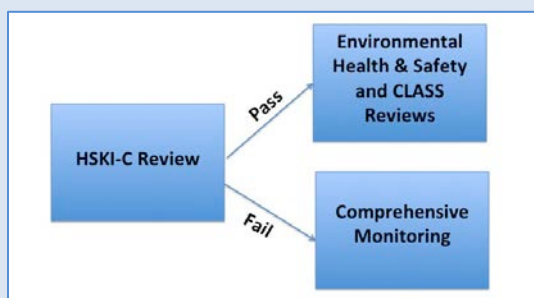
- No findings on the previous review cycle,
- No fiscal findings in the past two review cycles,
- No findings in the annual audits,
- No Designation Renewal System (DRS) criteria met,
- No significant program changes (e.g., changes in program leadership), and
- No concerns identified through input from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

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

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

Differential Monitoring Process: In an effort to recognize grantees that have demonstrated strong performance through a history of compliance, OHS developed the Differential Monitoring Process. Grantees eligible for this process will first receive the HSKI-C Review Event. Head Start grantees that are successful in the HSKI-C Review Event will receive the Environmental Health and Safety and CLASS Review Events. EHS grantees that are successful will receive Environmental Health and Safety and Comprehensive Services and School Readiness since CLASS is not used in EHS programs. Grantees that are unsuccessful in the HSKI-C Review Event, meaning one or more indicators are triggered during their HSKI-C Review event, will go through the Comprehensive Monitoring Process.

The HSKI-C Tool was developed in consultation with Richard Fiene. With Fiene's support, the OHS team analyzed monitoring data from FY 2012-FY 2014 (N = 1,099) to identify compliance measures that were 1) best suited to differentiate between high-performing grantees (i.e., compliant grantees) and low-performing grantees (i.e., grantees with findings) and 2) tended to be cited in reviews that have the most findings. Psychometric analysis examined whether HSKI-C review results agreed with the results of a comprehensive review. Based on FY2014 data, the results of the 27-item HSKI-C had a 91 percent agreement rate with the comprehensive review results.



Differential Monitoring Head Start

The monitoring system includes the ability to capture specific and timely performance

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

The key indicator approach is a promising one for child care monitoring systems, and in fact, many states currently use these methods. Using 2011 data, NCCCQI found that more than 50 percent of states are working on methods that target monitoring and TA resources. This approach will help ensure that support is made available to ECE programs who are struggling with licensing compliance.⁸⁰ These states include Kansas, Washington, Illinois, and California. Child care licensing staff from Kansas recently articulated the benefits of a key indicator system, including:⁸¹

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

80 National Center on Child Care Quality Improvement (NCCCQI) & National Association for Regulatory Administration (NARA). (2012). Trends in Child Care Center Licensing Regulations and Policies for 2011

81 Jackson, E., & Ritchey, Heather. (2014, September 29). The key licensing indicator system: A Kansas journey. Presented at the NARA Licensing Seminar, Orlando, Florida. Retrieved from <http://rikoinstitute.wikispaces.com/file/view/KLIS%20NARA%20PPT%202014.pdf/526755604/KLIS%20NARA%20PPT%202014.pdf>

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

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

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

- Probability of harm (high, medium, low);
- Severity of harm (extreme, serious, moderate, low); or
- Frequency of violations (numerous, repeated) based on those considered most critical to protecting children's health and safety⁸²

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

⁸² National Center on Child Care Quality Improvement (NCCCQI), & US Department of Health and Human Services, Office of Child Care (HHS/OCC). (2014). *Monitoring strategies for determining compliance: Differential monitoring, risk assessment, and key indicators*. Washington, DC: US Department of Health and Human Services, Office of Child Care. Retrieved from <https://childcareta.acf.hhs.gov/resource/contemporary-issues-licensing-monitoring-strategies-determining-compliance-differential>

Case Study: The development of a weighted key indicator licensing system in Illinois.

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

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

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

NARA is also administering a survey in English, Spanish, and Polish to relevant stakeholders,

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



A depiction of the Illinois' QRIS

The state's QRIS, ExceleRate, a major RTT-ELC implementation project, facilitated reform of the licensing system. The state is working to more fully integrate DCFS licensing with the larger system of supports for early care and education. Licensed providers, for example, are automatically enrolled in ExceleRate. The state hopes that administering inspections more efficiently will free child care licensing staff to mentor providers on attaining higher levels of quality, and licensing staff are excited about the new roles they may be able to take on through the weighted system.

These latest developments in designing and implementing differential monitoring strategies will continue as states consider ways to increase the efficiency of their monitoring systems. Research is also currently underway that compares results from monitoring systems associated with licensing, QRIS, and key indicator and risk assessment systems.⁸³ In some cases where state licensing or monitoring compliance records are extensive, Fiene has also conducted internal validation studies of key indicator systems. In these cases, false positive and negative rates of key indicator reviews are calculated by comparing compliance data from comprehensive reviews to compliance results from key indicator reviews.⁸⁴ To date, only Head Start (HSKI-C) and Georgia's Core Rule Approaches have been validated. Additional research must be conducted to validate the approaches to differential monitoring and to determine other approaches that show merit.

Options for monitoring across ECE settings

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

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

As stated earlier, *Caring for Our Children Basics*, a companion resource to the third edition of *Caring for our Children*, was released for public comment in 2014 and will provide voluntary guidance to state regulatory agencies on the minimum health and safety standards necessary in all ECE settings. These standards are aligned with both HS/EHS performance standards and OCC guidance to states about providers who meet the minimum recommended standards for serving children and families who are eligible for subsidies. In addition, *Basics* references common health and safety standards across other federal programs, including the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices/American Academy of Pediatrics/American Academy of Family Physicians-approved guidelines on immunizations,⁸⁵ the U.S. Department of

83 Fiene, R. (2015). Differential monitoring logic model (DMLM©): A new early childhood program quality indicator model (ECPQIM4©) for early care and education regulatory agencies. Middletown, PA: Research Institute for Key Indicators.

84 Fiene, R. (2015). Technical detail notes: Validation updates to the Fiene Key Indicator Systems. Middletown, PA: Research Institute for Key Indicators.

85 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2012) Recommended Immunization Schedule for Persons Aged 0 Through 18 Years—United States, 2012. <http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-11x17-fold-pr.pdf>

Agriculture’s (USDA) Child and Adult Care Food Program (CACFP) regulations,⁸⁶ and the Consumer Product Safety Commission guidelines for playground safety.⁸⁷ Incorporating research-based, interdisciplinary standards and recommendations in state regulations is intended to reduce the burden on programs, and increase the likelihood that children will be served in settings that are safe and conducive to their learning.

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

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

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

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

86 U.S. Department of Agriculture (USDA), Food and Nutrition Service (FNS) (2012) Child and Adult Care Food Program Regulations 7 CFR Chapter II Part 226. <http://www.fns.usda.gov/cnd/care/regs-policy/CFR226.pdf>

87 U.S. Consumer Product Safety Commission (2010) Publication #325: Handbook for Public Playground Safety. <http://www.cpsc.gov/cpscpub/pubs/325.pdf>

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

Differential monitoring, however, should not replace routine inspection of all licensed providers. A study of Vermont's differential licensing system demonstrates that although it can be effective to inspect centers with a poorer compliance record more frequently, centers with a good compliance record also need routine inspection or risk deteriorating compliance.⁸⁸ It is also important to put in place precautions that will prevent providers from anticipating abbreviated or more focused monitoring reviews.

At a minimum, all early care and education providers could receive a comprehensive inspection to determine the baseline level of compliance with standards and regulations. In addition, the National Association for Regulatory Administration (NARA) recommends that "routine monitoring inspections occur with sufficient frequency to protect consumers and to prevent or reduce compliance deterioration—at least twice-yearly— unless the agency has a reliable system to reduce the frequency of routine monitoring for stable, high-compliance facilities, provided that all facilities are inspected at least once a year."⁸⁹

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

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

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

Although 98 percent of military child care providers have attained national accreditation, only 10 percent of civilian ECE centers and 1 percent of family and group child care homes are accredited.⁹⁰ Providers who embark on accreditation are often committed to more

88 National Association for Regulatory Administration (NARA). (2009). Recommended best practices for human care regulatory agencies. Lexington, KY: National Association for Regulatory Administration (NARA). Retrieved from http://www.naralicensing.drivehq.com/publications/NARA_Best_Practices.pdf

89 NARA, 2009

90 Center for Law and Social Policy (CLASP). (2011). Charting Progress for Babies in Child Care: Expand Monitoring and Technical Assistance. Retrieved April 2, 2015, from <http://www.clasp.org/babiesinchildcare/recommendations/healthy-and-safe-environments-in-which-to-explore-and-learn/expand-monitoring-and-technical-assistance>

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

One way states and territories have created incentives to become nationally accredited is by offering ECE providers higher subsidy rates. Continuing to provide incentives to providers to commit to higher levels of quality takes some of the burden off state regulatory agencies, who are already struggling to meet the staff caseloads ratios of one child care consultant to 50 ECE providers that are recommended by the National Association for Regulatory Administration (NARA).⁹¹ National accreditation should also bear some relationship to QRIS in states. Toward this end, several states are consulting with NAEYC and other national accreditation organizations to determine how QRIS standards align with national accreditation standards.

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

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

91 NARA, 2009

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

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

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

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

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

Current research on aligning monitoring across sectors

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

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

Addressing these considerations, the Child Trends project will articulate the dimensions of a cross-sector monitoring system that will provide tools for state and federal agencies to think through the infrastructure necessary to institute such a system across funding streams. We hope that some of the foundational work in this white paper on state practice and the current federal system will inform work on cross-sector monitoring.

Conclusion

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



CONTEMPORARY ISSUES IN LICENSING

Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators

Introduction

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

- Identifying licensing rules¹ where violations pose a greater risk to children;
- Assigning a weight to each rule to further distinguish levels of regulatory compliance;
- Focusing monitoring visits on key indicators from the rules that predict compliance and reduce risks;
- Increasing monitoring frequency for programs with low levels of compliance;
- Increasing monitoring depth for programs with low levels of compliance;
- Helping providers, parents, and licensing staff better understand the potential consequences of serious noncompliance;
- Identifying providers in need of technical assistance; and
- Using more sophisticated data systems to target case management and improve consistency in enforcement actions.

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

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¹ Because licensing of child care facilities most often occurs at the state level, there are variances in terminology from State to State. For the purposes of this report, the terms identified are defined as follows and are used interchangeably throughout: *Regulations, Rules, Requirements, Policies and Administrative Code, Laws, Statutes.*

Methodology

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

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

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

Information from *Research Brief #1: Trends in Child Care Center Licensing Regulations and Policies for 2011* (NCCCQI, 2013) and *The 50-State Child Care Licensing Study: 2011-2013 Edition* (National Association for Regulatory Administration [NARA], 2013) are also included to provide national data and context to the information gathered from the nine States. Both of these reports include data gleaned from a national survey of licensing agencies conducted by NARA. Responses to the NARA survey were received from licensing agencies in all 50 States and the District of Columbia.²

Methods for Monitoring for Compliance

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

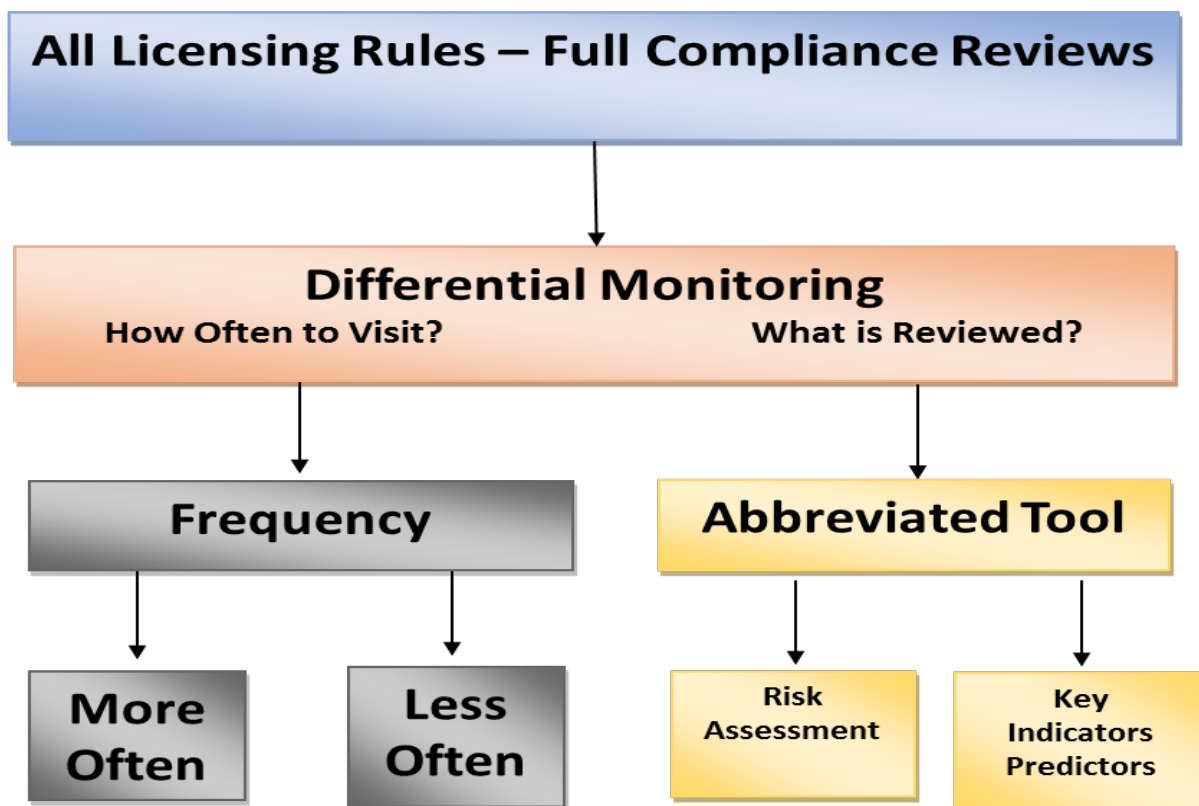
NARA, in *Recommended Best Practices for Human Care Regulatory Agencies* (2009), presents the characteristics of a strong licensing agency, including:

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

² In the NCCCQI and NARA reports, and in this report, the District of Columbia is included in state counts and not listed separately.

There are a variety of methods that many States are using, often in combination, in their monitoring and enforcement of licensing rules and regulations. This report explores these methods:

- **Differential Monitoring:** A regulatory method for determining the *frequency or depth of monitoring* based on an assessment of a facility's history of compliance with rules;
- **Full and Abbreviated Compliance Reviews:** Conducting an inspection by monitoring *all rules* (full review) or a *selected set of rules* (abbreviated review);
- **Risk Assessment:** An approach that focuses on identifying and monitoring those rules that place children at *greater risk of mortality or morbidity* if violations or citations occur; and
- **Key Indicators:** An approach that focuses on identifying and monitoring those rules that statistically predict compliance with all the rules.



Note: This graphic is adapted from a graphic developed by Dr. Richard Fiene and used in: Fiene, R. (2013) *Differential monitoring logic model and algorithm (DMLMA: A new early childhood program quality indicator model (ECPQIM4)© for early care and education regulatory agencies*, Middletown, PA: Research Institute for Key Indicators.

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

Differential Monitoring

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

Why Use Differential Monitoring?

- Increase monitoring frequency for programs with low levels of compliance;
- Identify providers in need of technical assistance;
- Recognize programs with strong compliance records with abbreviated inspections; and
- Use staff resources efficiently.

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

Differential Monitoring Policies in Oklahoma

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

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

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

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

Full and Abbreviated Compliance Reviews

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

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

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

- **Florida** inspects centers a minimum of three times per year and family child care (FCC) homes two times per year. As part of the 1996 WAGES Act, the Florida Legislature directed the Department of Children and Families and local licensing agencies to develop and implement an abbreviated inspection plan for child care facilities based on certain statutory criteria. Florida has an automated child care inspection system that tracks violation data and identifies the providers eligible for abbreviated inspections. Eligible providers have had no Class I or Class II (most serious) violations for two consecutive years. If violations are found during an abbreviated visit, the provider is no longer eligible to be monitored using the shorter form and must have a full compliance review. Florida's laws about conducting abbreviated inspections are available in *2013 Florida Statutes Sections 402.26 – 402.319 Child Care* at http://nrckids.org/default/assets/File/StateRegs/FL/FL_Statutes_402_26-402_319_Child_Care.pdf.
- The **Georgia** licensing agency conducts a minimum of two visits per year, including a licensing study and a monitoring visit. The *licensing study* is a full inspection using an inspection form that includes all rules, with the core rules highlighted (see page 8 for more detail). *Monitoring visits* involve the use of an abbreviated form that only includes the core rules.
- **North Carolina's** state statute requires that all providers are inspected by the licensing agency at least once per year, in addition to annual inspections by local or state health and fire inspection agencies. For programs to receive an abbreviated monitoring visit, they must have a four- or five-star license and a compliance score of 85 percent over the past 18 months prior to the scheduled visit date. In the rated license system, higher star levels are obtained by meeting additional requirements related to program quality standards and education levels of staff. "Chapter 110 Child Care Facilities," in *North Carolina General Statutes* (2013) is available at <http://nrckids.org/default/assets/File/StateRegs/NC/07-13%20Article%207.pdf>.
- **Texas** inspectors and investigators determine which standards to evaluate prior to the inspection but have the ability to add standards during the inspection, if needed. All standards must be evaluated at least once every two years. Standards may be re-evaluated as a result of investigations, follow up on previous deficiencies, or as part of a corrective action. Texas policies on Preparing for Inspections are in Section 4140 in the Texas' *Licensing Policy and Procedures Handbook* at http://www.dfps.state.tx.us/handbooks/Licensing/Files/LPPH_pg_4000.asp#LPPH_4140.
- **Utah** inspects centers and FCC homes twice a year. All providers receive an abbreviated unannounced compliance review and a full announced compliance review annually. All of Utah's announced (full) and unannounced (abbreviated) inspection checklists are available on its Web site at <http://health.utah.gov/licensing/centerinspectionchecklists.htm> (centers) and at <http://health.utah.gov/licensing/HomelnspectionChecklists.htm> (FCC homes).

Approaches to Identifying Critical Rules

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

- **Key Indicators:** An approach that focuses on identifying and monitoring those rules that *statistically predict compliance* with all the rules; and
- **Risk Assessment:** An approach that focuses on identifying and monitoring those rules that place children at *greater risk of mortality or morbidity* if violations or citations occur.

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

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

Key Indicators

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

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

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

Washington Employs Key Indicator System

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

- **Policies and Procedures**

- ◆ Monitoring Visit Policies:
<http://www.del.wa.gov/publications/licensing/docs/MonitoringVisitPolicy.pdf>
- ◆ Monitoring Visit Procedures:
<http://www.del.wa.gov/publications/licensing/docs/MonitoringVisitProcedure.pdf>

- **Monitoring Tools**

- ◆ Child Care Center Full Licensing Checklist:
<http://www.del.wa.gov/publications/licensing/docs/CenterLicensingChecklist.pdf>
- ◆ Child Care Center Abbreviated Monitoring Checklist:
<http://www.del.wa.gov/publications/licensing/docs/CenterMonitoringChecklist.pdf>
- ◆ FCC Home Full Licensing Checklist:
<http://www.del.wa.gov/publications/licensing/docs/FHLicensingChecklist.pdf>
- ◆ FCC Home Abbreviated Monitoring Checklist:
<http://www.del.wa.gov/publications/licensing/docs/FHMonitoringChecklist.pdf>

Risk Assessment

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

There are a number of ways licensing regulations can be assessed for risk, including the following:

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

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

- “Class I Violations” are the most serious in nature, pose an imminent threat to a child including abuse or neglect, and could or do result in death or serious harm to the health, safety, or well-being of a child;
- “Class II Violations” are less serious in nature than Class I violations, and could be anticipated to pose a threat to the health, safety, or well-being of a child, although the threat is not imminent; and
- “Class III Violations” are less serious in nature than either Class I or Class II violations, and pose a low potential for harm to children.

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

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

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

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

Texas' Weighted Standards Based on Risk

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

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

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

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

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

Georgia's Core Rules

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

Family Day Care Home Rule Categories

■ Criminal Records Check	■ Physical Plant
■ Discipline	■ Playgrounds
■ Field Trips	■ Staff:Child Ratios
■ Infant Sleeping Safety Requirements	■ Supervision
■ Overcrowding Registration Requirements	■ Swimming Pools and Water Related Activities

Child Care Learning Center and Group Day Care Home Core Rule Categories

■ Diapering Areas and Practices	■ Physical Plant
■ Discipline	■ Playgrounds
■ Field Trips	■ Staff:Child Ratios
■ Infant Sleeping Safety Requirements	■ Supervision
■ Hygiene	■ Swimming Pools and Water Related Activities
■ Medications	■ Transportation

Issues To Consider

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

- While abbreviated compliance forms are widely used, most are not developed using a methodology that statistically predicts compliance. Are all of these methods equally effective in measuring the level of compliance with licensing rules?
- Are all abbreviated compliance systems successful in creating both efficient and effective use of resources? What are the similarities and differences and what is their impact on effective regulation?
- What is the best mix of the measurement methodologies discussed in this report for consistent and strong enforcement of the licensing rules?

- How do these methods impact the relationship between licensing and other entities that monitor child care programs, such as Head Start, Quality Rating and Improvement Systems, prekindergarten, and national accreditation?

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

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JOINT STATEMENT



Coordinated Efficiencies in Monitoring and Oversight of Early Care and Education Programs

U.S. Department of Health & Human Services and U.S. Department of Agriculture

Purpose

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

This joint HHS and USDA policy statement aims to:

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

Target Audience

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

Overview

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

nation's most disadvantaged children have access to what they need to promote their optimal development.

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

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

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

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

Section I – Background

Throughout the United States, more than 266,000 child care programs (centers and homes) are licensed³ with a capacity for 9.8 million children.⁴ More than 177,000 programs (centers and homes) participate in CACFP with an average daily attendance of 4.1 million children.⁵ About 57,685 license-exempt providers currently serve children whose care is paid for through a CCDF subsidy and will now be required to have at least an annual inspection.

Funding to states through CCDF and CACFP represent the two largest federal funding streams that require monitoring visits to early care and education settings. Depending on the ECE program and services provided, other types of monitoring visits may also occur. These include State Quality Rating and Improvement Systems (QRIS), State-funded preschool, national accreditation, fire safety, sanitation, health, Early Head Start or Head Start, and potentially reviews related to children with special needs. Table 1 shows early care and education programs subject to monitoring throughout the states.

Although the content and frequency of monitoring visits required by the funding sources may vary based on legislative requirements, they have similar goals and basic programmatic requirements such as staff qualifications, background clearances, enrollment eligibility, attendance requirements, and certain health and safety requirements. It is within these common areas where there may be opportunities for greater efficiency.

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

Licensed Child Care	Number of Licensed Programs	Child Capacity
Total Licensed Programs:⁶	266,017	9,853,135
Child Care Centers	110,309	8,362,036
Family Child Care Homes	129,862	1,151,432
Group Child Care Homes	25,846	339,667
Quality Rating and Improvement Systems (QRIS) Participating Programs⁷	87,077	QRIS systems in 38 states
NAEYC Accredited Programs⁸	7,136	50 states
NAFCC Accredited Programs⁹	1,400	50 states
Unlicensed Care	Number of Programs	
Unlicensed non-relative family child care home providers caring for children receiving CCDF subsidies¹⁰	50,330	
License-Exempt child care centers caring for children receiving CCDF subsidies¹¹	7,355	
Non-relative caregivers receiving CCDF subsidies to care for children in the child's home¹²	27,739	
Child and Adult Care Food Program	Licensed/Approved Participating Programs	Average Daily Attendance
Total Programs¹³	177,825	4,057,714
Number of Centers	63,976	3,280,046
Number of Homes	113,849	777,668
Other Related Early Care and Education Programs	Enrollment	Location
State funded preschool¹⁴	1,383,450	57 programs in 42 states and DC
Head Start¹⁵	944,581	2,932 programs
Head Start		1,613 programs
Early Head Start (EHS)		1,061 programs
Migrant and Seasonal Head Start		37 programs
Migrant and Seasonal EHS		15 programs
American Indian/Alaska Native (AIAN) Head Start		148 programs
AIAN Early Head Start		58 programs

Over the last several decades, effective monitoring policies and practices have been an elusive goal. There are a combination of factors that have challenged states: the largest source of federal child care funding, the Child Care and Development Block Grant, had no requirement for inspections, states faced with budget challenges underfunded or cut funds for monitoring, and state policies were not strong as

agencies sought to draft policy without sufficient resources to undertake monitoring in a more effective manner. One trend is clear. Past reports of poor monitoring practices have not necessarily led to improvements. For example, a 2009 report in Connecticut, ["Ensuring Health and Safety in Connecticut's Early Care and Education Programs,"](#) an analysis of the Department of Public Health Child Care Licensing Specialists' reports of unannounced inspections was a comprehensive study reviewing 676 child day centers (41% of the state's supply) and 746 homes (28% of the supply). Among the violations that the report identified in child care centers:

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

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

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

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

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

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

The 2013-2016 series of OIG reports involving licensed child care centers and family child care homes in Arizona,^{23,24} Connecticut,^{25,26} Florida,^{27,28} Louisiana,^{29,30} Maine,^{31,32} Michigan,^{33,34} Minnesota,^{35,36} Pennsylvania,^{37,38} Puerto Rico³⁹ and South Carolina,^{40,41} shows that there are systemic weaknesses in

monitoring practices that include the same types of violations first identified 20 years ago. Therefore, it is not just about the number of inspections that are conducted but it is also about the effectiveness of how monitoring is conducted – including follow up steps taken after an initial visit where violations are found.

Stakeholder Listening Sessions

In 2016, the U.S. Departments of Health and Human Services and Agriculture held eight joint listening sessions with key stakeholders to better understand challenges with the current early care and education monitoring efforts.⁴² Included were child care center directors, family child care home providers, grantees operating Head Start, Migrant and Tribal grantees, child care resource & referral agencies, state agencies and sponsoring organizations administering CACFP, state licensing officials and representatives from national associations reflecting various ECE sectors. Nearly 100 people provided input on their experiences with the current monitoring system across the country.

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

Stakeholder Feedback

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

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

Perspective from a Provider Operating in Multiple States

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

April 2016 ACF-USDA Listening Session

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

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

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

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

State administrators of the CACFP program stressed the need to improve communication and coordination among monitoring agencies. In discussion with CACFP agencies,⁴³ three issues arose that require attention and closer coordination between agencies.

- **Responding to Reports of Imminent Danger.** While there may be written protocols within states with regard to cases where one agency contacts another to report a potential case of imminent harm for a child, CACFP agencies report that follow up by some licensing offices (or other appropriate agencies) can be delayed by a week or longer. This delayed response places children at risk and suggests that clear protocols are needed – not just on paper, but also in practice, for all responses to reports of imminent harm.
- **Protection of Children during Investigations.** CACFP agencies report that in some cases when CACFP participation is suspended for imminent threat to children, the children still attend the program (although the food program has been suspended). State licensing agencies should review such cases and determine appropriate next steps (e.g., whether parents should be notified, whether the program should be reviewed for appropriate enforcement actions, etc.).
- **Inspection Delays and Backlog.** CACFP agencies report delays in fire, safety, and health inspections that are needed for CACFP at-risk afterschool programs to operate (i.e., public or private nonprofit organizations eligible to offer afterschool meals and snacks). Inspection backlogs inhibit access to healthy meals and snacks for children. In one state, delays are reported of up to 2 years for a non-school site to obtain the required inspections they need.

Section II – Federal and State Monitoring Models

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

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

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

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

State Governance Models:

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

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

services.⁵⁰ In the BUILD Initiative ECE Governance policy statement, three models are described for states to consider. These include:

- **Coordinated Governance.** Coordinated governance places authority and accountability for early childhood programs and services across multiple public agencies. In states where this is the model, the SACs (or their equivalent) seek to improve coordination and collaboration among the agencies. Some have formal agreements or even State legislative guidance to support their work. For example, Pennsylvania’s Office of Child Development and Early Learning (OCDEL) is a collaborative venture between the State Department of Education and the Department of Human Services.
- **Consolidated Governance.** Consolidated governance places authority and accountability for the early childhood system in one executive branch agency – for example, the state education agency – for development, implementation, and oversight of multiple early childhood programs and services. One state that has done this is Maryland.
- **Creation of a new Agency.** In this model, a state might create a new executive branch agency or entity within an agency that has the authority and accountability for the early childhood system. The governing entity might be an independent state agency with a single mission focused on early childhood. Georgia, Massachusetts, and Washington have created stand-alone ECE agencies.

Examples of Recent State Monitoring Alignment Efforts

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

Rhode Island – Aligning among Agencies. In Rhode Island, multiple agencies are responsible for administering early learning settings: licensing regulations (Department of Children, Youth, and Families), QRIS- BrightStars (Department of Human Services), and Comprehensive Early Childhood Education (CECE) standards for preschool (Rhode Island Department of Education or RIDE). The three agencies worked to compare and align standards to produce a continuum of quality that includes a similar set of components across all three sets of standards for a better integrated monitoring system. Rhode Island’s work included developing:⁵¹

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

Georgia – Linking Compliance with Technical Assistance. The Department of Early Care and Learning (DECAL) changed the title of the state’s “licensing monitors” to “child care consultants” to better reflect responsibilities related to regulation and support in improving Georgia’s child care system. When hired, child care consultants complete standardized on-boarding [orientation] and then mentoring by

seasoned veteran staff for at least three months. Thereafter, DECAL conducts or contracts for relevant, appropriate professional development to ensure that licensing consultants are adequately equipped to maintain the balance of monitoring and technical assistance.

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

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

The task force recommended a progressive continuum of enforcement designed to better connect or link regulation and support for providers. The task force's review resulted in [an enforcement chart](#),⁵² which is based on a point system, and classifies enforcement actions as prevention (P), intermediate (I), or closure (C). Examples of prevention include technical assistance and/or citations. Intermediate enforcement options include fines and restrictions. Closures encompass both license suspension and revocation. The overall goal is to better support provider needs in attaining and sustaining compliance.

Use of the model began July 1, 2016 and is automated within the licensing database; a program's compliance zone designation and enforcement action, if applicable, automatically computes at each visit. A program's compliance zone (good standing, support, or deficient) is based on a summary measure of the program's 12 month monitoring history with child care licensing rules.⁵³

Section III: Moving Toward More Effective Monitoring Strategies Recommendations & Discussion

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

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

- Utilize SACs (or their equivalent) to:
 - Review any structural barriers that impede communication, coordination, and alignment among the various entities responsible for ECE programs and related funding support.
 - Identify the purpose, function, and expected outcomes of early care and education programs.
 - Determine options that could assist in building a more cohesive early childhood system, which could involve consolidating the governance of related early learning programs within one agency, within a collaborative venture between two agencies, or creating a new agency to house early childhood programs.

DISCUSSION: Many states and localities have worked to better coordinate programs and system infrastructure, accelerated by the Race to the Top Early Learning Challenge Fund and federal promotion of coordination in the 2014 CCDBG Act as well as Head Start policies.

Yet, in many cases, policies, goals, and oversight strategies are not aligned. Fragmentation in governance structure and authority can impede the ability to coordinate and share information across programs. There is no single model that is likely to work for every state, however, the Administration for Children & Families (ACF) recommends that every state review any structural barriers that impede communication, coordination, and alignment. How best to structure governance begins with identifying the purpose, function, and expected outcomes of early care and education programs. While it is not easy to re-align state governance structures, coordination, collaboration, alignment and accountability may be easier for related programs when they are housed under one roof.⁵⁴ Interviews with agency, department and division directors engaged in governance reform recommend that the exact form of governance should follow intended function and that *“these functions are present and linked in ways that encourage the system’s coordination, coherence, sustainability, efficiency, and accountability at all levels of service delivery.”*⁵⁵

Examples of State Governance Models that Promote Alignment

- Georgia has consolidated governance of child care, preschool, and CACFP in the Department of Early Care and Learning (DECAL), a stand-alone agency.⁵⁶
- Maryland⁵⁷ has consolidated governance of child care and preschool into the state education agency.
- Massachusetts has consolidated governance of child care and preschool into the Department of Early Education and Care, a stand-alone agency.⁵⁸
- Michigan has consolidated governance of child care, preschool, and early intervention in the Office of Great Start within the Department of Education.⁵⁹
- North Carolina has consolidated governance of child care and preschool into the Division of Child Development and Early Education within the Department of Health and Human Services.⁶⁰
- Pennsylvania has consolidated governance of child care, preschool, and early intervention programs within the Office of Child Development and Early Learning (OCDEL), a collaborative venture between the state Department of Education and Department of Human Services.⁶¹
- Vermont has consolidated governance of child care, preschool, and early intervention into the Department of Children and Families.⁶²
- Washington has consolidated governance of child care, preschool, and early intervention within the Department of Early Learning, a stand-alone agency.⁶³

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

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

Discussion: ACF’s Office of Child Care and the National Association for Regulatory Administration (NARA), published [*“Best Practices for Human Care Regulation”*](#)⁶⁴ in 2015, which helps states define key system characteristics of high-performing regulatory organizations. This document outlines best

practices, provides guidance to implement the best practices, and includes a self-study assessment tool⁶⁵ to help organizations score their performance and facilitate process recognition and improvements. Among best practices that are recommended are three types of assessments: for monitors, providers, and process to ensure that monitoring systems are working as intended.⁶⁶

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

Understanding the Terms

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

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

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

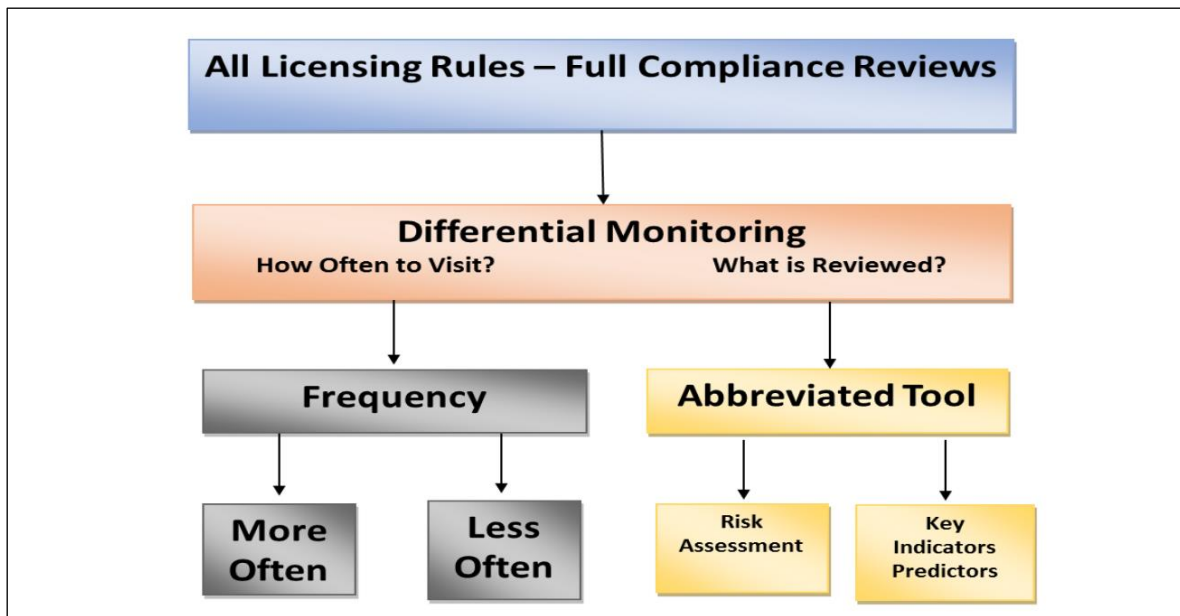
Key Indicators: An approach that focuses on identifying and monitoring those rules that statistically predict compliance with all rules.

Source: Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators. National Center on Child Care Quality Improvement, Office of Child Care. July 2014.

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

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

As of 2014, 37 states used abbreviated compliance forms during routine inspections and 13 states reported using differential monitoring.⁷⁰ It’s not about whether to conduct monitoring visits or not, but rather, it is about the type of monitoring visit to promote efficiencies and greater effectiveness, continuous quality improvement, and accountability. Continuous quality improvement applies to both internal monitoring protocols and practices as well as external provider improvement. Using information collected throughout monitoring visits can assist states in targeting support and resources (i.e., technical assistance) to providers moving the system from determining whether a provider complies on specific standards to helping providers understand why it is important to the health and safety of children that specific standards be met. Quality improvement and compliance are not mutually exclusive but rather components of a more seamless monitoring approach.



Source: Contemporary Issues in Licensing, Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators. National Center on Child Care Quality Improvement, Office of Child Care. July 2014. Graphic adapted from a graphic developed by Dr. Richard Fiene and used in Fiene, R. (2013) Differential monitoring logic model and algorithm (DMLMA: A new early childhood program quality indicator model (ECPQIM4)© for early care and education regulatory agencies, Middletown, PA: Research Institute for Key Indicators.

State Best Practices: Washington Key Indicator System

Washington's monitoring system is based on the 13 key indicators developed by Dr. Richard Fiene for the U.S. Department of Health and Human Services. The indicators are used across all programs (centers, FCC homes, and school-age programs). Providers with non-expiring full licenses are monitored using an abbreviated checklist when the site has demonstrated a high level of compliance since the prior visit. This includes, but is not limited to, no valid complaints, compliance agreements, or other information demonstrating noncompliance with licensing regulations. Licensors are required to move to a full checklist in cases where providers are not in compliance with any of the key indicators.

Washington also posts abbreviated checklists on line to inform providers.

- <http://www.del.wa.gov/publications/licensing/docs/CenterMonitoringChecklist.pdf>
- <http://www.del.wa.gov/publications/licensing/docs/FHMonitoringChecklist.pdf>

Source: Contemporary Issues in Licensing, Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators. National Center on Child Care Quality Improvement, Office of Child Care. July 2014.

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

- Conduct an organizational assessment to identify:
 - Who is monitoring providers,
 - The role of each monitor,
 - The frequency of monitoring,
 - Tools that are used in monitoring,
 - Staff competencies (qualifications, training, and oversight), and
 - Data systems used in monitoring.
- Review all standards used to monitor ECE programs and determine where there are inconsistencies, duplicative requirements or conflicts.
- Review whether the data and monitoring reports are shared or, could be shared between agencies to reduce duplication and maximize efficiency.
- Identify policies that stem from statute or regulations, cite specific requirements, corrective action requirements, remedies and penalties.

DISCUSSION: ACF recommends that states use “[Mapping the Early Care and Education Monitoring Landscape](#),”⁷¹ tool to assist in identifying how to begin developing a more efficient monitoring system. A coordinated approach could not only produce systemic efficiencies but also help evolve the culture of monitoring from compliance to continuous quality improvement. An aligned system with cross-training could assist monitors in better understanding how the pieces fit together and how fostering a culture of improvement could assist providers with the support they need to be successful.

Many state quality rating and improvement systems are separate from child care licensing and from child care subsidy systems. They operate independently, but are not integrated to promote provider participation and parent awareness. The majority of state QRIS are voluntary and in only 12 states is participation mandatory for providers caring for children on a CCDF subsidy.⁷² In some states, quality rating systems do not require programs to be licensed in order to participate.⁷³ Parallel systems create layers of monitoring that could be more efficient if the system components were better integrated.

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

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

Source: FY2016-2018 North Carolina State CCDF Plan.
https://www.acf.hhs.gov/sites/default/files/occ/north_carolina_stplan_pdf_2016.pdf

The monitoring of home-based programs is a particular concern because the number of licensed homes has been declining. Since 2011, the number of licensed homes has declined by 22,489 (14.7%).⁷⁴ The capacity within licensed homes has declined by spaces for 165,581 children (12.5%).⁷⁵ Home-based care

is an important choice for many families -- not just for its smaller environment but also because home-based providers may offer more flexible hours (including nontraditional hours). As states consider monitoring strategies, intentional approaches to better support home providers, including those with low literacy levels and also those who may not speak English as a first language, should be considered to ensure that the supply of child care homes does not continue to decline. Particularly in rural areas where home-based care may be the only option, it is concerning that the number of licensed homes is declining.

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

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

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

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

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

CCHCs are licensed health professionals with education and experience in child and community health as well as early care and education settings. While CCHCs do not provide clinical services, they do offer technical assistance and consultation to early care and education programs in a variety of areas including but not limited to national health and safety standards for out-of-home child care; state child

care licensing and public health requirements; indicators of quality early care and education related to health and safety; recognition and reporting requirements for infectious diseases; Early and Periodic Screening, Diagnosis, and Treatment screening recommendations and immunization schedules for children; importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children's Health Insurance Programs; development and implementation of health and safety policies and practices including poison awareness and poison prevention; health literacy on a variety of topics; and disaster planning resources and collaborations within child care communities (CCHCs also link programs with community resources for child, family, and staff health and mental health).⁷⁸

In Pennsylvania, initial evaluation of the Early Childhood Education Linkage System (ECLS) "Infant/Toddler Quality Improvement Project" clearly demonstrates the efficacy of utilizing a CCHC mentoring approach to improve compliance with selected Caring for Our Children Basics standards such as safe sleep practices and SIDS risk reduction, diaper changing procedures, training related to medication administration, hand hygiene, physical activity, and child abuse reporting. The evaluation also showed improvements in meeting the needs of children with disabilities.⁷⁹

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

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

DISCUSSION: The average child care licensing inspector caseload includes 97 centers.⁸⁰ The average licensing inspector caseload for home monitoring is 103.⁸¹ Monitoring caseloads range by state from 25-300.⁸² In some states, monitors inspect both centers and homes. For CACFP, federal regulations require sponsoring organizations to have one full time staff person for each 50 to 150 child care homes it sponsors and a sponsoring organization of centers must document one full-time staff person for each 25 to 150 centers it sponsors.⁸³ However, within the above ranges, it is the State CACFP agency's responsibility to determine the appropriate level of monitoring staff for each sponsoring organization.⁸⁴

In "[Best Practices for Human Care Regulation](#)," a document produced by ACF (the Office of Child Care) and NARA, workload assessments are recommended every 3 years or sooner. Effective caseload assessments use historical data to identify types of programs, types of activities, and time to conduct each activity (e.g., a person monitoring across funding streams may require a lower caseload compared to a person monitoring only one type of program). They also use geographic service areas and deployment patterns for efficient and effective monitoring visits, which includes travel time. NARA also recommends that workload calculations should include time for professional development activities.⁸⁵

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

- Consider maximizing CACFP monitoring to support quality care as well as to increase access to CACFP.
- Consider developing a Memorandum of Understanding (MOU) with the CACFP agency to potentially:
 - Develop cross-training initiatives based on key indicators;

- Provide reciprocity of certain monitoring items to reduce duplication and conflict;
- Develop common forms (e.g., attendance forms acceptable for both CACFP and CCDF subsidy); and,
- Promote efficiencies among and between systems.

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

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

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

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

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

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

ACF recommends the following to promote a more supportive approach to monitoring that fosters efficiency and mutual respect:

- Ensure all monitors are provided systematic comprehensive training before they begin work and routine in-service training throughout the year. This should include training on all standards, rationale for why the standards are important, and examples of what they should review to determine compliance.
- Ensure all monitors are trained in balancing compliance and continuous quality improvement.
- Ensure job descriptions reflect shared components of monitoring processes.
- Share monitoring checklists, along with the rationale for the requirements with the ECE providers and general public including parents to remove the element of surprise and to enable providers to fully understand standards for which they will be held responsible.
- Include mentoring and coaching for all newly hired monitors by experienced staff during a probationary period.
- Ensure that those who monitor family child care home providers have specialized training to fully understand child care home regulations and the operation of home-based programs.
- Determine appropriate caseloads for the various program types and ensure monitors are not overwhelmed. If warranted, adjust caseloads for monitors who have difficult programs or other unique circumstances.
- Support a shared vision among agencies and divisions to avoid unintended consequences when issues are identified during monitoring visits.
- Include inspection checklists in the materials providers receive during trainings, upon licensure and licensure renewal, and that providers can easily access online; and
- Conduct regular, systematic surveys of ECE providers in order to allow those monitored to provide feedback and to promote continuous quality improvement among providers and inspectors.

DISCUSSION: Currently, multiple agencies share responsibility for monitoring the same or similar standards across settings. Aligning monitoring strategies is part of implementing a coordinated process, however, it begins with cross-training and basic competencies of monitors. As of 2014, 39 states required child care inspectors to have at least a Bachelor's degree.⁸⁶ In 24 states, the content or major of the degree must be in early childhood education, child development, or a related field.⁸⁷ Twenty-one states also required experience working in a setting with children.⁸⁸ In addition, 28 states required licensing staff to complete additional training each year.⁸⁹ It is not known how many states engage in cross-training to promote monitoring across programs and funding streams. Only 6 states use inter-rater reliability studies to help promote consistency in monitoring.⁹⁰ Inter-rater reliability is a critical issue that needs to be addressed by states; it is as important as the issue of validity. With regard to CACFP personnel requirements, federal regulations require that each sponsoring organization provide adequate supervisory and operational personnel for the effective management and monitoring of the program at all facilities it sponsors.⁹¹

It is not easy to change the culture of monitoring from a framework of compliance to support for continuous quality improvement. Specific training on balancing compliance and continuous quality improvement is needed so that both inspectors and providers are supported. The listening sessions revealed challenges with licensing inspector knowledge of state regulations and too often the attitude of monitors in conducting inspections. The key to changing the culture of the monitoring framework is to have an underlying quality assurance program. This is a major paradigm shift in seeing the glass as half full rather than as half empty. NARA's "Best Practices for Human Care Regulation," includes a number of recommendations related to quality assurance programs such as monitor training, coaching, workload, and provider feedback.⁹² While each state may define quality assurance differently, at the core is the ability to have feedback on the system and how each of the components of the system is working. Florida, Georgia, Oklahoma and Texas have a formal quality assurance program with written policies designed to increase consistency across the state.⁹³

State Best Practices: Training of Licensing Staff

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

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

Quality Assurance & Consumer Feedback

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

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

Georgia's regional directors evaluate field staff by conducting quality assurance visits at least once per year for all consultants. Lead consultants also conduct joint visits with field staff throughout the year in a more informal quality assurance process. The purpose of the joint visits is to evaluate staff on:

- Professional practice
- Consistent and accurate evaluation and application of rules and regulations
- Principles of documentation; and
- Conducting an appropriate exit conference during the inspection.

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

Source: *Contemporary Issues in Licensing: Quality Assurance in Child Care Licensing*. National Center on Child Care Quality Improvement. September 2014. https://childcareta.acf.hhs.gov/sites/default/files/public/1409_quality_assurance_final_0.pdf; Emails exchanged with the Administration for Children and Families, August 2016.

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

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

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

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

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

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

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

State Best Practices: Oregon Equity Lens

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

Oregon Equity Lens:

<http://www.ode.state.or.us/superintendent/priorities/final-equity-lens-draft-adopted.pdf>

The benefit of interpretive guidelines is that both providers and monitoring staff can use them as a tool to more easily understand state policies and meet state expectations.

State Best Practices: Virginia and Washington Interpretive Guidelines

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

Standards for Licensed Family Day Homes with Interpretation Guidelines

https://www.dss.virginia.gov/files/division/licensing/fdh/intro_page/code_regulations/regulations/final_fdh_manual_071713.pdf

Standards for Licensed Child Day Centers, Technical Assistance

https://www.dss.virginia.gov/files/division/licensing/cdc/intro_page/code_regulations/tech_assist/ta.pdf

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

Child Care Center Licensing Guidebook

<http://www.del.wa.gov/publications/licensing/docs/ChildCareCenterLicensingGuide.pdf>

Family Home Child Care Licensing Guide

http://www.del.wa.gov/publications/licensing/docs/FHCC_guide.pdf

Source: Virginia Department of Social Services, <https://www.dss.virginia.gov/family/cc/index.cgi>. Washington Department of Early Learning, Publications, Forms and Research, <https://www.del.wa.gov/providers-educators/publications-forms-and-research>.

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

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

DISCUSSION: According to the National Center on Early Childhood Quality Assurance, 34 states report using portable devices to help staff more efficiently inspect and monitor licensed programs such as through laptops, tablets or other digital means.⁹⁷ Some of the benefits include:⁹⁸

- Monitoring data are recorded once during the inspection visit and do not have to be reentered upon return to the office.
- Pre-population of forms with program information can reduce the time spent on paperwork and allow more time for observing care.

- Software that performs spell-check, provides an alert when something has been overlooked, and allows for the selection of standardized text makes reports more consistent, quicker and more accurate.
- Licensors can access relevant monitoring information such as prior history, requirements and the licensing statute while in the field.
- Licensors can produce an inspection report on site.
- Posting the report onsite or on the internet is more efficient.

Some states work internally within their agency and others contract with private vendors.⁹⁹ Greater use of technology can not only make the monitoring system more efficient (and cost-effective) but also can be used for strategic purposes. For example, states that can integrate compliance issues can better target training for providers and monitors to better address identified challenges. In Georgia, software enables the state to track programs, trainers, and monitoring consultants, to track types of violations, and to address them regionally by trend such as if there is an uptick in playground problems, trainings can be specifically targeted based on identified need.¹⁰⁰

State Technology Best Practices: Indiana Family and Social Services Administration

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

Cost Reductions

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

Productivity Increases

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

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

In addition to a greater use of technology is the critical need for data and information sharing. A coordinated monitoring strategy depends on the ability to share data and information among and between agencies. In too many states, there is no sharing of data and no sharing of information (e.g. monitors do not have access across programs to previous inspection reports to reduce duplication or to promote follow-up). Monitors should know across settings the spectrum of programs in which providers participate (e.g., licensing, CACFP, Head Start, QRIS, State Pre-K, etc.) to promote efficiencies in monitoring approaches. Head Start data could be shared for community birth-to-five planning purposes as well as CLASS® results where appropriate for use in quality rating systems (e.g., 15 states use CLASS® observations as part of state QRIS ratings).¹⁰¹

With the requirement under the CCDBG Act of 2014 to post inspection reports on the internet, some of the information sharing will be facilitated. However, the challenge with data and information sharing goes beyond the posting of licensing reports. For example, although allowed, in most states, CACFP participation data and disqualification actions are not shared with the state licensing office. Conversely, the state licensing data is not shared with the state CACFP administering agency.

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

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

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

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

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

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

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

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

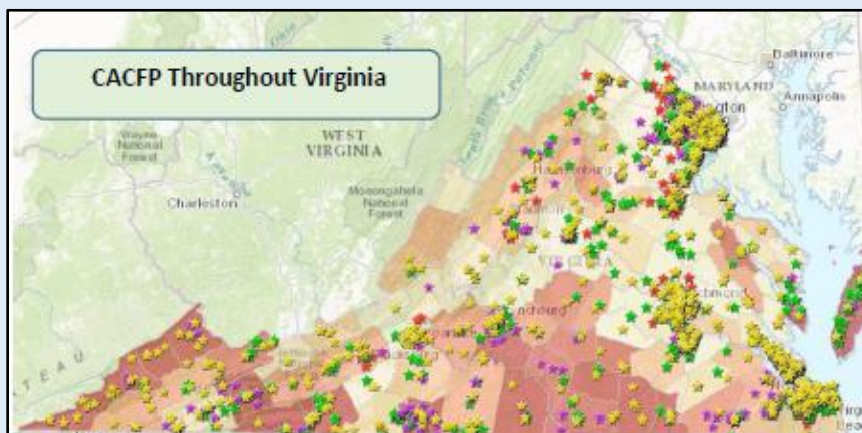
In addition, there should be more information sharing with the public, particularly families. While posting inspection reports on the internet is required under the CCDBG Act of 2014, the content of those reports should be easy to understand and prioritized related to severity. Merely posting reports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

Data sharing among state agencies and Tribes where applicable can also help promote state outreach strategies (e.g., strategies related to assisting more providers to become licensed or to participate in CACFP). Data sharing when combined with data visualization (e.g., geocoding licensed program data and

CACFP participation data) can help both agencies identify areas within a state where there is an imbalance between supply and demand leading to proactive strategies to better serve children.

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

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



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

Section IV. CONCLUSION

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

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

Using [Caring for our Children Basics](#) across programs will ensure that there is a core set of health and safety standards regardless of early learning setting. Developing MOUs between state agencies or departments with reciprocity or agreement on common standards (e.g., CACFP meal and food safety rules, attendance forms, etc.) can help promote more effective and efficient monitoring approaches. Promoting continuous quality improvement and compliance will lead to a culture of support bolstered

by monitor training, the use of interpretative guidelines, customer feedback, and reasonable monitoring workloads. Utilizing today's technology and greater sharing of data and information will not only make monitoring systems more efficient but will also enable greater resource targeting that is data-driven. With cross-training and MOUs, it is possible to achieve greater efficiencies across agencies.

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

Appendix I:

Head Start's Aligned Monitoring System

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

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

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

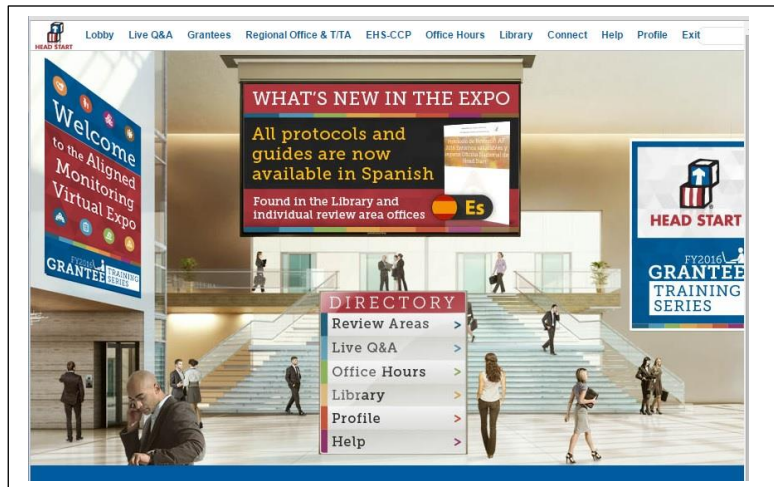
The new Aligned Monitoring System (AMS) takes into account compliance and quality by using a program's track record to determine the intensity of monitoring. The AMS provides two different approaches to monitoring based on a grantee's history: the Comprehensive Monitoring Process and the Differential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

The Comprehensive Review involves the five content-focused assessments in the first three years of the grant. The Differential Monitoring process focuses on a shorter list of key indicators selected from the Comprehensive Monitoring tool. Grantees with a strong track record of compliance receive the shorter, key indicator review. If they are in

compliance, the Office of Head Start will only monitor the Environmental Health and Safety and CLASS® during the grant cycle. If they are not compliant, they will receive a Comprehensive Monitoring review. For grantees with findings or deficiencies, a corrective action plan is put into place and OHS staff work with grantees to come into compliance. Targeted technical assistance is provided. A follow up review is conducted to ensure that identified findings have been addressed.



Finally, the Office of Head Start has increased transparency and partnership with grantees, which has helped transform the culture from one of compliance anxiety to continuous quality improvement. To assist grantees in better understanding the areas that will be monitored, OHS has developed an online “[Aligned Monitoring Virtual Expo](#).” The on-line expo describes specific content areas that will be reviewed, allows grantees to access videos and supporting information, and offers grantees an opportunity to ask questions. The transparency of the information has helped reduce the anxiety and mystery associated with the monitoring process so that grantees can be successful. Revamping the monitoring process and creating greater transparency with regard to standards and monitoring tools has helped transform the culture and helped to promote a link between monitoring and quality practices (rather than a focus on the negative).



For more information on any of the monitoring areas, access to communications toolkits, and protocols, please visit [the Virtual Expo](#) hosted by the Office of Head Start.

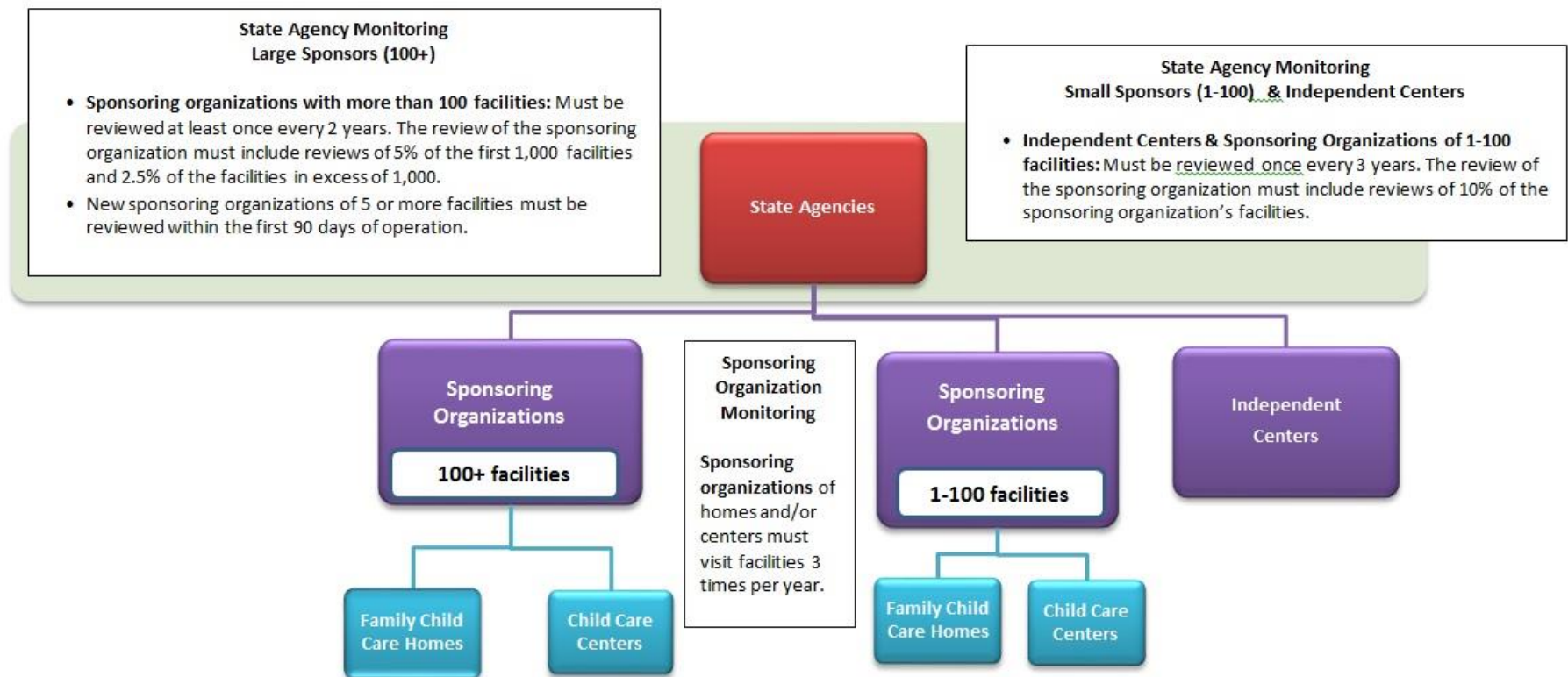
While Head Start programs are federally funded, they are required to be licensed by states (or meet comparable standards) and participate in CACFP.¹⁰² In addition, many Head Start programs participate in state quality rating and improvement systems. Therefore, in addition to the federal aligned monitoring system, programs are also subject to other inspections. With greater sharing of information, duplication in monitoring could be avoided.

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

Through USDA, CACFP provides reimbursement for meals and snacks in child care, Head Start, and other early childhood settings serving low income children. Child care home providers and affiliated and unaffiliated centers are required to operate under a sponsoring organization. Independent centers are not required to participate under a sponsoring organization. Instead, they can conduct their own administrative tasks and participate directly under a state agency.¹⁰³

State agencies must annually review at least 33.3 percent of all programs. Independent centers and sponsoring organizations with 1 -100 facilities must be reviewed at least once every 3 years. Such reviews must include reviews of 10 percent of the sponsoring organization’s programs. Sponsoring organizations with more than 100 facilities must be reviewed at least once every 2 years. Such reviews must include at least 5 percent of the first 1,000 facilities and 2.5% of the remainder in excess of 1,000. Sponsoring organizations of homes or centers must visit programs at least 3 times per year. Programs participating in CACFP must be licensed. If licensing is not required by state agencies, USDA offers some flexibility on alternative approval, including a minimum set of standards for health and safety that are part of CACFP regulations for use when licensing and alternative approval is not available.¹⁰⁴ The state agency requires submission of health/sanitation and fire/safety permits or certificates for all independent centers and programs seeking alternate child care standards approval.

Child and Adult Care Food Program (CACFP) Monitoring State Agency Reviews & Sponsoring Organization Reviews



Source: U.S. Department of Agriculture, Child and Adult Care Food Program (CACFP Federal Regulations, <http://www.fns.usda.gov/sites/default/files/CFR226.pdf>)

U.S. Military Child Care Monitoring Framework

The Department of Defense operates the nation's largest employer-sponsored child care system assisting 200,000 children of military families every day.¹⁰⁵ At the core of the military's support for child care: high quality standards and enforcement of those standards, workforce preparation, parent engagement, and affordable access.¹⁰⁶ However, the military child care system was not always the model it is today.

A 1982 U.S. General Accounting Office (GAO) study found that many military child care programs *"currently in use are neither safe nor suitable places for child care programs."*¹⁰⁷ The majority of the Army child care facilities did not meet fire and safety codes. The majority of Navy facilities needed upgrading to comply with fire, safety, and sanitation standards. One-fifth of Air Force programs needed improvements and additional facilities were needed to meet Marine Corps demand.¹⁰⁸ A 1989 GAO study found extensive and growing demand for child care and deemed child care services to military families as an "essential service" and "mission critical."¹⁰⁹

The GAO reports, a series of public scandals involving military care, and parent demand fueled Congressional hearings and ultimately enactment of the Military Child Care Act of 1989 (P.L. 101-189),¹¹⁰ which called for the military to establish a comprehensive cross-system (i.e., Army, Navy, Marine Corps, and Air Force) of health and safety regulations, training for the workforce, and an enforcement system including quarterly unannounced inspections as well as tough sanctions for noncompliance.

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

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

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

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

Although DoD has its own child care system, it depends on state policies and practice to meet the needs of military families who cannot access on installation care.



NATIONAL CENTER ON Early Childhood Quality Assurance

Administration for Children & Families National Center on Early Childhood Quality Assurance (ECQA)

ACF's National Center on Early Childhood Quality Assurance (ECQA) supports state and community leaders in devising innovative models to promote more effective monitoring systems among quality initiatives. The ECQA Center's priorities include advancing strong health, safety, and quality standards and licensing regulations within states and territories. ECQA Center staff have developed resources and tools that address two main areas of child care licensing: policies and practices (e.g., monitoring, enforcement, and licensing staff development), and program requirements.

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

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

Technical assistance tools include the following:

- **The National Database of Child Care Licensing Regulations** is a repository of State and Territory licensing regulations and agency contact information. It is organized by State/Territory and allows users to access child care licensing regulations that apply to child care centers, family child care homes, school-age programs, infant care programs, and other specialized programs. In addition, website links are provided for other early childhood programs standards, such as quality rating and improvements system (QRIS) standards, prekindergarten program requirements, and state health and safety requirements for child care providers receiving payment from the federal Child Care and Development Fund.
<https://childcareta.acf.hhs.gov/licensing>
- **The CCDF Data Explorer** contains State-level data about licensing requirements and is available on the ECTTA website. Child Care and Development Fund (CCDF) data include child-staff ratios and group sizes, criminal background checks, minimum preservice qualifications, ongoing training hours, and types and frequency of routine licensing inspections.
<https://childcareta.acf.hhs.gov/data>
- **The National Program Standards Crosswalk Tool** is prepopulated with national early childhood program standards (such as Head Start, accreditation, Caring for Our Children). It is designed to help States that are developing and aligning program standards for licensing, QRIS, or prekindergarten programs to search and compare the content of several sets of national standards. <https://occqrisguide.icfwebservices.com/index.cfm?do=crosswalk>

Additional information and resources from the ECQA Center are available at <https://childcareta.acf.hhs.gov/quality-improvement>.

¹ P.L. 113-186, the Child Care and Development Block Grant Act of 2014, <https://www.gpo.gov/fdsys/pkg/BILLS-113s1086enr/pdf/BILLS-113s1086enr.pdf>

² Ibid.

³ Research Brief #1: Trends in Child Care Center Licensing Regulations and Policies for 2014. National Center for Early Childhood Quality Assurance (November 2015)

https://childcareta.acf.hhs.gov/sites/default/files/public/center_licensing_trends_brief_2014.pdf

⁴ Ibid.

⁵ U.S. Department of Agriculture, Food & Nutrition Service, National Data Bank, FY2015.

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Research Brief #2: Trends in Family Child Care Home Licensing Regulations and Policies for 2014. National Center for Early Childhood Quality Assurance (November 2015),

https://childcareta.acf.hhs.gov/sites/default/files/public/315_1511_fcch_licensing_trends_brief_2014_final_508_0.pdf;

Research Brief #3: Trends in Group Child Care Home Licensing Regulations and Policies for 2014. National Center for Early Childhood Quality Assurance (November 2015)

https://childcareta.acf.hhs.gov/sites/default/files/public/gcch_licensing_trends_brief_2014.pdf

⁷ BUILD Initiative, QRIS Compendium, Create a Report, 87,077 programs in 38 states. (2016).

<http://griscompendium.org/create-a-report>; There are additional states such as Alaska, Alabama, New Jersey, and Texas that have begun implementing a statewide QRIS but were not included in the most recent BUILD Compendium. Refer to the Compendium web site for updated reports expected in the fall of 2016.

http://nwlc.org/wp-content/uploads/2015/08/final_nwlc_louisianataxcreditsreport.pdf

⁸ NAEYC Accreditation as of June 2016

⁹ NAFCC Accreditation as of June 2016

¹⁰ FY2014 Child Care and Development Fund data. <http://www.acf.hhs.gov/occ/resource/fy-2014-ccdf-data-tables-preliminary>

¹¹ Ibid.

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¹⁵ Head Start Program Facts FY2015, U.S. Department of Health and Human Services, Office of Head Start, <http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets/docs/head-start-fact-sheet-fy-2015.pdf>, FY2015 Program Information Report Data.

¹⁶ GAO: "Child Care, States Face Difficulties Enforcing Standards and Promoting Quality," November 1992 (GA/HRD-93-13). "In most cases, budget cutbacks and the resulting lack of staff in addition to increased numbers of providers were the major reasons states cited for difficulties in conducting on-site monitoring." Page 7. <http://www.gao.gov/assets/220/217095.pdf>

¹⁷ U.S. Department of Health and Human Services, Office of Inspector General, "Review of Health and Safety Standards at Child Care Facilities in North Carolina," (A-12-92-00044) March 23, 1993. Also, memo from Bryan Mitchell, Principal Deputy Inspector General to Laurence Love, Acting Assistant Secretary for Children and Families, March 23, 1993.

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<http://oig.hhs.gov/oas/reports/region1/11302506.pdf>
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April 14, 2016 National Head Start Association (grantees and delegate agencies)
April 15, 2016 Child Care Aware of America (Child Care Resource & Referral Agencies)
April 18, 2016 National Association of Family Child Care (family child care homes)
April 28, 2016 USDA Food & Nutrition Service/State Agencies (State agencies administering CACFP)
May 2, 2016 USDA Food & Nutrition Service/Sponsors (Sponsoring agencies for CACFP)
May 23, 2016 National Association for Regulatory Administration (state licensing officials)
May 23, 2016 Migrant and Tribal Head Start Programs (grantees)
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Updated June 2017

Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States

Hannah Matthews, Karen Schulman, Julie Vogtman, Christine Johnson-Staub, and Helen Blank

THE CENTER FOR LAW AND SOCIAL POLICY (CLASP)

advocates for public policies that reduce poverty, improve the lives of poor people, and create ladders to economic security for all, regardless of race, gender, or geography. CLASP targets large-scale opportunities to reform federal and state programs, funding, and service systems and then works on the ground for effective implementation. CLASP's research, analysis, and advocacy foster new ideas, position governments, and advocate to better serve low-income people.

THE NATIONAL WOMEN'S LAW CENTER (NWLC)

is a non-profit organization working to expand the possibilities for women and their families by removing barriers based on gender, opening opportunities, and helping women and their families lead economically secure, healthy, and fulfilled lives—with a special focus on the needs of low-income women and their families.

ACKNOWLEDGEMENTS

This guide would not have been possible without the generous support of the Alliance for Early Success, Annie E. Casey Foundation, Ford Foundation, George Gund Foundation, Heising-Simons Foundation, Irving Harris Foundation, JPB Foundation, W.K. Kellogg Foundation, the Moriah Fund, and an anonymous donor.

Karen Schulman is Child Care and Early Learning Research Director at the National Women's Law Center; Hannah Matthews is Director of Child Care and Early Education at CLASP; Julie Vogtman is Senior Counsel & Director of Income Support Policy at the National Women's Law Center; Christine Johnson-Staub is Senior Policy Analyst at CLASP; and Helen Blank is Director of Child Care and Early Learning at the National Women's Law Center.

The authors thank Anitha Mohan, Beth Stover, and Christina Walker for their assistance with the report. The authors extend a special thank you to the many advocates and policymakers who helped inform the content of this report. While the authors are grateful for all assistance and funding related to this paper, the authors alone are responsible for its content.

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Introduction

In November 2014, Congress reauthorized the Child Care and Development Block Grant (CCDBG),¹ the major federal child care program, for the first time since 1996. It offered states a framework to improve their child care assistance programs to help families access safe, reliable, affordable child care, better enabling parents to go to work or school and furthering children's healthy growth and development. The law's goals of raising health and safety standards for all children receiving CCDBG-funded child care and increasing the quality of care are essential for the well-being of children, especially the most vulnerable children.

The importance of child care assistance for low-income parents and their children is clear. CCDBG helps parents afford reliable child care, which can help them gain and maintain stable employment. It also helps them access higher-quality care than they could otherwise afford.² Research demonstrates the importance of high-quality child care to children's development and success in school and in life.³

It was certain when the law passed that states would need significant new resources to seize the opportunities offered by the law to improve child care to benefit children, parents, and providers. However, the law itself did not guarantee any new resources and Congress has not followed through with sufficient funds to support its implementation. CCDBG received minimal increases in funding in the years following the reauthorization; even so, federal funding for CCDBG has actually declined by about 10 percent since 2002 in constant dollars.⁴ States are attempting to do more with less—an unsustainable struggle that is directly affecting low-income children, families, and providers.

The CCDBG reauthorization stands at a critical juncture. Some states are moving forward with legislative proposals and the promulgating of rules or with particular pieces of the reauthorization. Many states, however, are limited in their capacity to move forward without the requisite resources. While all agree on the worthy goals of the CCDBG reauthorization, its ultimate success will depend on federal and state lawmakers' commitment to investing in this vital work support and child care program.

CURRENT STATUS OF IMPLEMENTATION

At the time of this guide's publication, implementation of the reauthorization was a mixed picture across the states. State CCDBG plans, including implementation plans, were approved and effective June 1, 2016 covering a three-year period. States were asked to create implementation plans based on their best interpretation of the law. Many states are putting key provisions into effect and moving implementing legislation through their legislatures.⁵ In some cases, states took the opportunity to make improvements to policies—including those not specifically required by the reauthorization, but consistent with its larger goals—to better serve children and families. For example, Louisiana revised its rules to reduce the total number of activity hours of work, education, and/or job training required for eligibility for assistance from 30 hours to 20 hours, thereby reducing barriers to parents' access to subsidies. Florida approved the use of direct contracts for slots for children in areas of concentrated poverty.⁶

But momentum has stalled. Thirty-five states submitted waivers for at least one provision of the law.⁷ The reasons for requesting waivers varied. For example, some states needed more time to pass legislation or go through rulemaking processes. Others preferred to wait for the federal regulations to be finalized, which did not occur until September 2016, after state plans were approved. Still others submitted waivers due to a lack of resources available to implement the law.

Waivers were approved in all areas for up to one year with an opportunity to request an extension, with the exception of basic health and training requirements which were to be met by October 2016.⁸ The most common waivers were for provisions related to graduated phase-out, 12-month eligibility, health and safety topics, and license-exempt care inspections.⁹

Some states, rather than making progress, have actually moved backward in addressing the child care needs of children and families. For example, some states—including Connecticut, Georgia, and Texas—closed enrollment to new applicants or limited enrollment to priority groups.¹⁰ Others—including North Dakota and West Virginia—reduced or plan to reduce income eligibility for assistance.¹¹ Some states, in an effort to control implementation costs, have taken steps to restrict the types of providers that can receive CCDBG dollars, effectively limiting the choices of care and potentially making it impossible for some parents in low-wage jobs—who often need child care options that are flexible enough to match variable or nonstandard work schedules—to use child care subsidies.

STATE COSTS AND IMPACT

While states are positioned differently with respect to the extent of policy changes needed to comply with the law, all states face some new costs, and in many states these costs are substantial. On-site inspections for an expanded pool of providers, health and safety trainings, and background checks

for providers all have hard costs. Many states have also cited large costs associated with implementation of 12-month eligibility without reducing the overall number of children served or placing more children on waiting lists. Meeting other objectives of the law, such as building the supply of high-quality care, paying higher rates for higher-quality care, and expanding the number of low-income children in high-quality care, also necessitates higher subsidy costs per child.

While all agree on the worthy goals of the CCDBG reauthorization, its ultimate success will depend on federal and state lawmakers' commitment to investing in this vital work support and child care program.

Already, the number of children receiving assistance has declined significantly. The U.S. Department of Health and Human Services (HHS) estimated that only 15 percent of children eligible under federal eligibility rules actually received assistance in 2012.¹² In 2015, CCDBG served the smallest number of children in its history, with an estimated 373,100 fewer children receiving child care assistance than in 2006.¹³ The number of child care providers receiving CCDBG funds has fallen as well, declining by over half (nearly 52 percent) during that time period.¹⁴

The absence of new resources to implement the law raises the possibility that states could make tradeoffs that will undermine the very goals of the reauthorization. The challenges of balancing policy reforms with unmet need are immense for states. The value of enabling families to have more continuity of care and stability, allowing children to access higher-quality care, and prioritizing vulnerable populations, such as children experiencing homelessness and children with special needs, simply cannot be overstated. Continuing to operate child care subsidy programs

in ways that disrupt both parental employment and children's continuity of care is counter-productive to meeting CCDBG's goals. And yet, moving a reform forward without adequate funding leaves states with no choice but to trade off among essential priorities: basic health and safety assurances; quality improvements; economic stability for families; and resources for providers.

We are especially concerned about providers and how we ensure that high-quality providers continue to care for low-income children in CCDBG. Providers are central to child care quality. Research demonstrates that high-quality interactions between teachers and children are critical to children's well-being—and the providers' understanding of child development and effective teaching strategies necessary to produce those interactions requires both professional development and ongoing support.¹⁵ If states shortchange investments in educating the child care workforce, providers will lack the knowledge and skills they need to offer a high-quality learning experience for children in their care. Moreover, state payment rates are currently so low that they fail to provide sufficient resources for providers to meet standards in the law. Underpaying child care providers leads to poor job quality, including poverty wages for the early childhood workforce.

Finally, further shrinking the reach of CCDBG is counter-productive for our country. Helping parents work and promoting children's well-being are interrelated. When parents are able to work and earn a steady income, they can offer their children more stability, opportunities, and resources. Families can live in better neighborhoods with better schools, provide nutritious meals, and buy books and toys that allow their children to learn and explore. And when parents have peace of mind that their children are in child care that offers a safe, nurturing environment, they are more likely to be productive at work, and thus more likely to stay employed and possibly even advance to a position with higher pay.¹⁶ With less help, fewer parents will

be able to work and provide for their families while knowing their children are safe and well cared for.

MOVING FORWARD

We remain hopeful that Congress and states will allocate the new resources necessary towards the important and broadly supported goals of the reauthorization. States can also examine how they can use data, technology, staff training, and other approaches and tools to improve the way they administer their child care assistance programs. In a number of states, administrators and policymakers have made significant strides making access to child care assistance more family-friendly, more efficient, and more accountable.¹⁷

ABOUT THIS GUIDE

This guide is an update of the implementation guide published by CLASP and NWLC in April 2015 and includes an outline and discussion of provisions in the final rule implementing CCDBG issued by the Administration for Children and Families in September 2016. We are pleased that many of the suggestions we, together with other national and state child care advocates, made in our original implementation guide to maximize key provisions in the law were included in the final rule, in particular those that would strengthen the provisions of child care financial assistance for families to support economic stability and child well-being.

This guidebook summarizes and analyzes key sections of the law, offers recommendations—and cautions—for states as they consider how to implement those sections, and suggests related resources that may be useful for background information or model policies.

We hope the updated guide is useful in better understanding the implementation of new provisions and making the case for the necessary legislative and administrative policy changes at the state level and for the necessary funding increases at the federal and state level.

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Purposes and Select General Administration Provisions

The CCDBG Act of 2014 broadens the general purposes of the program, placing greater emphasis on the quality and continuity of care and fostering children's development. The law's overarching provisions on administration retain state flexibility while establishing some new parameters on the uses of CCDBG funds.

Key Provisions in the Law and Regulations CCDBG Purposes

The reauthorization and corresponding regulations amended and expanded upon the purposes of the CCDBG program, which are to:

1. Allow each state maximum flexibility in developing child care programs and policies that best suit the needs of children and parents within that state.
2. Promote parental choice to empower working parents to make their own decisions regarding the child care services that best suit their family's needs.
3. Encourage states to provide consumer education information to help parents make informed choices about child care services and to promote involvement by parents and family members in the development of their children in child care settings.
4. Assist states in delivering high-quality, coordinated early childhood care and education services to maximize parents' options and support parents trying to achieve independence from public assistance.
5. Assist states in improving the overall quality of child care services and programs by implementing the health, safety, licensing,

training, and oversight standards established in CCDBG and in state law (including state regulations).

6. Improve the child care and development of participating children.
7. Increase the number and percentage of low-income children in high-quality child care settings.

Lead Agency Responsibilities

- A state Lead Agency may be a state agency or a joint interagency office as designated or established by the governor of the state.¹ Lead agencies serve as the single point of contact for all child care issues; determine the basic use of CCDBG funds and priorities for spending CCDBG funds; and promulgate the rules governing overall administration and oversight.
- Lead Agency duties also include administering the CCDBG program, developing the state plan with opportunity for public comment, and coordinating the provision of services with other federal, state, and local child care and early childhood development programs.
- The state plan period is now three years (changed from two years). States have the option, as before, of submitting amendments to state plans during this time period to reflect updated policies.
- To the extent practicable, CCDBG services must be efficiently coordinated with programs operated at the federal, state, and local levels for children in preschool programs, tribal early childhood programs, and other early childhood

programs in order to expand accessibility and continuity of care and assist children to receive full-day services. If the state elects to combine funding for CCDBG with that of other early childhood programs, it must describe the funding streams in its state plan and explain how it will use the combined resources.

Eligibility for Child Care Assistance

- Eligible children are defined as those under 13 years of age (or between ages 13 and 19 and physically and/or mentally incapable of self-care or under court supervision); in families whose income does not exceed 85 percent of the state median income (SMI) for a family of the same size based on the most recent SMI data that are published by the U.S. Census Bureau; and residing with a parent or parents who are working or attending a job training or educational program or receiving, or needing to receive, protective services.²

Use of CCDBG Funds

- The reauthorization maintains the existing allowable uses of funds, including the priority given to children of families with very low incomes and children with special needs, and adds children experiencing homelessness as a priority group. States must also prioritize investments for children of families in areas with significant concentrations of poverty and unemployment and without high-quality child care.
- Specifically, states may use CCDBG funds for:
 - Child care services on a sliding fee scale basis
 - Activities that improve the quality or availability of such services
 - Activities that improve access to child care services, including for homeless children and the establishment/support of a system of local/regional child care resource and referral (CCR&R) organizations (coordinated by a statewide lead CCR&R). Under this provision, the CCR&R agency must be designed to provide parents with complete consumer education

information about all available child care options; work directly with families receiving CCDBG assistance to help them enroll their children in appropriate, high-quality child care settings; collect data and provide information on coordination of services and supports and the supply of and demand for child care; establish partnerships with public agencies and private entities; and coordinate activities among the Lead Agency and local agencies that administer CCDBG funds.

- The reauthorization maintains a 5 percent limit on administrative expenditures.
- States must reserve the required quality set-aside funds, increasing from 4 percent to 9 percent of CCDBG funds in FY 2020 (in addition to 3 percent for improving the supply and quality of infant-toddler care beginning in FY 2017), and from the remainder must spend a minimum of 70 percent of discretionary funds on direct services (i.e., access to child care) and 70 percent of mandatory funds on families using Temporary Assistance for Needy Families (TANF), families transitioning off of TANF, and families at risk of receiving TANF.

Waiver Authority

- The Secretary of the U.S. Department of Health and Human Services (HHS) is permitted to waive provisions or penalties in the statute for up to three years (with the option of a one-year extension) based on a request from a state identifying duplicative requirements preventing the effective delivery of child care services; extraordinary circumstances, such as a natural disaster or financial crisis; or an extended period of time for a state legislature to enact legislation to implement the statute. Waivers are probationary and are subject to termination by the Secretary at any time.
- In order to be considered, the waiver application must do the following:
 - Describe the circumstances that prevent the state from complying with the statutory or regulatory requirements.

- Demonstrate that the waiver enhances the state's ability to carry out the purposes of the statute.
 - Show that the waiver will not contribute to inconsistency with the Act.
 - Request one of the allowable types of waivers.
- The final rule clarified two types of waivers that can be requested:
 1. Transitional and legislative waivers: Waivers that are designed to offer temporary relief from conflicting or duplicative requirements or that allow lead agencies one full legislative session to enact legislation necessary to implement the provisions of the reauthorization law or rule. These waivers are limited to a one-year initial period, and may be renewed for an additional one-year period, should the state have a two-year legislative cycle or need additional time.
 2. Waivers for extraordinary circumstances: Waivers that address temporary circumstances or situations, such as a natural disaster or financial crisis. These waivers are limited to an initial period of no more than two years from the date of approval, and at most, an additional one-year renewal from the date of approval of the extension.

Federal Reports on State Waiting Lists and State Noncompliance

- Beginning November 2016, and every two years thereafter, the U.S. Comptroller General must produce a report on waiting lists for child care assistance that includes the number of families in each state that are eligible for CCDBG assistance, have applied for assistance (identified by the type of assistance requested), and have been placed on a waiting list for the assistance.
- Beginning September 30, 2016 and each September 30 thereafter, the HHS Administration for Children and Families (ACF) must determine whether each state uses CCDBG funds for child care services or activities that improve quality, availability, or access to such services, with priority given to services for children with very low family incomes or special needs, or that are

experiencing homelessness. The final rule adds a new provision requiring ACF to annually prepare a report that contains this information, highlighting whether lead agencies used funds in accordance with the priority for services provisions.

- A state found to be noncompliant with these priority for services requirements will have six months to appropriately modify its state plan, after which 5 percent of the state's CCDBG funds may be withheld.
- This penalty may be waived for one year if the noncompliance is determined to be the result of extraordinary circumstances.

Implementation Considerations

CCDBG Purposes

While maintaining state flexibility and parental choice, the revised goals of CCDBG emphasize parental involvement, the coordination of high-quality early care and education services, improvements to the overall quality of child care, and improved access to high-quality care for low-income children. Achieving these goals requires a critical assessment of state child care assistance policies, policies that better support access to high-quality care for children of parents who are working or enrolled in school or training programs, and efforts to promote continuity so that children can stay in high-quality settings for longer periods. In achieving all aspects of this vision, states will need to address the challenges posed by the costs of improving and maintaining quality, continuity, and access.

Lead Agency Responsibilities

States have flexibility to select a Lead Agency and states vary in whether the Lead Agency is an education agency, human services agency, or an independent early childhood agency. Coordination across state agencies and high-level leadership can produce stronger, more comprehensive early care and education. However, even when state-level offices of early education or early learning have been created, the administration of the subsidy

system often remains separate from quality improvement initiatives and other early childhood programs. The reauthorization of CCDBG offers an opportunity to think about how subsidies promote access to high-quality child care and to ensure that child care subsidies, regardless of which agency is the Lead Agency, are fully integrated into statewide early learning efforts and/or broader goals of any early childhood offices.

In states with locally administered systems, lead agencies will need to consider new approaches to ensure that the provisions of the updated CCDBG law are fully implemented. For example, changes in eligibility policies will require intensive training of eligibility staff, implementation monitoring, and support at the local level to ensure the new policies are fully carried out in compliance with the law. This will be particularly important in states where counties or other local entities have a major role in administering subsidies, or that subcontract to CCR&R agencies or other regional entities for subsidy administration.

State Plan. The CCDBG state plan period was extended from two to three years. States' FY 2016-2018 state plans became effective June 1, 2016. States were asked to complete state plans based on their "reasonable interpretation of the Act," pending completion of a final regulation, which was not published until September 2016. States were able to outline implementation plans in areas where they were not yet in compliance with new requirements. Compliance with the final regulations will be determined through the next plan cycle

(FY 2019-2021). States may submit amendments to their current plan in the interim.

Coordination. The reauthorization promotes coordination activities at the state level that can strengthen the role of child care subsidies in expanding access to high-quality child care and early education programs. Key subsidy policies addressed in the reauthorization—for example,

12-month eligibility periods—make it easier to align CCDBG with Head Start, including Early Head Start-Child Care Partnerships. States can also use that flexibility to extend access to care for children participating in state prekindergarten programs, offering longer days and full-year opportunities by providing child care assistance to cover the additional hours when parents are at work. While coordination cannot sufficiently address gaps in access to early childhood programs, it can allow for existing programs to better meet the needs of families served.

Eligibility for Child Care Assistance

The reauthorization did not make changes to the eligibility of children for child care assistance. Eligibility criteria in states beyond the criteria identified above have been developed at the states' discretion and are therefore under state control to revise or eliminate. The federal law also does not specify how states should define, collect, or verify any eligibility elements, which gives states wide latitude to design their subsidy programs.³

Ages of Children. Nationally, 27 percent of children receiving CCDBG-funded child care are under three years old; 27 percent are ages three and four; 10 percent are age five; and 35 percent are ages six and older.⁴ As states consider implementation of new policies, including enhanced alignment with other early learning programs, states should maintain their support for school-age children in CCDBG. Many of these families have few other options for safe, affordable after-school care, and for families with multiple children, different rules around access to care for different ages of children can be burdensome. School-age programs and providers not only offer enrichment opportunities for low-income children that can improve their chance of succeeding in school but also ensure their safety and well-being and decrease the potential of risky behavior.⁵

Use of CCDBG Funds

Direct Services. Direct services refer to the provision of child care assistance to eligible families. The reauthorization law's requirement that at least 70 percent of funds be used for direct services reinforces the importance of ensuring that CCDBG funds support access to child care for low-income working families. The regulations specify that 70 percent of the mandatory and matching funds allocated to states must be used for direct services to families who are receiving assistance through TANF, transitioning off TANF, or at risk of becoming dependent on TANF (who may be eligible based on work, training, or education). After accounting for the required quality and administrative expenditures from the discretionary federal funds, 70 percent of funds must go to providing direct services. Any funds remaining must go to provide direct services to low-income families who are working or attending training or education.

Administrative Costs. The reauthorization maintains the existing 5 percent limit on administrative costs within CCDBG. While the law does not define administrative activities, it specifies that such costs do not include the costs of providing direct services. The final rule lists activities that are, and are not, administrative costs. As states calculate administrative costs, the regulations note that the following should be included: salaries and related costs of staff engaged in the administration and implementation of the program; travel costs incurred for official business in carrying out the program; administrative services, including accounting services; audit services; other costs for goods and services required for the administration of the program, including rental or purchase of equipment, utilities, and office supplies; and indirect costs as determined by an indirect cost agreement or cost allocation plan. The following activities should not be considered administrative: eligibility determination and redetermination; preparation and participation in judicial hearings; child care placement;

recruitment, licensing, inspection, reviews, and supervision of child care placements; payment rate setting; resource and referral services; training of child care staff; and establishment and maintenance of computerized child care information systems or a certificate program.

Priority Populations. States must give priority for child care assistance to children of families with very low incomes, children with special needs, and children experiencing homelessness, as defined by states. States have to describe how they will give priority to children from families in areas that have significant concentrations of poverty and unemployment, also defined by states. States may choose to give priority to additional categories of children.

In addition, states must describe in their state plans how they will implement strategies to increase the supply and improve the quality of child care for children in underserved areas, including rural areas; infants and toddlers; children with disabilities; and children who receive care during non-traditional hours.

Waiver Authority

The legislation lays out the criteria under which a state may seek a waiver of one or more requirements in the law. The waiver authority is provided to deal with extraordinary circumstances or an extended period of time needed for state legislative action to implement CCDBG provisions. The circumstances must prevent the state from complying with any statutory or regulatory requirement of CCDBG and the waiver must, by itself, improve the state's ability to carry out CCDBG purposes.

Granted waivers must be consistent with CCDBG objectives and must not compromise the health, safety, and well-being of children served by CCDBG. HHS has 90 days to approve or disapprove a waiver request. Granted waivers will be no longer than two years in cases of extraordinary circumstances, and

no longer than one year for legislative action, with an option to renew for no more than one year for each type of waiver. Thirty-five states requested at least one waiver, and 22 of them had waivers approved and are currently operating with waivers.⁶

Federal Reports on State Waiting Lists and State Noncompliance

Eligibility, Applicants, and Waiting Lists. While the responsibility for utilization and waiting list data collection is assigned to the federal level under the reauthorization law, states too can consider how their policies and data help to illustrate—or disguise—unmet need. States that limit the pool of families eligible for or applying for subsidies by setting restrictive eligibility criteria and/or doing little to advertise the availability of child care assistance may show data that obscure the actual need for assistance. States should keep centralized

waiting lists in order to have that data available for tracking at the state and national levels. Conducting outreach to potentially eligible families, doing initial screening for eligibility, and creating and maintaining an active waiting list help create a more accurate picture of the need for child care subsidies and make the case for increased resources over the long term.

State Noncompliance. The reauthorization increases accountability provisions within CCDBG, including a first-ever provision to withhold 5 percent of a state's funds for noncompliance with the statutory directive to use CCDBG funds for child care services or activities that improve quality, availability, or access to such services, with priority given to services for children with very low family incomes or special needs, as well as for noncompliance with background check provisions.

While coordination cannot sufficiently address gaps in access to early childhood programs, it can allow for existing programs to better meet the needs of families served.

1 Lead agencies may also be a territorial or tribal entity. This guide does not address CCDBG rules for tribes.

2 A qualifying work activity is defined by states and may include looking for employment.

3 For more on simplifying core eligibility criteria, see Gina Adams and Hannah Matthews, *Confronting the Child Care Eligibility Maze: Simplifying and Aligning Child Care with Other Work Supports*, Urban Institute and CLASP, 2013, <http://www.clasp.org/resources-and-publications/publication-1/WSS-CC-Paper.pdf>.

4 U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, "FY 2015 Preliminary Data Table 9 - Average Monthly Percentages of Children In Care By Age Group (FY 2015)," 2017, <https://www.acf.hhs.gov/occ/resource/fy-2015-preliminary-data-table-9>.

5 Afterschool Alliance, *Afterschool Programs: Making a Difference in America's Communities by Improving Academic Achievement, Keeping Kids Safe and Helping Working Families*, http://www.afterschoolalliance.org/Afterschool_Outcomes_2013.pdf; Afterschool Alliance, *Evaluations Backgrounder: A Summary of Formal Evaluations of Afterschool programs' Impact on Academics, Behavior, Safety and Family Life*, 2015, http://afterschoolalliance.org/documents/Evaluation_Backgrounder.pdf.

6 NWLC, *Child Care and Development Fund Plans FY 2016-2018: State Waivers and Corrective Actions*, 2016, <https://nwlc.org/wp-content/uploads/2016/08/CCDF-State-Plans-FY-2016-2018-State-Waivers-and-Corrective-Actions-FINAL.pdf>.

Consumer and Provider Education and Provider Compliance with Health and Safety Standards

The CCDBG Act of 2014 includes important provisions to protect the health and safety of children in child care through more consistent standards and monitoring of standards. Additionally, the law seeks to increase parents' and providers' knowledge of child care quality, child development, and public resources. The law also aims to promote parental choice and consumer education in selecting child care and parental involvement in the development and care of children.

In this Chapter:

- Consumer Education
- Enforcement of Licensing and Other Regulatory Requirements
- Establishment and Enforcement of Health and Safety Requirements
- Criminal Background Checks

CONSUMER EDUCATION

Key Provisions in the Law and Regulations

Consumer Education Website

States must create a consumer education website that, as laid out in the regulations, includes the following seven components:

- Plain-language information on lead agencies' policies and procedures related to child care, including those related to licensing and licensing-exemptions, monitoring, and criminal background checks.
- A list of child care providers searchable by zip code, differentiating between licensed and

license-exempt providers, that indicates if a serious injury or death due to a substantiated health and safety violation occurred at the provider.

- Information about the quality of CCDBG providers as determined by the state through a quality rating and improvement system (QRIS) or other transparent system of quality indicators, if such information is available.
- At least three years (if available) of provider-specific monitoring results (in plain language or including a plain-language summary or interpretation) that include reports of major substantiated complaints about the failure to comply with health and safety requirements, for all licensed and CCDBG-eligible providers, excluding relative providers.
- The aggregated number of deaths, serious injuries, and instances of substantiated abuse occurring in child care annually, by provider setting and licensing status.
- Referral information to local child care resource and referral (CCR&R) agencies.
- Information about how a parent can contact the state agency, a designee, or another program that can help parents understand information on the consumer education website if needed.

The website must provide the widest possible access to individuals with limited English proficiency and persons with disabilities.

Information on Child Care Assistance, Other Benefits and Programs, and Child Development

States must make available information on the following topics:

- The availability of child care services and child care assistance, through CCDBG and other programs; this information should be provided through the consumer education website and resource and referral agencies.
- Other assistance that may be available for CCDBG-eligible families, including Head Start and Early Head Start, the Supplemental Nutrition Assistance Program (SNAP), the Low-Income Home Energy Assistance Program (LIHEAP), Temporary Assistance for Needy Families (TANF), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid and the Children's Health Insurance Program (CHIP), Preschool Grants (Part B, Section 619) and Grants for Infants and Families (Part C) under the Individuals with Disabilities Education Act (IDEA), and the Child and Adult Care Food Program (CACFP).
- Research and best practices concerning children's development, meaningful parent and family engagement, and physical health and development (particularly healthy eating and physical activity).
- State policies regarding the social-emotional behavioral health of children (which may include positive behavioral intervention and support models).
- State policies to prevent suspension, expulsion, and denial of services to young children in child care and other childhood programs receiving CCDBG funds.
- Access to developmental screenings and referrals to services, including coordinated use of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) through Medicaid and developmental screening under IDEA Section 619 and Part C; the information should be provided to parents as part of the CCDBG intake process and to providers through training and education.

In addition, states must establish a hotline for parental complaints of possible health and safety violations. This hotline must provide the widest possible access to people with limited English proficiency and people with disabilities.

Consumer Statement

The final rule requires states to provide parents receiving CCDBG-funded child care with a consumer statement that includes the following information:

- Provider-specific information, including health and safety requirements, licensing or regulatory requirements, or quality standards met by the provider; the provider's most recent date of inspection; and any history of violations.
- Information on the state's background check requirements and whether the provider is subject to the checks.
- Information on the state's hotline for parental complaints.
- Information on how the state promotes CCDBG's "equal access" provisions (described in detail in the section on Provider Payment Rates, Policies, and Practices).

The consumer statement may be available as a hard copy or electronically, or can be provided as a referral to the consumer education website to retrieve the provider's profile. The statement should be accessible by individuals with limited English proficiency and individuals with disabilities.

National Toll-Free Hotline and Website

The Secretary of the U.S. Department of Health and Human Services (HHS) must operate a national toll-free hotline and website for consumer education.

- The national website must be hosted by childcare.gov, must be available 24 hours a day, and must offer the widest possible access to services for families who speak languages other than English.

- The national website should provide or link to information on CCDBG-eligible child care providers and provider-specific information on quality indicators and compliance with licensing and health and safety requirements.
- The national website must include referrals to local CCR&R agencies and state information about child care subsidy programs and other financial support for families.
- The final rule requires states to link the information on state consumer education websites, including a list of licensed and license-exempt providers, information about the quality of providers, and monitoring and inspection reports, to the national website.
- The toll-free hotline must allow parents to be able to anonymously report CCDBG providers suspected of child abuse or neglect, or violations of health and safety requirements.

Implementation Considerations

Consumer Education

The reauthorization law and regulations strengthen CCDBG consumer education requirements. The rule puts an emphasis on the provision of consumer education through the consumer education website. States must ensure that consumer education is accessible to everyone, including individuals with limited English proficiency and individuals with disabilities. To achieve this goal, states should consider multiple modalities for providing child care information, including mobile optimized websites, as well as non-electronic means such as partnership with pediatricians' offices and health clinics, radio and television, and local businesses. States should work to identify effective and trusted partners for sharing information with hard-to-reach groups, including language-minority communities and immigrant communities. States may also consider collaboration with resource and referral agencies, labor organizations, schools, and others in direct contact with parents and providers.

Linking Families to Available Programs and Services

Connecting to Other Early Learning Programs. To implement the provision that states provide families applying for or receiving child care assistance with information about other early childhood programs, including Head Start or Early Head Start programs, states can consider strengthening coordination at the local level to identify programs when slots open up. Administering agencies and resource and referral agencies can also refer families with infants and toddlers to child care programs participating in Early Head Start-Child Care Partnerships when spaces are available. Families with eligible preschool-age children could be referred to state-funded prekindergarten in those states that have it. By linking families with other early learning programs, states can provide additional options and allow families to combine programs that operate on a part-day schedule—as is the case with many Head Start and prekindergarten programs—with CCDBG funds to cover the remaining hours of the day while parents work.

Connecting to Other Public Benefits and Programs.

Families receiving child care assistance may be eligible for other public benefits and not receiving them. A study using 2001 data found that only 5 percent of low-income working families obtained a full work support package of Medicaid/CHIP, SNAP, and child care subsidy.¹

States should consider not only informing families about the availability of these programs during the eligibility and intake process for child care assistance but also streamlining parents' access to benefits and services. For example, states have created online portals allowing clients to screen, apply for, and track multiple benefits, including child care assistance.

In addition to those benefit programs specified in the legislation and regulations, states should consider outreach to inform parents and providers about other programs that provide

important support for working families, including the Child Tax Credit, the Earned Income Tax Credit, the Child and Dependent Care Tax Credit, and health coverage through the Affordable Care Act.

Connecting to Developmental Screening. The rule recommends, but does not require, that states align developmental screening policies for CCDBG with those for Head Start and ensure that all children receive a developmental screening within 45 days of enrollment (as is required in Head Start). States should coordinate screening efforts with other agencies and entities, such as those administering early intervention services, Head Start, Medicaid, and IDEA Section 619 and Part C. While most states do not use CCDBG funds to conduct developmental screenings, some have used the CCDBG quality set-aside to build the capacity of providers to conduct developmental screenings.

States should work to identify effective and trusted partners for sharing information with hard-to-reach groups, including language-minority communities and immigrant communities.

Behavioral Health

Guidance from the U.S. Departments of Education and HHS recommends that state efforts in this area focus on “prevention, developing and communicating clear behavioral expectations, and ensuring fairness, equity, and continuous improvement” in early childhood settings.² For example, the guidance encourages states not only to develop and distribute state policies based on best practices, but to track and analyze data on the effect of those policies, include technical assistance and training on the policies in their professional development systems, and integrate them into quality standards. State policies can include training providers on developmentally appropriate behavior interventions and increasing access to

comprehensive services, including health and behavioral health services. States should also use data to inform their practices, paying particular attention to providing intervention services, as well as to data on preschool expulsions by age, race, gender, disability, and home language.

Online Licensing and Monitoring Information

Online sources of licensing and monitoring information available to the public and potential consumers can positively influence parents’ choices in caregivers. States must make a searchable list of all licensed providers available on their consumer education website. States have the option to include license-exempt providers, who in some cases may only be providing care for a short time or for families they know. States should consider what portion of their child care is license exempt and the various providers represented in the category, to determine whether to include license-exempt non-relative providers in the searchable database. If states do include license-exempt providers in the database, they should take precautions to ensure that providers’ privacy is respected, and that providers who do not wish to serve children beyond their friends and families are not presented as a care option for other families.

It is also important that the information that states are providing to parents is accurate, and that providers have mechanisms available to easily and quickly correct any misinformation. The regulations require states to have procedures in place to review and correct erroneous information about providers in a “timely” manner, which is not specifically defined. States should also consider policies to offer all providers opportunities to challenge inspection findings with which they disagree and a process for correcting information if necessary based on an appeals process and review. Some states currently sharing this type of information electronically allow providers to do an initial review of the posting or respond publicly when complaints or violations are posted.³

In addition, the regulations require states to include information about the quality of individual providers, if information is available, on the consumer education website, and are strongly encouraged to use QRIS ratings or another transparent system of clear, research-based quality indicators for this purpose. In meeting this requirement, states with QRIS may want to consider the number of providers in their state participating in their QRIS systems, and whether it is a reasonable representation of the full range of quality programs available to families. States are not required to include information about providers for whom it is not available, but if QRIS data do not provide a sufficient picture of families' options, states should strive to identify indicators easily or already collected in other ways (e.g. through licensing or professional development registries) that they can use to give families the most information possible in choosing care for their children.

States may consider requiring all child care providers to report incidents of serious child injuries or death to improve tracking capabilities. The final rule strongly encourages states to coordinate efforts with their state's child care licensing agency, state Child Death Review program, and the National Center for the Review and Prevention of Child Death.⁴

ENFORCEMENT OF LICENSING AND OTHER REGULATORY REQUIREMENTS

Key Provisions in the Law and Regulations Inspections of Providers

- The Act required that by November 19, 2016, states must put policies and practices in place to regulate and monitor all providers offering services under CCDBG, including license-exempt providers. The final rule clarified that states can develop alternative means of monitoring care taking place in a child's home, and that relative caregivers are exempt from this requirement.
- Inspections for licensed, regulated, registered, and license-exempt care may be conducted by licensing inspectors or qualified inspectors as designated by the state.⁵
- The final rule requires states to make efforts to coordinate across different programs and agencies that do on-site monitoring of child care providers, including QRIS, Head Start, and CACFP, to prevent duplication of services and ease the burden on both the state and the provider.
- The final rule allows—and encourages—states to use differential monitoring strategies, as long as the monitoring is representative of the required health and safety standards and all CCDBG providers receive an annual inspection.

Licensed Child Care

- States must certify that they have licensing requirements and describe in their state plans how those requirements are enforced.
- The law requires licensed CCDBG providers to receive a pre-licensing inspection. The final rule clarifies that licensed providers already caring for children under CCDBG can meet this requirement through their regular annual inspection.
- Licensed providers providing care to children under CCDBG must be subject to at least one annual, unannounced inspection for compliance with all child care licensing standards, including health, safety, and fire standards.
- Licensing inspectors must be qualified and receive training in related health and safety requirements and all aspects of the state's licensure requirements.
- States must ensure a sufficient ratio of licensing inspectors or qualified inspectors to child care providers to maintain annual inspections.

License-Exempt Child Care

- License-exempt providers caring for children under CCDBG (except for those related to all children in their care) must be subject to an annual inspection—which does not need to be

unannounced—for compliance with health, safety, and fire standards at a time to be determined by the state.

- State plans must include an explanation of how care provided by license-exempt providers does not endanger the health, safety, or development of children.

Implementation Considerations

Every state currently has child care licensing requirements and mechanisms for enforcement. All states also determine which providers are required to be licensed or regulated and which providers may be legally exempt from licensing. Regular monitoring of child care settings is an important element of protecting children's health and safety in child care, and incorporating unannounced inspections can increase the likelihood that key health and safety regulations are implemented correctly and consistently. When information from monitoring visits is coupled with technical assistance, providers can get help complying with standards.⁶

The reauthorization requirement for annual inspections is limited to providers receiving CCDBG funds. However, the preamble to the final rule encourages states to conduct annual inspections on all licensed providers regardless of whether they are receiving CCDBG funds. States without annual inspections of all licensed child care centers and family child care homes risk creating a bifurcated system in which children receiving CCDBG assistance have access to only some licensed child care providers because the rest have not been inspected. States may consider various approaches to monitoring, such as reducing the frequency of full compliance reviews for licensed providers and instead adopting abbreviated monitoring systems based on valid methodologies, as allowed under the differential monitoring provision of the final rule.

Pre-Licensing and Annual Inspections of Licensed Providers

All state lead agencies currently have licensing

standards that must be met by licensed providers, and licensors on staff to ensure providers are meeting those requirements. However, many states are not yet meeting the requirements of the reauthorization law because they do not require regular inspections of all types of providers, do not require monitoring visits to be unannounced, and/or do not require these visits to be conducted annually. Even fewer states meet the National Association for Regulatory Administration's (NARA's) recommendation for no fewer than two inspections, including one unannounced visit, per year for every licensed child care provider.

For monitoring to be effectively conducted, licensing staff need reasonable caseload sizes that allow them to monitor on a regular basis and promptly investigate complaints against providers.

Prior to the reauthorization law, 50 states conducted a pre-licensure inspection of child care centers and most states conducted a pre-licensure inspection of family child care homes. In the majority of states, pre-licensure visits were announced.⁷ Forty-seven states conducted *annual* or more frequent monitoring visits of licensed centers prior to the law, and 23 states conducted annual or more frequent monitoring visits for licensed family child care providers; some states did not require that these visits be unannounced.⁸

The reauthorization law requires that states have a sufficient number of licensing inspectors to fulfill the inspection requirement. Prior to the law, many states' caseload sizes for licensing staff did not meet this provision. The average caseload size across the country was 103 centers and homes for every one licensing line staff, with caseloads as high as 231 facilities in Vermont.⁹ While the CCDBG law

does not specify a standard caseload size, NARA recommends an average inspector caseload of a maximum of 50 to 60 facilities. For monitoring to be effectively conducted, licensing staff need reasonable caseload sizes that allow them to monitor on a regular basis and promptly investigate complaints against providers.

While the provisions of the law will move states toward best practice in licensing and monitoring, they will require significant additional resources. In order to visit more providers more frequently, states have turned to various monitoring methods that may be more cost effective, such as differential monitoring.

Annual Inspections of License-Exempt Providers

On-site monitoring is an important part of ensuring safe child care settings, and if done well, can bring valuable technical assistance and support to help providers—including license-exempt providers, or family friend and neighbor (FFN) providers—better promote children's health and safety and increase the quality of care. However, monitoring license-exempt providers can present a number of challenges different from those involved with monitoring licensed providers—and few states have experience with monitoring license-exempt providers receiving CCDBG funds.¹⁰

The law allows flexibility for states to determine the most appropriate methods for inspecting license-exempt care, and it explicitly allows states to exclude relative caregivers from the inspection requirements. For license-exempt caregivers that are subject to the requirements, inspections do not have to be unannounced. By opting for announced visits for license-exempt providers, states can help providers who are unfamiliar with an inspection visit become accustomed to the new requirement. Announced visits also accommodate the needs of the many license-exempt caregivers that do not have regular program hours or that provide care on the weekends or during evening hours. States will need to consider the implications of having inspectors visit providers when children are

present, or not, during non-traditional hours, and design policies that are both effective and responsive to the needs of those providers and children. For license-exempt providers, states should consider identifying different or non-traditional inspectors (for example, those that are trusted by the communities in which they work) and designing an on-site inspection that meets legal requirements and helps providers comply with requirements.

States should also think about how to use annual inspections as a technical assistance opportunity, rather than solely a compliance review. Inspectors can visit providers equipped with resources that they may need, such as fire extinguishers, child safety plugs, smoke detectors, first aid kits, and other supplies to help providers meet standards, as well as educational materials for children and providers. If providers are not compliant with health, safety, and fire standards, states should allow providers at least some time to come into compliance, unless there is an immediate threat to children's well-being. If inspectors are used to provide technical assistance, states will need to provide specialized training to broaden the inspectors' expertise. In conducting inspections, states may be able to leverage other resources and programs already in contact with license-exempt providers.

A small number of states and communities have used home visiting as a strategy to bring resources and support to license-exempt caregivers. Because many home-visiting models address health and safety and optimal child development practices, states can consider coordinating with state home-visiting programs and qualifying home visitors to meet the CCDBG inspection requirement. Here, too, states would need to think through the full range of implications and ensure compliance with the statute.

While the law establishes new requirements for license-exempt providers that may prove challenging for states, it is essential that

license-exempt providers remain an option for families receiving child care subsidies. License-exempt care is often the preferred option because the family feels comfortable with a friend or family caregiver, or because the caregiver understands the family's language or culture. In many cases, license-exempt care is the family's only option because the parent works night, early morning, or weekend hours and no licensed providers are available during those times or because the parent has variable, unpredictable hours and licensed providers are unable to manage a constantly changing work schedule. It also may be the only option in some communities, particularly in rural areas. In such cases, license-exempt care is the best choice for meeting the law's dual goals of supporting both children's access to high-quality care and parents' employment.

As states collect and report on data from monitoring visits, they should identify areas of recurring non-compliance in order to focus training and technical assistance efforts for child care and licensing staff. In this way, states can use increased on-site monitoring as a tool for continuous quality improvement, not just an enforcement mechanism.

Alternative Methods for Monitoring In-Home Care

A very small share of CCDBG-funded care is provided in the child's own home. However, the few families that use care in the child's own home may do so because of circumstances that severely limit their access to other options—circumstances such as a child's serious disability or a parent's work schedule that requires overnight care. Therefore, it is very important that states not further restrict access to care provided in the child's home. The final rule clarifies that care in children's homes must meet the monitoring requirements under the law, but that states can develop alternative methods for monitoring care taking place in the child's home. The HHS Administration for Children and Families (ACF) encourages states using alternative methods to emphasize training and technical assistance on

the safety of families' home environments. States are also encouraged to consider appropriate entities for monitoring, such as resource and referral or other community organizations.

ESTABLISHMENT AND ENFORCEMENT OF HEALTH AND SAFETY REQUIREMENTS

Key Provisions in the Law and Regulations Ratios and Group Size

- States must determine standards for CCDBG providers that address: group size limits for different ages; appropriate child-to-provider ratios, in terms of age of children; and required qualifications for providers.

Health and Safety Training

- The CCDBG law required states to certify that they have established health and safety requirements applicable to CCDBG child care providers in 10 substantive areas: prevention and control of infectious diseases (including immunizations); prevention of sudden infant death syndrome and use of safe sleeping practices; administration of medication; prevention of and response to emergencies due to food and allergic reactions; building and physical premises safety; prevention of shaken baby syndrome and abusive head trauma; emergency preparedness and emergency response planning; the handling and storage of hazardous materials and the appropriate disposal of biocontaminants; appropriate precautions in transporting children (if applicable); and first aid and CPR. The final rule added the recognition and reporting of child abuse and neglect to that list of health and safety topics.
- States must ensure that providers receiving CCDBG funds complete minimum pre-service or orientation health and safety training as well as ongoing training. The final rule requires that pre-service or orientation training must be completed within three months of caring for children and that providers must be supervised until specific trainings are complete.¹¹

- Training must be appropriate to the provider setting, age of children served, and address the 11 health and safety topics identified in the law and the final rule. The final rule also requires that the training cover child development.
- States are encouraged to include training requirements related to nutrition, physical activity, caring for children with special needs, or other areas determined to promote child development or protect children's health and safety.

Compliance with Health, Safety, and Child Abuse Reporting Requirements

- States must certify that they have procedures to ensure that providers receiving CCDBG funds comply with all state or local health and safety requirements.
- States must certify that all child care providers comply with the state's child abuse reporting requirements as required by the federal Child Abuse Prevention and Treatment Act (CAPTA).

Disaster Planning

- The state plan must include a Statewide Child Care Disaster Plan to ensure children are safe before, during, and after a major emergency.
- The Disaster Plan should outline coordination of activities among the state Lead Agency, the licensing agency, local resource and referral organizations, the state resource and referral system, and the State Early Childhood Advisory Council. It must provide for the continuation of subsidies and services, and must cover at least providers who receive funding under CCDBG, and other providers as determined by the state.
- The final rule clarifies that Statewide Disaster Plans should address and ensure providers have provisions in place for, "evacuation, relocation, shelter-in-place, and lock-down procedures; procedures for staff and volunteer emergency preparedness training and practice drills; procedures for communication and reunification with families; continuity of

operations; and accommodation of infants and toddlers, children with disabilities, and children with chronic medical conditions."

- The rule specifically addresses the need for procedures and health and safety standards that address instances where parents or legal guardians cannot be reached.
- The rule requires that the Disaster Plan address the need to have adequate supplies available to accommodate very young children or those with disabilities or medical conditions.

Implementation Considerations

Ratios and Group Size

Having sufficient staff available to provide the supervision and individualized care that children need is a critical component of high-quality child care. When one caregiver is responsible for only a small number of children, the caregiver is better able to offer one-on-one attention to each child and have more interactions that encourage language and healthy social-emotional development. Research shows that both child development and caregiving quality improve when provider-to-child ratios, as well as group sizes (i.e., the number of children assigned to a caregiver or team of caregivers in a classroom, or well-defined space within a larger room), are better.¹²

While states are not required to set requirements for provider-to-child ratios or group sizes at any particular level, in setting or adjusting their requirements, the final regulations urge states to consider the research-based recommendations of *Caring for Our Children Basics*, which are a set of minimum, baseline standards for health and safety. *Caring for Our Children Basics* is based on *Caring for Our Children: National Health and Safety Performance Standards (Caring for our Children)*, a joint effort by the American Academy of Pediatrics (AAP), the American Public Health Association (APHA), and the National Resource Center for Health and Safety in Child Care and Early Education.¹³ *Caring for Our Children Basics*

recommends that ratios and group sizes be established based on the ages and needs of children and offers recommended ratios and group sizes for centers and family child care homes.¹⁴ As *Caring for Our Children Basics* are minimal standards, states may also consult *Caring for Our Children's* recommendations, which set higher standards, as well as Head Start and Early Head Start standards for guidance.

Prior to the CCDBG reauthorization, 11 states did not regulate group size for any age groups of children and an additional 10 states did not regulate group size for at least one age group.¹⁵ Seventeen states did not regulate group size for at least one age group of children under five years old.¹⁶ As states adopt new group size requirements or improve existing requirements, they will need to plan for the changes and offer support and assistance to providers to help them come into compliance with these requirements—for example, by making space modifications or hiring additional staff.

Health and Safety Training

The establishment of minimum health and safety training requirements is an important step forward for improving children's safety in care. Pre-service or orientation training and ongoing training will allow providers to be better prepared to care for children. States should have a plan in place for approving training content and the expertise of training providers to ensure the accountability and quality of training. In order to take advantage of existing resources and avoid duplication, states should coordinate any new training with existing training opportunities available through CCR&Rs, community colleges, and other entities.

The CCDBG law allows the pre-service training requirement to be met during an orientation period, which ACF has defined as three months. The rule requires that providers caring for children must be supervised during the orientation period until certain fundamental trainings critical to children's health and safety—pediatric first aid and CPR, safe

sleep, prevention of communicable disease, poison prevention, and shaken baby syndrome/abuse head trauma—are complete. Since such supervision is typically unavailable to license-exempt and family child care providers, and therefore they cannot take advantage of this additional time, states should consider how they can facilitate these providers' access to the required health and safety training.

To expand providers' access to training opportunities, states should help providers overcome the barriers they face, including cost, limited English proficiency, and inability to take time off of work to attend classes. Increasing the education levels of the provider workforce also requires addressing the needs of non-traditional students who must juggle work and family responsibilities. Training should be accessible for providers through many avenues—including online and community based—and the training should articulate to credentials and degrees. To the extent practicable, trainings should be offered in multiple languages.

Compliance with Health and Safety Requirements

The reauthorization law specifies health and safety requirements for CCDBG-funded providers. While these requirements apply to all CCDBG providers, states have the option of exempting individuals caring only for related children from some or all CCDBG health and safety requirements. States that choose to exempt relative caregivers must provide a description of any exemptions to health and safety requirements and explain the exemption to the parent via the consumer education statement. Prior to reauthorization, as of 2012, 19 states reported requiring relative CCDBG providers to comply with all health and safety requirements, while 26 states required compliance with a subset of health and safety requirements.¹⁷

Disaster Preparedness

Maintaining the safety of children in the event of a

disaster or emergency is of critical importance. Following a large disaster or emergency, the need for emergency child care services or the rebuilding of child care facilities in a community can be an important priority. ACF's Office of Child Care (OCC) has offered guidance to states in emergency preparedness and response (see additional resources at the end of this chapter).

CRIMINAL BACKGROUND CHECKS

Key Provisions in the Law and Regulations Background Check Requirements

- States must require a comprehensive set of criminal background checks for all child care staff of licensed, regulated, and registered child care providers—regardless of whether they are receiving CCDBG funds—and all eligible CCDBG providers unless they are related to all children in their care.
- Persons subject to background checks include any individual employed by a child care provider for compensation, including contract employees, or whose activities involve the care or supervision of children for a child care provider or unsupervised access to children who are cared for or supervised by a child care provider.
- The final consolidated list of required checks, based on the law and final rule, are: a Federal Bureau of Investigation (FBI) fingerprint check using Next Generation Identification; a search of the National Crime Information Center's (NCIC's) national Sex Offender Registry; and a search of the state criminal registry or repository, state sex offender registry or repository, and state-based child abuse and neglect registry and database in the staff person's current state of residence and any state where he or she has resided within the past five years.
- All individuals subject to checks must undergo this comprehensive criminal background check at least every five years.
- Prospective staff who have undergone the check while previously employed with another provider within the past five years do not need a new check to start working with a new provider.¹⁸
- Providers awaiting background check results may care for children on a provisional basis, provided that the staff person is under supervision, and that either the FBI fingerprint check or the search of the state criminal repository in the state where the staff member resides has been completed.
- Any provider who employs a staff member for whom the checks described above reveal a disqualifying conviction (or who refuses to consent to the criminal background check or knowingly makes a materially false statement in connection with such criminal background check) will be barred from receiving CCDBG assistance. Disqualifying convictions include specific felonies, as well as violent misdemeanors involving children.¹⁹
- For staff members employed prior to the enactment of the reauthorization law, providers must request background checks by September 30, 2017.
- States must meet all background check requirements by September 30, 2017. A one-year extension may be granted if the state demonstrates a good faith effort to comply with the requirements. HHS is authorized to withhold 5 percent of CCDBG funds from states for non-compliance with background check requirements.

Required Protections for Providers

- A state must complete a background check within 45 days of the request for the check.
- States must have policies and procedures in place for individuals to appeal the findings of the criminal background checks. If a finding is appealed, states must attempt to verify the finding. The appeals process should be timely, with states acting on appeals within 30 days.
- States completing background checks may disclose to the provider only whether the staff member (or potential staff member) is eligible for

employment, without revealing any disqualifying crime. If the staff member is ineligible, however, the state must provide that individual with a notice identifying the specific disqualifying crime(s), as well as information at the same time about the process to appeal the determination. Only convictions may be considered disqualifying, not arrests.

- States are permitted to charge providers a fee for costs associated with processing applications and administering the criminal background check system, but are prohibited from charging more than the actual cost to the state or profiting from background check fees.

Implementation Considerations

The CCDBG Act of 2014 includes important provisions to strengthen criminal background check requirements for child care providers. The provisions apply to all licensed, regulated, or registered child care providers (including child care centers and family child care homes); all providers receiving CCDBG funds, excluding relative caregivers; and adult members of family child care homes. Because the definition of eligible CCDBG provider is broad and inclusive of in-home providers and providers of child care services for compensation, the background check requirement is applicable to all child care providers known to the state, regardless of whether the state has a different term for a provider group, such as “certified” or “listed.” The rule clarifies that parent volunteers with supervised access to children are not intended to be included in the background check requirement. While all states have required at least some background checks, when the reauthorization law was approved no states had in place the full set of checks mandated by the law.

The rule made technical changes to the required components of a comprehensive background check for the purposes of complying with CCDBG law. In the preamble to the final rule, ACF acknowledges overlap, as well as discrepancies, between the multiple federal and state checks. Additionally, ACF explains many challenges in using the NCIC, which

is a law enforcement tool and restricted to use by law enforcement agencies. Due to these challenges, ACF will not require compliance with the requirement to search the National Sex Offender Registry of the NCIC until issuing joint guidance with the FBI on how to conduct such a search. To date, such guidance has not been released.

The preamble also acknowledges additional challenges to cross-state checks, including closed-record states that will not release records to other states and the lack of uniformity in information contained in state child abuse and neglect registries and records. ACF states that it will not “penalize states that have made a good faith effort to request information from other states.” Further, ACF urges caution in handling child abuse and neglect findings as state definitions of substantiated cases differ and some state records include unsubstantiated complaints or instances. The existence of a child abuse or neglect registry finding is not on its own disqualifying event; rather, each finding must be evaluated individually. The rule clarifies that cross-state fingerprint checks are not required as there is currently not an automated mechanism to share fingerprints across many states, and permits the use of name-based searches when conducting searches of other states’ records. However, states should thoroughly investigate any findings yielded by name-based searches to ensure that the results are for the individual being investigated.

The law establishes a set of disqualifying convictions, including specific felonies as well as violent misdemeanors involving children, that apply to individuals serving children receiving CCDBG funds. States are permitted to identify similar disqualifying crimes for child care providers who are not receiving CCDBG funds, as well as additional disqualifying crimes for CCDBG providers. However, the final rule discourages states “from considering additional disqualifying crimes. Casting too wide a net could have adverse effects on the supply of family child care providers and other consequences for individuals returning from incarceration.” States

adding disqualifying crimes are encouraged to establish strong waiver and appeals processes that conform to the recommendations of the U.S. Equal Employment Opportunity Commission (EEOC) on the consideration of criminal records in employment decisions to ensure compliance with the prohibition against employment discrimination in Title VII of the Civil Rights Act of 1964 (see additional resources), which includes individualized consideration of the nature of the conviction, its relationship to the ability to care for children, and the length of time since the conviction, as well as other circumstances and considerations.

States need to design procedures to ensure background checks are completed within 45 days of the request. Obtaining results of background checks quickly is crucial for parents who need child care immediately in order to start a job or an education or training program, as well as for providers waiting to be eligible for payments. States are permitted to allow providers to care for children provisionally, under supervision, while background checks are being completed provided that either the FBI or state criminal records check has been completed using a fingerprint search. This requirement does not allow home-based providers to care for children provisionally without being under the supervision of another individual. States may want to use creative strategies to address such situations—for example, by establishing a pool of supervisors who have completed background checks and who could be available for in-home providers while checks are being completed.

States must also develop an appeals process that can be completed in a reasonable timeframe. Individuals must have an opportunity to challenge the accuracy or completeness of background checks and ensure that erroneous results do not impair their employment prospects. FBI records in particular are often incomplete and do not include the final disposition of an individual's case, yet in many cases this missing information is favorable to

job seekers—making it particularly important that affected individuals have an opportunity to show, for example, that an arrest did not result in conviction or was reduced to a lesser offense.²⁰ The final rule includes important protections for providers, including a requirement that disqualifying results be shared with individuals along with information on the appeals process. If an appeal is filed, states must attempt to verify the accuracy of the information challenged and locate any missing disposition information. In a timely manner, individuals should receive notice of the result of the appeal, including the state's efforts to verify the accuracy of the information (in the case of a negative determination).

States must also offer the individualized review process authorized by the law, during which they can determine whether a prospective employee who has been convicted of a disqualifying drug-related offense can be deemed eligible for employment despite that record. The reauthorization law specifies that this review process must be consistent with Title VII. States should consult the EEOC's guidance in designing their review process.

States are encouraged to establish procedures that prevent child care providers from having to undergo duplicative checks—for example, having to complete the full set of background checks for a second time within less than five years due to a change of employment. Prior to the new CCDBG requirements, Utah minimized such duplication by running fingerprint checks on individual caregivers every five years and renewing background screenings every year, and then issuing a card to travel with the caregiver to present for employment at any child care facility.

Finally, the costs entailed by the new background checks include costs to develop a process for the background checks and to run the checks; infrastructure for gathering information required for the background checks; and resources for

coordinating among different agencies responsible for different background checks. While states are prohibited from charging providers excessive fees beyond the costs of process background checks, those background check costs alone may be prohibitively expensive for family child care providers. States may use CCDBG funds to pay background check fees for providers and household members.

ADDITIONAL RESOURCES

Connecting Families with Benefits and Services and with Information on Child Development

- CLASP and Urban Institute, *Confronting the Child Care Eligibility Maze: Simplifying and Aligning Child Care with Other Work Supports*, <http://www.clasp.org/resources-and-publications/publication-1/WSS-CC-Paper.pdf>.
- U.S. Department of Health and Human Services, *Birth to 5: Watch Me Thrive*, <http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive>.
- CLASP, *First Steps for Early Success: State Strategies to Support Developmental Screening in Early Childhood Settings*, <http://www.clasp.org/resources-and-publications/publication-1/State-Strategies-to-Support-Developmental-Screening-in-Early-Childhood-Settings.pdf>.
- U.S. Departments of Education and Health and Human Services, *Policy Statement on Expulsion and Suspension Policies in Early Childhood Settings*, http://www.acf.hhs.gov/sites/default/files/ecd/expulsion_suspension_final.pdf.

Emergency Preparedness

- ACF Information Memorandum (CCDF-ACF-IM-2011-01), *Framework for Developing Child Care Emergency Preparedness and Response Plans, Attachment A: Emergency Preparedness and Response Resources for Child Care*, <http://www.acf.hhs.gov/programs/occ/resource/information-memorandum-ccdf-acf-im-2011-01>.

Licensing and Inspections

- Child Care Aware of America, *We Can Do Better—2013 Update: Ranking of State Child Care Center Regulations and Oversight*, <http://usa.childcareaware.org/families-programs/background-checks/>.
- National Center on Child Care Quality Improvement and National Association for Regulatory Administration, *Briefs on Trends in Child Care Licensing Regulations and Policies for 2014*, <http://www.naralicensing.org/2014-cc-licensing-study>.
- CLASP, *Charting Progress for Babies in Child Care: Expand Monitoring and Technical Assistance*, http://www.issuelab.org/resource/charting_progress_for_babies_in_child_care_expand_monitoring_and_technical_assistance.
- CLASP, *Extending Home Visiting to Kinship Caregivers, and Family, Friend, and Neighbor Caregivers*, <http://www.clasp.org/resources-and-publications/files/homevisitingkinshipffn.pdf>.
- CLASP, *Home Away From Home: A Toolkit for Planning Home Visiting Partnerships with Family, Friend, and Neighbor Caregivers*, <http://www.clasp.org/resources-and-publications/files/Home-Away-from-Home.pdf>.

Background Checks

- Child Care Aware of America, *Background Checks*, <http://usa.childcareaware.org/families-programs/background-checks/>.
- U.S. Equal Employment Opportunity Commission, *Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions under Title VII of the Civil Rights Act of 1964*, http://www.eeoc.gov/laws/guidance/upload/arrest_conviction.pdf.

- 1 Gregory Mills, Jessica F. Compton, and Olivia Golden, *Assessing the Evidence about Work Support Benefits and Low-Income Families*, Urban Institute, 2011, <http://www.urban.org/research/publication/assessing-evidence-about-work-support-benefits-and-low-income-families>.
- 2 U.S. Department of Health and Human Services and U.S. Department of Education, *Policy Statement on Expulsion and Suspension Policies in Early Childhood Settings*, 2014, <https://www2.ed.gov/policy/gen/guid/school-discipline/policy-statement-ece-expulsions-suspensions.pdf>.
- 3 National Association for Regulatory Administration (2013), *The 50-State Child Care Licensing Study: 2011-2013 Edition*, <http://www.naralicensing.org/child-care-licensing-study>.
- 4 For more information, see The National Center for the Review and Prevention of Child Deaths, http://www.who.int/pmnch/about/members/database/Center_Review_Prevention_Child_Deaths/en.
- 5 The law specifies that inspection requirements apply to licensed, regulated, and registered providers. States differ with respect to which providers are required to be licensed, regulated, or registered, or are exempt from licensing. For purposes of this guide, references to licensed providers include those regulated and registered providers to whom the law applies.
- 6 Stephanie Schmit and Hannah Matthews, *Better for Babies: A Study of State Infant and Toddler Child Care Policies*, CLASP, 2013, <http://www.clasp.org/docs/BetterforBabies2.pdf>.
- 7 National Association for Regulatory Administration, *The 50-State Child Care Licensing Study: 2011-2013 Edition*, 2013, <http://www.naralicensing.org/child-care-licensing-study>.
- 8 National Association for Regulatory Administration, *The 50-State Child Care Licensing Study: 2011-2013 Edition*, 2013, <http://www.naralicensing.org/child-care-licensing-study>.
- 9 U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, National Center on Child Care Quality, *Trends in Child Care Center Licensing Regulations and Policies for 2011, 2013*, http://www.qrisnetwork.org/sites/all/files/resources/Debi%20Mathias/2012-12-01%2007:08/999_1208_Center_Licensing_Trends_Brief_FINAL.pdf.
- 10 A 2005 survey of states found that six states made home visits to license-exempt providers receiving subsidies. Georgia, Idaho, and New Jersey required caregivers to agree to one home inspection. Louisiana made one unannounced home visit annually. Arizona required two annual visits, and Arkansas required three annual visits. Nevada required home visits for non-relative caregivers, during which it provided health and safety kits. Toni Porter and Shannon M. Kearns, *Supporting Family, Friend and Neighbor Caregivers: Findings From a Survey of State Policies*, 2005, <http://www.researchconnections.org/childcare/resources/4790/pdf>.
- 11 The rule requires supervision until training related to pediatric first aid and CPR, safe sleep, prevention of communicable disease, poison prevention, and shaken baby syndrome/abuse head trauma are complete.
- 12 See U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Child Health and Human Development, *The NICHD Study of Early Child Care and Youth Development: Findings for Children Up to Age 4 ½ Years*, 2006, https://www.nichd.nih.gov/publications/pubs/documents/seccyd_06.pdf.
- 13 American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care, "Standard 1.1.1.2: Ratios for Large Family Child Care Homes and Centers," *Caring for Our Children, Third Edition*, 2011, <http://cfoc.nrckids.org/StandardView/1.1.1.2>. See also "Standard 1.1.1.1: Ratios for Small Family Child Care Homes," *Caring for Our Children, Third Edition*, 2011, <http://cfoc.nrckids.org/StandardView/1.1.1>.
- 14 Administration for Children and Families, *Caring for our Children Basics*, Department of Health and Human Services, 2015, https://www.acf.hhs.gov/sites/default/files/ecd/caring_for_our_children_basics.pdf.
- 15 U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, National Center on Child Care Quality, *Trends in Child Care Center Licensing Regulations and Policies for 2011, 2013*, http://www.qrisnetwork.org/sites/all/files/resources/Debi%20Mathias/2012-12-01%2007:08/999_1208_Center_Licensing_Trends_Brief_FINAL.pdf.
- 16 Child Care Aware of America, *We Can Do Better: Child Care Aware® of America's Ranking of State Child Care Center Regulations and Oversight*, 2013, <http://usa.childcareaware.org/advocacy-public-policy/resources/reports-and-research/we-can-do-better-2013-update/>.
- 17 CLASP review of 2012-2013 state CCDF plans.
- 18 Staff must have been employed by the prior provider within the previous 180 days.
- 19 The complete list includes: murder, child abuse or neglect, a crime against children, including child pornography; spousal abuse; a crime involving rape or sexual assault; kidnapping; arson; physical assault or battery; a drug-related offense committed within the preceding five years; a violent misdemeanor committed as an adult against a child including child abuse, child endangerment, sexual assault; or a misdemeanor involving child pornography.
- 20 See Madeline Neighly and Maurice Emsellem, National Employment Law Project, *Wanted: Accurate FBI Background Checks for Employment* (9-10), 2013, <http://www.nelp.org/page/-/SCLP/2013/Report-Wanted-Accurate-FBI-Background-Checks-Employment.pdf?nocdn=1>.

Child Care Program Standards and Quality Improvement Activities

To support the goals of improving the quality of care and increasing the number and percentage of low-income children in high-quality child care settings, the CCDBG Act of 2014 increases the amount of funds states are required to spend on quality improvement activities. The law also drives quality funds toward improving the supply and quality of care for infants and toddlers. High-quality infant-toddler care is among the least available and affordable care for families, despite the critical importance of nurturing care during the earliest years. CCDBG quality dollars are used to support quality improvement for all children, not just low-income children, and in many cases are the foundation of other early learning initiatives, such as quality rating and improvement systems. Finally, the law offers strategies for increasing the quality of care through more robust program standards and training and professional development for providers.

In this Chapter:

- Activities to Improve the Quality of Child Care
- Early Learning and Development Guidelines
- Professional Training Requirements

ACTIVITIES TO IMPROVE THE QUALITY OF CHILD CARE

Key Provisions in the Law and Regulations Quality Set-Aside

- The reauthorization law increases the portion of CCDBG funds that states must reserve to improve child care quality among all providers (not just CCDBG providers) and increase access to high-quality care (the “quality set-aside”), which was 4 percent through FY 2015. States must reserve at least:
 - 7 percent in FY 2016 and FY 2017
 - 8 percent in FY 2018 and FY 2019 and
 - 9 percent in FY 2020 and each year thereafter.
- The regulations clarify that the amount of the quality set-aside—as well as the amount of the infant-toddler set-aside discussed below—is calculated as a percentage of the state’s full CCDBG award, including discretionary, mandatory, and federal and state matching funds (although not non-federal maintenance-of-effort funds). The regulations also codify the longstanding policy that targeted funds for quality improvement and other activities included in appropriations law may not count towards meeting the minimum quality set-aside requirement, unless otherwise specified by Congress. In addition, the preamble to the regulations notes that the quality set-aside percentages are minimum requirements; states may devote a larger amount than required to quality.
- States must expend quality set-aside funds on at least one activity specified in the reauthorization law and based on an assessment of need. The list of quality improvement activities allowed under the law is extensive and includes:
 - Supporting training and professional development of the child care workforce
 - Improving upon the development or implementation of the state’s early learning and development guidelines
 - Developing, implementing, or enhancing a tiered quality rating system
 - Improving the supply and quality of infant and toddler care programs

- Establishing or expanding a statewide system of child care resource and referral services
- Facilitating compliance with state requirements for inspection, monitoring, training, health and safety, and licensing
- Evaluating quality and effectiveness of child care programs
- Supporting providers seeking national accreditation
- Supporting efforts to develop high-quality health, mental health, nutrition, physical activity, and physical development program standards
- Carrying out other activities determined by the state to improve the quality of care for which measurement of outcomes related to provider preparedness, child safety, child well-being, or kindergarten entry is possible.
- The regulations explicitly allow the use of quality set-aside funds for financial incentives and compensation improvements for child care providers that obtain additional education credentials.
- The regulations specifically permit quality activities to be carried out by the state through grants and contracts with local child care resources and referral organizations or other appropriate entities.

Infant-Toddler Set-Aside

- In addition to the quality set-aside funds, beginning in FY 2017, 3 percent of CCDBG funds must be reserved for quality improvement activities related to care for all infants and toddlers. Activities to improve the supply and quality of infant-toddler care may include:
 - Establishing or expanding high-quality community- or neighborhood-based family and child development centers and/or neighborhood-based family child care networks to support the provision of high-quality care
 - Training and professional development for infant-toddler caregivers
 - Coaching and technical assistance from statewide networks of qualified infant-toddler specialists

- Coordination with early intervention specialists
- Developing infant-toddler components within the state's quality rating system, licensing regulations, or early learning and development guidelines
- Consumer education on high-quality infant-toddler care
- Other activities that will improve the quality of infant-toddler care.

Reporting Requirements

- Under the law, beginning in FY 2016, states must annually certify compliance with the quality set-aside requirements during the preceding fiscal year. Each state must submit an annual report describing the CCDBG funds reserved for quality improvement activities, the activities carried out, and measures the state will use to evaluate its progress in improving the quality of child care programs and services. The regulations require that each quality activity must be linked to some measurable indicator of progress (although multiple activities may share the same indicator).

Implementation Considerations

Quality Set-Aside

Improving the quality of services available to families receiving CCDBG assistance is a primary goal of the program's reauthorization. The law and regulations present a wide array of policy choices that can help states achieve that objective, and an in-depth discussion of all allowable quality improvement activities is beyond the scope of this guide.

States are required to assess the need for quality improvement activities and, in the preamble to the regulations, are encouraged to do so at least every three years. This is an important opportunity to direct quality dollars strategically to support child care goals. States should assess the full range of program quality improvement needs, from start-up grants and basic materials to access to postsecondary education for providers and specialized programs and supports. States must

carefully balance competing demands on their quality dollars, which, depending on the availability of additional state investments, may be relied on to fund all parts of the early childhood system from licensing to subsidy enhancements and systems-building such as quality rating and improvement systems (QRIS).

Each state should endeavor at the outset to develop a cohesive quality improvement strategy that can guide its policy choices within the framework outlined by the reauthorization law. For example, if a state plans to use some of its quality funds to support training and professional development for child care staff, it should consider how it will encourage individuals to remain in the field once they have completed an educational program—such as by offering financial rewards—so that children in child care have an opportunity to benefit from providers' additional skills and knowledge. If a state plans to use some of its quality funds for a new or enhanced QRIS, it should consider not only the administrative costs of designing a rating system and assessing programs for the purpose of rating them, but also the costs of reaching, engaging, and helping child care programs to improve their quality to achieve higher ratings, as well as the higher payment rates that are necessary to give programs an incentive to improve and maintain a higher level of quality (and to help the programs cover the additional costs entailed in doing so). States' costs of implementing QRIS also include the costs of reaching out to parents through multiple channels with information about what QRIS are, how they work, and how parents can use the systems to find high-quality child care.

Any quality improvement strategy should be designed to address the needs of all children, including children with special needs and children from diverse cultural and linguistic backgrounds. In addition, quality improvement strategies should take into account the comprehensive needs of children and families, including children's physical,

social-emotional, and cognitive development, as well as family engagement opportunities that encourage families' support for their children's learning in child care and at home.

While states are struggling to implement multiple policy requirements under the reauthorization law with limited resources, they should strategize on using these funds to support high-quality care in a comprehensive way. Although states may be tempted to devote all of their quality funds to a single narrow purpose—for example, covering the costs of implementing newly required inspections—such health and safety measures, while critical, are not sufficient to accomplish the goal of substantially raising the quality of care. At the same time, however, states can consider how their approaches to meeting requirements in the law may serve more than one objective. For example, if on-site inspections of license-exempt providers are designed thoughtfully, they may serve as a quality improvement strategy for child care in underserved areas, infant-toddler care, and non-traditional-hour care. Inspections can be an opportunity to offer providers technical assistance, materials, and supplies that help providers not simply meet minimal licensing requirements but enhance their overall quality.

With the increased quality set-aside comes increased accountability in the form of requiring outcome measures and evaluation of quality activities. In determining which outcomes to measure and how to do so, states should consider the range of ways that the research demonstrates quality activities can positively affect children and their families—and states should avoid narrowly focusing on one particular type of outcome measure or one particular dimension of children's development. For vulnerable children, quality supports include those that address physical, mental, emotional, and cognitive development. When measuring the outcomes of their quality improvement strategies, states should ensure that they use a variety of data and approaches

to evaluate the impact and effectiveness of those strategies.

If states use child assessments as a part of their evaluations, they must be appropriate for young children and follow the recommendations and cautions of the National Research Council reports on the use of child assessments.¹ Child assessments should not be the primary or sole method of assessing program activities. As stated in the law, assessment should be used to inform teaching practices and for continuous program improvement—not for high-stakes decisions about funding a particular program or provider, or for providing rewards or sanctions for individual children, teachers, or programs.

Infant-Toddler Set-Aside

With the provision establishing a permanent and expanded infant-toddler quality set-aside of 3 percent of a state's CCDBG funds, the reauthorization law also provides an opportunity for states to focus on specific strategies to improve the quality of care for very young children. The 3 percent set-aside is an increase from approximately 1.4 percent of CCDBG funds, or \$115 million, spent on infant and toddler program quality in 2014.² The importance of the earliest years for children's development³ makes it all the more essential to address the challenges families have in finding affordable, high-quality care for their infants and toddlers—which tends to be more costly than care for older children⁴ and is in short supply in many communities.⁵

As with their plans for using the overall quality set-aside, states should employ a carefully thought-out approach with their infant-toddler quality set-aside. States should take steps to both improve the quality of care for infants and toddlers and ensure parents have access to high-quality care for infants and toddlers, including by expanding the slots available for this age group (which is an allowable use of the set-aside funds). Direct contracts for high-quality infant-toddler care have been an effective strategy in states to increase the

supply of high-quality center- and home-based care for infants.⁶ Rate differentials for infant-toddler providers are also critical as current rates do not adequately cover the incremental costs for the provision of care that meets the needs of vulnerable young children. For example, the average cost of infant-toddler care is almost double the average subsidy payment in CCDBG.⁷ Quality funds may be used for direct services, in particular when they are tied to quality improvement efforts such as contracting directly with providers to build the supply of high-quality infant-toddler care.

In considering how to improve the quality of care for infants and toddlers, states should examine the unique needs of this age group—and the specialized professional development needs of the staff who work with them. In addition to the general professional development considerations discussed below, states can implement strategies tailored to staff serving very young children by, for example, providing access to infant and toddler specialists who can offer support and coaching to child care programs in meeting the developmental needs of very young children. At least 26 states have reported funding networks of infant and toddler specialists in the past.

States can use increased resources directed to infants and toddlers to build on other investments in the youngest children. For example, Early Head Start-Child Care Partnerships—federally funded grants for Early Head Start programs to partner with child care providers to provide full-day, full-year high-quality early care and education services—offer an opportunity to better align child care and Early Head Start. As grantees work to implement the partnerships successfully, states can direct infant-toddler resources in ways that support partnerships and increase the supply of child care providers who are able to meet high-quality standards to participate in partnerships.

Other strategies to consider—which a number of states have already implemented—include developing core competencies specific to

infant and toddler child care staff; offering specific infant-toddler certifications; providing targeted reimbursement and compensation for professional development among infant and toddler teachers; and offering higher payment rates to providers who serve infants and toddlers, in part to allow for increased compensation and better provider-to-child ratios that enable very young children to receive more individualized attention.⁸

Washington State funds a network of 35 infant-toddler specialists. The state's Department of Early Learning (DEL) funds each of its 10 Early Learning Regions to provide infant-toddler interdisciplinary child care consultations to licensed family child care homes and centers, and to coordinate an infant-toddler consultant network within each region. The DEL also hosts regular statewide interdisciplinary infant and toddler consultation networking meetings.⁹

EARLY LEARNING AND DEVELOPMENT GUIDELINES

Key Provisions in the Law and Regulations Elements of Early Learning and Development Guidelines

- The state must develop, maintain, or implement early learning and development guidelines for children from birth to kindergarten entry, describing what children should know and be able to do and covering the essential domains of early childhood development. The guidelines must be:
 - Research-based
 - Developmentally appropriate for children
 - Aligned with entry to kindergarten
 - Implemented in consultation with the state educational agency and the State Advisory Council on Early Childhood Education and Care
- Be designed for use by child care providers statewide and
- Be updated as determined by the state.
- The reauthorization law emphasizes that states retain independence over the content of the guidelines; the federal government is barred from prescribing the guidelines or requiring states to submit them for review.

Assessments

- The law clarifies that the early learning guidelines should not serve as the basis for any assessment that will be the sole basis to determine a provider is ineligible to participate in CCDBG; be used as the primary or sole basis to reward or sanction an individual provider; be used as the primary or sole method for assessing program effectiveness; or be used to deny children eligibility to participate in CCDBG. No CCDBG funds may be used to develop or implement any such high-stakes assessment.
- The law permits states to use a single assessment of children for any of the following purposes:
 - Supporting learning or improving a classroom environment
 - Targeting professional development
 - Determining need for health, mental health, disability, developmental delay, or family support services
 - Obtaining information for the state-level quality improvement process
 - Conducting a program evaluation to provide program improvement and parent information.

Implementation Considerations

The vast majority of states currently have early learning and development guidelines in place, including guidelines for infants and toddlers. However, even if they already have guidelines, states should review them to ensure they align with the state's professional development plan and other quality improvement efforts as designed or revised to comply with the reauthorization law. For example, states should examine how their professional development plan ensures that child

care providers have complete training on effectively using the guidelines to encourage children's learning and development. States should also ensure that the guidelines encourage children's individualized development and learning in a forward progression, with children building their knowledge and skills step by step—rather than, for example, taking a backward-mapping approach that determines where children should be in the infant, toddler, and preschool years based on where they are “expected” to be in kindergarten or a later grade. In addition, states should ensure the guidelines are designed and implemented with recognition of children's diverse linguistic and cultural backgrounds.¹⁰

The preamble to the regulations recommends that states coordinate their early learning and development guidelines with the Head Start Early Learning Outcomes Framework. Head Start's framework is a useful benchmark for states because it is based on extensive research regarding what young children should know and be able to do during their early years and how programs can foster children's development; because it is comprehensive, covering five central domains—approaches to learning, social and emotional development, language and literacy, cognition, and perceptual, motor, and physical development; and because it is designed to meet the needs of all children from birth to age five, including children from diverse linguistic, economic, and cultural backgrounds and children with disabilities. In addition, coordinating state guidelines with the Head Start framework can lay the groundwork for further collaboration between state child care assistance programs, other state early care and education programs, and Head Start. The preamble also encourages states to expand learning and development guidelines for school-age children.

Once states have developed or strengthened early learning and development guidelines, they should take steps to make the guidelines accessible to parents and providers—for example, by posting

them online in an easy-to-understand format, with examples of learning activities to illustrate the different standards and explanations of why specific standards are part of the guidelines. Providers should be encouraged to offer parents information about the guidelines so that they can understand what their children are learning in child care and how they can reinforce it at home.

In developing and applying any child assessments tied to the early learning guidelines, states should carefully follow the recommendations of the National Research Council on appropriate assessments and uses of assessments. When used appropriately—and as one of a variety of evaluation measures—assessment of children can help inform teaching practices and services, support continuous improvement, and strengthen the quality of children's early learning experiences. However, the use of child test scores for evaluations of teacher or program performance or for high-stakes funding decisions are not appropriate uses of child assessments, especially for the earliest years of education.¹¹

When used appropriately—and as one of a variety of evaluation measures—assessment of children can help inform teaching practices and services, support continuous improvement, and strengthen the quality of children's early learning experiences.

PROFESSIONAL DEVELOPMENT AND TRAINING REQUIREMENTS

Key Provisions in the Law and Regulations

In addition to recognizing training and professional development for the child care workforce as an authorized use of CCDBG quality set-aside funds, the reauthorization law and regulations require

states to have training and professional development requirements applicable to caregivers, teachers, and directors receiving CCDBG funds that promote child development and improve the knowledge and skills of the workforce.

Under the law and regulations, this training and professional development must:

- Be conducted on an ongoing basis and provide for a progression of professional development (which may include encouraging postsecondary education).
- Reflect current research and best practices relating to skills necessary for the child care workforce to meet developmental needs of children and to improve the quality of, and stability within, the workforce.
- Improve the diversity of the child care workforce and increase retention of child care providers, teachers, and directors. The rule specifically notes that states can improve retention by including financial incentives and higher compensation in their professional development plans.
- Be developed in consultation with the State Advisory Council on Early Childhood Education and Care (and may also engage providers in aligning training opportunities with the state's training framework). The regulations encourage states, in developing their professional development framework, to also consult with entities that set state teacher standards and certificates, entities that award early childhood education credentials, institutions of higher education, child care providers, and early childhood education professional associations.
- Incorporate the state's early learning and development guidelines (where applicable), health and safety standards, and social-emotional behavior intervention models.
- Be accessible to providers supported through Indian tribes or tribal organizations that receive CCDBG assistance.
- Prepare staff to work with different age groups, English learners, children with developmental delays or disabilities, and Native Americans (to the extent practicable).
- To the extent practicable, be credit bearing or award continuing education credits.

The regulations require each state's training and professional development framework to address six components:

- Professional standards and competencies: The set of knowledge and skills caregivers, teachers, and directors need to be able to provide high-quality child care and school-age care, including the foundational core knowledge as well as specialized competencies and professional development.
- Career pathways: Sequences of qualifications, credentials, and specializations from entry level that can build to more advanced professional competency recognition.
- Advisory structures: A formal effort to communicate and coordinate across multiple agencies offering training and professional development opportunities.
- Articulation: Agreements to ensure that higher education institutions match their courses or coursework requirements with one another, and allow the credit earned for an associate degree to count toward credits for a baccalaureate degree, to prevent students from repeating coursework when changing institutions or advancing toward a higher degree.
- Workforce information: Collection and evaluation of data to identify gaps in professional development accessibility, affordability, and quality.
- Financing: Funding for professional development infrastructure and the costs for individuals to access professional development, including postsecondary education.

In addition, the law requires each state's plan to indicate the number of hours of training required annually for providers (as determined by the state). The law also requires states to develop and implement strategies to strengthen the business practices of child care providers to expand the supply and improve the quality of child care services; the Secretary of the U.S. Department of Health and Human Services (HHS) may provide technical assistance to help states carry out this provision.

Implementation Considerations

Promoting Meaningful Professional Development and Retention of Qualified Providers

Providers are central to the learning experience of children in child care, and quality of care is closely tied to quality of providers.¹² Yet many providers do not receive the preparation they need to offer high-quality care to children—because it is not required by the state and/or because providers are not able to access training and education opportunities—and those providers who do receive advanced education may choose to leave the field for higher-paying jobs. The reauthorization encourages states to develop a coherent strategy to ensure a stable, diverse, qualified child care workforce that has the skills and knowledge necessary to offer high-quality care. In designing their professional development plan, states should consider how to leverage and coordinate existing resources—including child care resource and referral agencies (CCR&Rs), community colleges, and other community and educational institutions—to expand training and education opportunities for providers.

In addition to key components of a comprehensive professional development system for the child care workforce laid out in the law and regulations, there are several additional elements to ensure the effectiveness of that system. To best understand the challenges and needs of the state's early childhood workforce, including challenges related to equity across programs, funding streams, and

communities, states should conduct comprehensive workforce studies and use the findings to inform their professional development systems.¹³

Providers are central to the learning experience of children in child care, and quality of care is closely tied to quality of providers.

Professional development providers and institutions of higher education, also, need to revisit strategies to effectively meet the needs of a diverse workforce, including support for coursework in non-English languages and supports for non-traditional students working full time and balancing their own caregiver roles.¹⁴ For example, states' professional development plans should include strategies—across provider types—for maximizing providers' ability to take advantage of professional development opportunities by making sure that classes are available during weekends and evenings when providers are not working and are offered in convenient locations (and/or online).

The regulations require, to the extent practicable, that professional development opportunities are credit bearing or result in continuing education credits. Research shows both a relationship between staff credentials and quality, as well as a relationship between higher educational attainment and wages.¹⁵ It is therefore important for states to consider how training and professional development link to stackable credentials, degrees, and professional advancement as well as to financial supports for students who need them.¹⁶

States' professional development systems should support providers in developing the skills necessary to work with an increasingly diverse young child population.¹⁷ Providers of all backgrounds should receive meaningful training in cultural competency and in knowledge of dual or second language

acquisition. Professional development opportunities should also address family engagement strategies for working with diverse families and both racial bias and positive discipline practices designed to address the disproportionate suspension and expulsion of Black boys and girls from early education programs.¹⁸ In addition, states should recruit and support a diverse workforce through steps such as offering community-based training in multiple languages and helping individuals who speak languages other than English access licensing and professional development systems.

States' plans should address methods for keeping providers in the field once they have received additional training and education on early childhood education and care. For example, states could adopt the T.E.A.C.H. Early Childhood® Project, which currently operates in 23 states and the District of Columbia,¹⁹ or a similar approach that offers scholarships or other financial supports to child care staff for furthering their education and increased compensation once they complete their coursework if they agree to remain with their child care program for a certain period of time. States can also adopt approaches such as WAGE\$®, which aims to increase the compensation of providers who already have attained credentials.²⁰ The ability to use quality set-aside funds for compensation and financial incentives, as specified in the regulations and discussed above, can be helpful with this approach.

Improving Business Practices

Many child care providers and directors could benefit from training in business practices given the challenges involved in operating a program on a tight budget—and given the fact that many providers' educational background is in early childhood care and education rather than in business management. Training in business practices can be particularly helpful to individuals running independently operated small child care centers or family child care homes that do not have the support of a larger umbrella corporation or organization to handle administrative and financial

responsibilities. The business training should be specifically tailored to the unique needs and circumstances of the child care industry and should reflect the mix of program types. For example, many child care programs are operated by non-profit organizations, which have specific legal and financial requirements and considerations related to that designation. In addition, if business practices are one of the criteria used in a state's QRIS, the training should be aligned with those criteria.

The practice of shared services has recently emerged as a strategy for strengthening child care business practices. Under a shared services model, agencies providing child care share the cost of administrative functions, such as payroll, procurement of food and supplies, human resources, and bookkeeping, to minimize overhead costs and improve efficiency. Shared services arrangements are often administered by an intermediary organization, such as a community-based non-profit or professional association. The CCDBG reauthorization identifies shared services as one strategy for developing public-private partnerships.

Training in this area should promote a broad range of good business practices. For example, the preamble to the regulations cites paid sick leave for child care providers as an example of a good business practice. It is recommended as a strategy for keeping child care programs healthy, by making it feasible for a staff member to take time off from work when sick, rather than coming to work and spreading her illness to the children in care and other staff members. Other positive business practices include paid family leave and reasonable scheduling practices.

ADDITIONAL RESOURCES

Quality Initiatives

- NWLC and CLASP, *A Count for Quality: Child Care Center Directors on Rating and Improvement Systems*, <http://www.nwlc.org/sites/default/files/pdfs/ACountforQualityQRISReport.pdf>.
- National Association for the Education of Young Children (NAEYC), *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8*, <http://www.naeyc.org/files/naeyc/file/positions/PSDAP.pdf>.
- QRIS National Learning Network, Build Initiative, <http://www.buildinitiative.org/>.
- Early Learning Ventures and the David and Laura Merage Foundation, *Shared Services: A New Business Model to Support Scale and Sustainability in Early Care and Education*, http://www.earlychildhoodfinance.org/downloads/2009/SharedServicesELVreport_2009.pdf.

Improving Care for Infants and Toddlers

- CLASP, *Charting Progress for Babies in Child Care: Research, Policy Recommendations and State Examples*, <http://www.clasp.org/babiesinchildcare>.
- CLASP, *Better for Babies: A Study of State Infant and Toddler Child Care Policies*, <http://www.clasp.org/docs/BetterforBabies2.pdf>.
- ZERO TO THREE, *Infants and Toddlers in the Policy Picture*, <https://www.zerotothree.org/resources/359-infants-and-toddlers-in-the-policy-picture-a-self-assessment-toolkit-for-states>.
- ZERO TO THREE, *Supporting Babies Through QRIS: Inclusion of Infant and Toddler Quality Standards*, <https://www.zerotothree.org/resources/190-supporting-babies-through-qr-is-inclusion-of-infant-and-toddler-quality-standards>.

Early Learning and Development Guidelines

- ZERO TO THREE, *Early Learning Guidelines for Infants and Toddlers: Recommendations for States*, https://www.del.wa.gov/sites/default/files/imported/publications/development/docs/ZerotoThree_guidelines.pdf.
- NAEYC and National Association of Early Childhood Specialists in State Departments of Education, *Where We Stand on Early Learning Standards*, <http://www.naeyc.org/files/naeyc/file/positions/earlyLearningStandards.pdf>.

Professional Development

- U.S. Department of Health and Human Services, *Policy Statement on Early Childhood Career Pathways*, https://www.acf.hhs.gov/sites/default/files/ecd/career_pathways_policy_final.pdf.
- Early Educator Central, <https://earlyeducatorcentral.acf.hhs.gov/>.
- Career Pathways Resources, <http://www.clasp.org/issues/postsecondary/wioa-game-plan>.
- T.E.A.C.H. Early Childhood® National Center, <http://teachechnationalcenter.org/>.
- Child Care Services, Child Care WAGES® Project—North Carolina, <http://www.childcareservices.org/wagesapps/index.php>.
- Center for the Study of Child Care Employment, *Using the Early Childhood Workforce Index to Inform State Advocacy, Policy, and Action: Strategies for State Leaders*, <http://cscce.berkeley.edu/strategies-for-state-leaders/>.

- 1 See generally National Research Council, *Early Childhood Assessment: Why, What, and How?*, Committee on Developmental Outcomes and Assessments for Young Children, Board on Children, Youth and Families, Board on Testing and Assessment, Division of Behavioral and Social Sciences and Education, 2008, <https://www.nap.edu/catalog/12446/early-childhood-assessment-why-what-and-how>.
- 2 U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, "FY 2014 CCDF Table 3a - All Expenditures by State - Detailed Summary: State and Federal Expenditures Including MOE," 2016, <https://www.acf.hhs.gov/occ/resource/fy-2014-ccdf-table-3a>.
- 3 Stephanie Schmit and Hannah Matthews, *Better for Babies: A Study of State Infant and Toddler Child Care Policies*, CLASP, 2013, <http://www.clasp.org/docs/BetterforBabies2.pdf>.
- 4 Child Care Aware of America, *Parents and the High Cost of Child Care: 2016*, 2016, <http://usa.childcareaware.org/advocacy-public-policy/resources/costofcare>.
- 5 See, e.g., Child Care Aware of America, *Parents and the High Cost of Child Care: 2016*; National Association of Child Care Resource and Referral Agencies, *Child Care in Thirteen Economically Disadvantaged Communities*, 2006, <http://www.researchconnections.org/childcare/resources/11661>; Helen Raikes, Brian Wilcox, Carla Peterson, et al., *Child Care Quality and Workforce Characteristics in Four Midwestern States*, The Gallup Organization, 2003, http://ccfl.unl.edu/projects_outreach/projects/current/ecp/pdf/final_11-25-03.pdf; Mary Carpenter, Mary Martin and Sue Russell, *Who's Caring for Our Babies Now? Revisiting the 2005 Profile of Early Care and Education for Children Birth to Three in North Carolina*, Child Care Services Association, 2008, http://www.childcareservices.org/_downloads/research/IT_State%20report_08.pdf; California Child Care Resource and Referral Network, 2013 *California Child Care Portfolio*, 2013, http://www.rrnetwork.org/2013_portfolio.
- 6 Hannah Matthews and Rachel Schumacher, *Ensuring Quality Care for Low-Income Babies Contracting Directly with Providers to Expand and Improve Infant and Toddler Care*, CLASP, 2008, <http://www.clasp.org/resources-and-publications/files/0422.pdf>.
- 7 U.S. Department of Health and Human Services, Administration for Children and Families, *Justification of Estimates for Appropriations Committees*, 2015, https://www.acf.hhs.gov/sites/default/files/olab/2016_acf_cj_final_for_print_1_28_upted.pdf.
- 8 Schmit and Matthews, *Better for Babies*.
- 9 Schmit and Matthews, *Better for Babies*.
- 10 Hannah Matthews, *Meeting the Early Learning Challenge: Supporting English Language Learners*, CLASP, 2011, <http://www.clasp.org/resources-and-publications/files/ellsandelc.pdf>.
- 11 National Research Council, *Early Childhood Assessment* (358-59, 425). The National Research Council defines high-stakes assessments as "[t]ests or assessment processes for which the results lead to significant sanctions or rewards for children, their teachers, administrators, schools, programs, or school systems" and urges "even more extreme caution" when using assessments of children from birth to age five for accountability.
- 12 Institute of Medicine and National Research Council, *The Early Childhood Care and Education Workforce*, 2012, http://www.nap.edu/download.php?record_id=13238#.
- 13 Tackling An Early Childhood Workforce Study: Important Considerations, is an example of a guide for conducting a workforce study. http://teachecnationalcenter.org/wp-content/uploads/2014/10/FactSheet_WorkforceStudies.pdf.
- 14 See for example, "Yesterday's Non-Traditional Student is Today's Traditional Student," CLASP, 2015, <http://www.clasp.org/resources-and-publications/publication-1/CPES-Nontraditional-students-pdf.pdf> and Amy Ellen Duke-Benfield, "Bolstering Nontraditional Student Success: A Comprehensive Student Aid System Using Financial Aid, Public Benefits, and Refundable Tax Credits," CLASP, 2015, <http://www.clasp.org/resources-and-publications/bolstering-non-traditional-student-success>.
- 15 U.S. Department of Health and Human Services, *Policy Statement on ECE Career Pathways*, https://www.acf.hhs.gov/sites/default/files/ecd/career_pathways_policy_final.pdf.
- 16 Evelyn Ganzglass, *Scaling "Stackable Credentials"*, CLASP, 2014, <http://www.clasp.org/resources-and-publications/files/2014-03-21-Stackable-Credentials-Paper-FINAL.pdf>.
- 17 Hannah Matthews, "Support a Diverse and Culturally Competent Workforce," *Charting Progress for Babies in Child Care Project*, CLASP, 2008, <http://www.clasp.org/babiesinchildcare/recommendations/nurturing-and-responsive-providers/support-a-diverse-and-culturally-competent-workforce>.
- 18 Cemere James and Hannah Matthews, *Child Care and Development Block Grant and Racial Equity*, 2017, NBCDI, CLASP, https://www.nbcdi.org/sites/default/files/resource-files/NBCDI_CLASP%20Policy%20Brief%20CCDBG%20and%20Racial%20Equity.pdf.
- 19 See generally Child Care Services Association, *T.E.A.C.H. Early Childhood® National Center*, http://www.childcareservices.org/ps/teach_ta_qac/.
- 20 See generally Child Care Services Association, *Child Care WAGE\$ National*, http://www.childcareservices.org/ps/teach_ta_qac/child-care-wage-national/.

Family-Friendly Policies

The CCDBG reauthorization includes important subsidy policy changes designed to reduce burdens for families trying to get and keep child care assistance. By minimizing reporting requirements and complexity that can result in families unduly losing their assistance, these improvements will help families have the stable, continuous child care that parents need to succeed on the job and that children need for their healthy development. These improvements can also facilitate partnerships between child care and other programs such as Early Head Start, Head Start, or prekindergarten that increase low-income families' access to high-quality early learning opportunities. In addition to the benefits for children and families, more streamlined subsidy policies can allow public agencies to operate more efficiently and effectively and better ensure program integrity.

In this Chapter:

- Supply and Quality of Care for Targeted Populations, Parental Choice, and Priority Populations
- Eligibility Determination, Redetermination, and Protection of Working Parents
- Family Copayment Policies

SUPPLY AND QUALITY OF CARE FOR TARGETED POPULATIONS, PARENTAL CHOICE, AND PRIORITY POPULATIONS

Key Provisions in the Law and Regulations Strategies to Improve Supply and Quality of Care for Targeted Populations

- State plans must identify shortages in the supply of high-quality child care providers.
- States must describe in their state plans how they will implement strategies to increase the supply

and improve the quality of child care for infants and toddlers, children in underserved geographic areas, children with disabilities, children who receive care during non-traditional hours, children in poor communities, and children experiencing homelessness.

- States must describe in their state plans how they will coordinate the provision of child care services with other federal, state, and local programs—including programs serving Native American children, infants and toddlers, children with disabilities, children experiencing homelessness, and children in foster care—to expand access to care, continuity of care, and full-day care.
- State strategies may include alternative payment rates to child care providers; direct contracts or grants to community-based organizations; certificates to parents; combining funds; or other means determined by the state.
- States must describe in their plans how they will use investments to increase access to high-quality child care and prioritize those investments for children in areas with significant concentrations of poverty and unemployment and a lack of high-quality child care programs.

Parental Choice

- Parents must have a choice of enrolling their child in child care with a provider who has a grant or direct contract for providing child care services or receiving a child care certificate or voucher to use with a provider of their choice.
- The CCDBG Act clarifies that CCDBG law should not be considered to favor the use of grants or contracts over the use of child care certificates.

Priority Populations

- States must give priority for services to children in low-income families, children with special needs, and children who are experiencing homelessness.
- States must allow for grace periods after an initial eligibility determination for children experiencing homelessness and children in foster care to allow time to comply with immunization and other health and safety requirements. States are also required to coordinate with licensing agencies and other relevant agencies to help families experiencing homelessness and foster children comply with such requirements.
- States must conduct outreach to families experiencing homelessness and provide training and technical assistance to child care providers on identifying and serving children and families experiencing homelessness.

Implementation Considerations

Strategies to Increase the Supply and Quality of Child Care for Targeted Populations

The CCDBG Act and its regulations focus on improving access to high-quality care for those populations for whom access is most challenging. For instance, high-quality child care for infants and toddlers and children with disabilities is in short supply because it requires a highly prepared workforce, better provider-to-child ratios, small group size, special equipment, and additional space. These components involve additional costs that parents may not be able to support without help.

The supply of certain types of care may also be limited due to a lack of a sufficient concentration of children in a particular area to support a program that offers that specialized care, difficulties in finding and keeping qualified staff with specialized skills, or high operational or transportation costs. License-exempt providers can play an important role in filling the unmet need for some particular types of care that are otherwise in short supply, such as care in rural or economically

disadvantaged communities or during non-traditional hours. But these providers may be as isolated as the families whose children they serve and may require support to provide high-quality care.

The final rule encourages states to analyze data from market rate surveys, alternative methodologies, child care resource and referral agencies, and other community needs assessments—such as Head Start needs assessments—as well as look at all categories of care from center-based to family child care in order to appropriately determine supply shortages.

States can address supply shortages by targeting funds to support providers serving infants and toddlers, children with disabilities, children in underserved geographic areas, and children who receive care during non-traditional hours; offering incentives to encourage more providers to serve these populations; and supporting organizations that have experience in offering training and technical assistance to help providers serve these populations.

Direct Contracts. While CCDBG has always required states to offer parents a choice of care through direct contracts, grants, or certificates, most CCDBG-funded care (89 percent) is paid for through certificates or vouchers.¹ If designed well and funded adequately, direct contracts for child care offer opportunities to build capacity or improve the quality of care for targeted populations, including infants and toddlers and children with disabilities. As part of the contract, states can require that child care providers meet higher quality standards beyond basic licensing requirements. Contracts can be used to create or stabilize care in particular communities or for specific populations (such as teen parents or families experiencing homelessness); create child care slots meeting quality standards, above minimum child care licensing standards; expand the availability of comprehensive services through

partnerships with Head Start or Early Head Start, or by providing additional resources to contracted providers to meet the costs of providing comprehensive services; extend the day or year of Head Start, Early Head Start, or state prekindergarten programs; or improve the quality of family child care by awarding contracts through supportive family child care systems and increasing quality standards for participating family child care homes.²

Massachusetts, Illinois, and New York City have all used contracts with family child care networks or systems to serve infants and toddlers in the subsidy system; funds go directly to the network, and the network facilitates payments to individual providers caring for the children. Family child care networks provide administrative, professional development, and quality improvement support to individual family child care providers. Networks vary in size and operate as free-standing agencies or as programs of larger agencies serving children, some of which also serve children with subsidies in center-based child care.³ States can consider using quality funds to support those networks.

Direct contracts have the potential to offer more stable revenue to providers, who are then able to make investments in better-qualified teachers, supplies, materials, and other resources they may not have been able to afford. Contracts guarantee payment for a specific number of children, may guarantee payments over several years, and may be paid prospectively, which provides even more stability for a child care provider. However, it is critical that contracts are sufficiently funded; if states do not provide enough to meet the higher costs of a contract's requirements, it undermines the purpose of the contract.

Tiered Payment Rates. To further incentivize the expansion high-quality child care capacity for particular populations, states may provide tiered payment rates or other financial incentives to those providers offering care for specific populations,

during non-traditional hours, or in underserved geographic areas. As of 2016, 38 states have child care assistance systems that provide higher payment rates to child care providers that meet specific quality requirements. Yet even at the highest quality tiers, most states still do not have rates that reach the federally recommended 75th percentile of the market, limiting options for high-quality care for families with subsidies. As of 2016, more than three-quarters (30) of states offering tiered payment rates did not reach the 75th percentile of the market rate at their highest payment level.⁴

Grants and Other Supports. States may consider start-up grants or equipment grants to centers, family child care homes, and license-exempt caregivers in underserved areas to improve quality. Providers who cannot afford basic materials and equipment have difficulty creating environments that support children's positive development.

Supports for Non-Traditional-Hour Care. Many parents work nonstandard hours (during evenings, nights, or weekends) and/or have irregular, unpredictable schedules. In one study, roughly half of low-wage hourly workers reported working nonstandard schedules.⁵ Yet there is an inadequate supply of licensed care during evenings and weekends, and significant barriers to expanding the supply. For many parents working non-traditional hours, license-exempt care is the option that best meets their needs, and in many cases the only option. Given increased requirements for caregivers in the law, including training and background checks that must be completed prior to caring for children unsupervised, it is essential that states find ways to meet families' needs for non-traditional-hour care and do not reduce options for families. Home-based providers, including those who are licensed and license-exempt, will need support to meet new requirements. States can address these barriers with a range of strategies, which may include higher payment rates for providers during those

hours or direct contracts to support extended-hour care. States can also support family, friend, and neighbor (FFN) caregivers, who are often the providers of care during nonstandard hours. In the past, states such as California and Minnesota have offered targeted funding to organizations working with FFN providers. It is important to provide support that recognizes the wide variety of FFN providers and to design programs that meet their varied circumstances.

The CCDBG Act includes a number of other provisions related to increasing the supply and quality of care, particularly for certain target populations, outlined in the Quality Improvement section of this guide.

Parental Choice

Parental choice has always been a core value of CCDBG. While states make efforts to increase the number of children in high-quality child care, it is important that parental choice be retained. The final rule clarifies that parental choice provisions do not prohibit a state from requiring providers receiving subsidies to meet quality standards, such as particular levels of a quality rating and improvement system (QRIS), or incentivizing parents to select high-quality child care. For example, states have adopted copayment systems that reduce copayments for children in higher-quality care. Yet parents may not be able to take advantage of financial incentives for using high-quality care if such care is not conveniently located in their neighborhoods or near their place of employment or does not accommodate their work schedules. Therefore, even as states encourage the use of high-quality care, they should not preclude families from using those child care options that best meet their needs.

Priority Populations

The reauthorization maintained the requirement for states to prioritize services for children of families with very low income and children with special needs, while adding prioritization for children experiencing homelessness. The former categories

are defined by states and—in accordance with the final rule—the definition for the latter category is consistent with that used for the [McKinney-Vento Homeless Education Assistance Act](#), which also applies to Head Start and Department of Education programs. States may also choose to prioritize additional populations and can decide what strategies to use to prioritize care. In addition to prioritizing enrollment for these populations, states may pay higher rates to support higher-quality care for certain populations, waive copayments for poor families, or use grants and contracts to reserve slots for priority populations.

The reauthorization law and regulations require states to recognize the distinct challenges facing homeless families by permitting children in homeless families to enroll in the child care assistance program prior to having complete documentation, and establishing a grace period to allow families to receive services while they take steps to comply with immunization and other health and safety requirements. States can look to current outreach and training efforts in place through Head Start and schools to identify opportunities for coordination and leveraging existing efforts and collaborate with other community partners, such as shelters and other homeless service providers, to most effectively implement these provisions.⁶

Under CCDBG law, states may choose to expedite enrollment, use presumptive eligibility, or establish grace periods for other populations as the state desires. The state should also establish policies to ensure that payments made during that time are not considered improper payments if eligibility is not approved. The rule includes clarifying language that care provided during the required grace period for children experiencing homelessness should not be considered an improper payment. This type of strategy prevents administrative procedures from hindering access to care, so parents can quickly begin work while their children receive the care they need—and providers are assured of receiving payment.

ELIGIBILITY DETERMINATION, REDETERMINATION, AND PROTECTION OF WORKING PARENTS

Key Provisions in the Law and Regulations

The CCDBG Act of 2014 includes several provisions that simplify eligibility policies to improve access and stability for families.

- Once a child has been determined eligible for child care assistance, states must consider the child eligible for a minimum of 12 months regardless of temporary changes in a parent's work, education or training activities, or family income, as long as income does not exceed 85 percent of state median income (SMI), based on the most recent SMI data.
- The rule defined "temporary changes" to include: 1) any time-limited absence from work; 2) any interruption in work for a seasonal worker; 3) any student holiday or break for student parents; 4) any reduction in work, training, or education hours; and 5) any cessation of work or attendance at a training or education program that does not exceed a minimum of three months.
- States may not terminate child care assistance based on parental job loss or cessation of education and training unless they continue assistance at least at the same level for a period of at least three months to provide time for job search.
- During the 12-month eligibility period, states may only require families to report information that affects their eligibility during the 12-month period and may only act on other changes that benefit the family.
- States must describe how their redetermination procedures and policies do not require working parents, and in particular parents receiving Temporary Assistance for Needy Families (TANF) assistance, to disrupt employment in order to comply.
- States must demonstrate how they take into account irregular fluctuations in parents' earnings when determining and redetermining eligibility.
- At redetermination, states must have policies in place to continue child care assistance at the beginning of the new eligibility period for parents who are working or attending job training or education but whose income exceeds the state's qualifying income eligibility and is below 85 percent of SMI. The rule clarifies that states with initial income eligibility set under 85 percent of SMI must have two-tier income eligibility. States can set the upper tier at 85 percent of SMI, or a lower level.
- The final rule requires states to take into consideration children's development and learning and promote continuity of care when authorizing child care services.
- The final rule allows states to expand the protective services eligibility category to include other vulnerable populations.

Implementation Considerations

To effectively implement the above changes to the eligibility and redetermination processes and make subsidy policies work better for families, states will need to take a number of steps, including: assessing the administrative bottlenecks, duplicative paperwork, and other requirements that may impede families' access to assistance; considering improved processes, technological solutions, and other strategies to address these barriers; and providing guidance and training to ensure consistent implementation of changes throughout the system, including at the local level and among individual caseworkers. These efforts should encompass all stages of the child care subsidy program—including application, eligibility determination, approval for assistance, interim reporting requirements, and redetermination—even if a particular stage is not explicitly addressed in the reauthorization, given that the stages are interrelated.

While these subsidy policy changes are good for children and parents and reduce administrative costs, they do entail additional costs for services,

since the changes enable families to retain child care assistance for longer periods. States will need increased resources to ensure that these changes do not result in more children being placed on waiting lists for assistance or certain groups of children being denied assistance. With additional resources, states will be able to manage their caseloads not by depending on families to lose their assistance after only a few months—which has negative consequences for children's well-being and parents' employment—but by designing their programs in a way that truly works for families.

Annual Eligibility

Prior to this reauthorization, states had the discretion to set their maximum eligibility period for child care assistance (the period during which families can remain eligible without recertifying) and were roughly evenly divided between having six-month and 12-month eligibility periods. Even so, families commonly experienced much shorter periods of assistance, and a modest increase in earnings or a brief period of unemployment could cause a family to lose child care assistance, resulting in a large increase in the family's child care costs. A study of administrative data across 35 states found that families used child care subsidies for relatively short time periods in most states, usually less than a year. In 31 states, the median length of subsidy receipt was between four and eight months. The same study showed that families frequently returned to the subsidy programs after exiting.⁷ A study of child care subsidy receipt in Maryland found that, despite the state policy of allowing up to a 12-month eligibility period, only 35 percent of children were given eligibility periods of more than 48 weeks. In practice, clients were assigned shorter eligibility periods based on short-term training programs, temporary jobs, and other factors subject to caseworker discretion.⁸

Now, under the updated CCDBG law, all children determined eligible for child care assistance must be considered eligible for a *minimum* of 12 months, regardless of temporary changes in parental

employment, participation in education or training, or income, as long as household income remains below 85 percent of SMI. Research suggests that longer authorizations reduce the risk of losing benefits, supporting stable parental employment and continuity of care for the child.⁹ Annual eligibility also provides more stable revenue for child care providers accepting child care subsidies, as they will have more predictable and reliable payments for services.

Annual eligibility has benefits for states and administering agencies as well. State and local agencies do not have to spend resources on frequent redeterminations for families whose circumstances have not changed and can better align their child care assistance programs with other programs in which CCDBG-eligible families commonly participate, including Medicaid and the Supplemental Nutrition Assistance Program (SNAP) as well as Head Start, Early Head Start, and state prekindergarten. States will want to examine existing eligibility policies, as well as how they differ for families with different circumstances, such as those participating in education or training and those qualifying for child care under TANF, to ensure that 12-month eligibility is implemented in accordance with the reauthorization law.¹⁰

The final rule codifies that additional state-imposed eligibility criteria, beyond those included in the federal law, must only apply at the time of initial eligibility determination and at annual redeterminations. If states have minimum work hour requirements, child support enforcement cooperation requirements, or other additional eligibility criteria, families may not lose subsidies during the eligibility period for not meeting those criteria.

The rule also makes clear that in county-administered states, a child must retain eligibility for subsidy even if they move to a different county within the state. In implementing this provision, states will have to determine which county covers

the costs of continued eligibility and how policy differences across counties will be handled.

The rule identifies a few circumstances in which a family's assistance can be terminated, including: the family moves out of state, the child has excessive unexplained absences despite attempts to contact the family, or there is a substantiated fraud or intentional program violation that invalidates prior determinations of eligibility. States also have, under a separate provision, the option to terminate assistance in the case of permanent job loss. If they take that policy option, however, they must provide that parent with three months of child care eligibility for job search (see below).

With additional resources, states will be able to manage their caseloads not by depending on families to lose their assistance after only a few months—which has negative consequences for children's well-being and parents' employment—but by designing their programs in a way that truly works for families.

Actualizing *continuous* 12-month eligibility depends on strong policies as well as caseworker training to understand this policy requirement and how it relates to all families and their employment or education and training circumstances. States will need to assess the actual eligibility periods granted to families under this policy to better understand and address situations in which families do not receive child care subsidies for their full 12-month eligibility period. States should also consider interim reporting requirements (discussed below) and how they may impede goals of continuous eligibility.

Despite the challenges of growing waiting lists and increased costs, enabling those families accessing care to take advantage of continuous 12-month eligibility is important for parents' economic stability and success and children's stable relationships with caregivers. Short-changing the 12-month eligibility provision would significantly undermine the goals of the law to support parents' employment and children's healthy development.

Interim Reporting

In between redeterminations, subsidy agencies commonly require parents to report changes in their circumstances that may affect their eligibility for (or the level of) benefits. The rule requires states to limit reporting requirements to only those changes that would affect their eligibility: 1. If the family's income exceeds 85 percent of SMI; or 2. If the family experiences a non-temporary loss of work, training, or education (for states choosing to end assistance in those circumstances) and information that affects a state's ability to communicate with parents or providers (such as a change of address). If a state chooses to require reporting for non-temporary changes in circumstances during the eligibility period, the state plan must describe how the state will ensure that these reporting requirements will not place a burden on eligible families or lead to terminating assistance prior to the end of the eligibility term (unless the family's income exceeded 85 percent of SMI or the parent had a non-temporary job loss or cessation of education or training). States also must not require in-person visits to report changes and must offer a range of options for notifying agencies of changes (such as phone and email options, and/or offering services during nonstandard business hours.)

Families must be given the option to report changes that are to their benefit; for example, if a family is working additional hours and needs additional hours of care, or if a family experiences a loss of earnings that warrants a reduction in copayment in accordance with the sliding fee scale.

Assistance in the Event of Job Loss

The CCDBG legislation gives states the option of terminating assistance after a parent's permanent job loss or cessation of education or training, once the family has received a minimum of three months of continued assistance at the same level for job search. Employing this option is not a requirement, and the regulations clarify that the default policy is for the state to allow families to retain their eligibility until the next redetermination, despite the job loss. There is also no limit to the number of times a family can receive continued assistance for a job search. Further, the rule codifies that the level of assistance may not be reduced during the period of job loss, as this would undermine the intent of providing stability to the family.

Should the state choose to employ this option of terminating assistance after a minimum of three months of job search, the rule clarifies that the state is not required to apply this policy uniformly but may allow some populations, such as priority populations, to remain eligible for the remainder of the 12-month period, despite a parent's job loss or cessation of education program. This reinforces continuity for children most in need of consistent care settings and for families who may have the most difficulty in the labor force.

The regulations also clarify that if, by the end of the period of continued assistance, the parent is re-engaged in work, education, or training, child care assistance should not be terminated. The state has the option at this time to continue assistance until the next scheduled redetermination point, or consider the family redetermined eligible for an additional minimum 12-month period. The latter would minimize the burden on the families, alleviating stress on the parents and promoting continuity of care for the children.

As states decide whether or how to employ this option, they should think of the dual-generation purpose of CCDBG. The vast majority of low-income families work, even if they experience

periods of disruption in employment.¹¹ During periods of instability—such as job loss—children may be even more dependent on the stability of a trusted child care provider while their household is experiencing upheaval. Parents, too, may need more than three months to secure employment, or potentially decline an offer of employment if their ability to pay for child care is uncertain. According to the U.S. Department of Labor, approximately 41 percent of unemployed persons do not find work within 14 weeks of losing a job, which is slightly more than three months.¹²

Redetermination Process

Periodically proving eligibility is common across benefit programs and can be important to ensure that individuals do not continue to receive benefits for which they are no longer eligible. However, how states implement eligibility redetermination, what they require of parents, and how often, are central to whether eligible clients are able to keep benefits easily. Overly burdensome redetermination requirements and processes not only cause eligible families to lose assistance, but also create significant administrative costs when families cycle off and on the program because of procedural problems (also known as “churn”).

To ease this burden, the law states that compliance with the redetermination process must not force parents to disrupt employment. In the final rule, the U.S. Department of Health and Human Services Administration for Children and Families (ACF) suggests that states evaluate their processes and procedures for redetermination in order to reduce duplicative requirements across programs, as well as provide training and guidance to case workers and other child care staff to ensure that these new policies are implemented correctly. To improve their redetermination process for families, states can take several specific steps that increase accessibility, simplify and streamline the process, and increase coordination between child care and other work support programs:

Increased Accessibility. States can make the redetermination process (as well as the initial eligibility determination process) more accessible and less disruptive for families by offering processes electronically or via telephone, not requiring in-person visits, and/or offering services during nonstandard business hours. States can also create new procedures to inform families and child care providers of upcoming redeterminations ahead of time, and remind them what the family is required to do in order to be redetermined eligible.

Simplification and Streamlining. States can seek first to verify information from existing data sources and only ask parents to produce documentation as a last resort. States should also only ask for documentation that has changed or is strictly needed to determine eligibility, and not re-collect information that was already collected, such as birth certificates and identification cards. Maryland's child care subsidy program, for example, instructs case managers not to request verification from families that is available and current in other systems. In Medicaid, states rely on information available through electronic databases and only ask for information they do not already have access to electronically.¹³ And both Medicaid and SNAP consider elements that do not change, such as date of birth and Social Security numbers, to be "permanent" verifications that do not need to be re-verified. In CCDBG, some states ask parents for the same information every time the family's eligibility is assessed, regardless of whether it is likely to have changed—but a better strategy, which states are increasingly using, is to prepopulate renewal or interim change reporting forms with any information that states already have and ask the family to note where information has changed.

Coordination Across Work Support Programs. Families receiving multiple public benefits—such as child care, SNAP, or Medicaid/CHIP—have the cumulative burden of redetermining eligibility for all programs. Families may undergo multiple, frequent redetermination processes owing to each system's distinct requirements. Systems often

require families to provide the same information to multiple offices or caseworkers, creating unnecessary burden and confusion. Coordinating recertification across benefit programs can help eligible families retain benefits and help states reduce administrative burden and undue burden on parents. Should states choose to employ more coordinated procedures across work support programs, the final rule clarifies that the family should not lose child care assistance before the end of the 12-month eligibility period, even if the redetermination process for another work support program reveals a change in the family's circumstances (unless the family's income increases above 85 percent of SMI or the family experiences a non-temporary loss of work, training, or education program and the state chooses to end assistance).

Income Eligibility

Initial Income Eligibility. Under the reauthorization law, states can continue to set income eligibility limits for CCDBG-funded child care assistance at any level up to 85 percent of SMI. Once children are determined eligible, during the 12-month eligibility period, states are required to allow them to continue receiving assistance even if their income has increased above the state income eligibility limit as long as it remains at or below 85 percent of SMI—unless there is a non-temporary change in the parent's work, education, or training activity. It is essential that states set adequate initial income eligibility limits, so families are able to qualify for the child care assistance they need. As of February 2016, a family with an income above 150 percent of poverty could not qualify for assistance in 17 states, and a family with an income above 200 percent of poverty could not qualify for assistance in a total of 39 states—even though a study by the Economic Policy Institute indicates that a family needs an income equal to at least 200 percent of poverty to meet its basic needs.¹⁴ Even without a separate exit eligibility limit, appropriately set initial income eligibility limits that take into account the cost of basic needs allow room for families' incomes to grow without them immediately losing assistance.

Irregular Fluctuations in Earnings. States must design their eligibility and redetermination policies to consider irregular fluctuations in parents' earnings. Such policies ensure that if families work overtime hours or additional hours at specific times of the year due to the seasonal nature of their work, they will not risk losing their child care assistance nor will they experience an increase in family copayments. States retain flexibility in setting their policies for income calculation and verification; however, language in the final rule provides some examples of how to implement this properly. Many states already employ these approaches—for instance: states may take an average of families' earnings over a longer period of time (i.e. 12 months); request earning statements that are most representative of the family's income; or simply deduct temporary increases in wages from the families' standard income level.¹⁵

Graduated Phase-Out of Assistance. States that have set income eligibility below 85 percent of SMI are required to establish a graduated phase-out of assistance for families as their earnings increase. If at redetermination after 12 months, a child's household income is above the state's initial income eligibility threshold (but below 85 percent of SMI) and the child is otherwise eligible for assistance, the state must continue assistance for a graduated phase-out period. According to the final rule, states will be able to comply with this requirement by establishing an income eligibility threshold at redetermination that is higher than that for initial eligibility (commonly known as tiered-income eligibility). If establishing a tiered income eligibility system, states can set the higher eligibility level as high as 85 percent of SMI (the federal cap), or at a level below 85 percent of SMI that takes into account the typical household budget for a low-income family, and is sufficiently set to accommodate increases in family income. This policy can support families as their income rises so that exceeding the initial eligibility threshold—which may result from even a small increase in income—

does not result in losing benefits, and may help families better avoid the “cliff effect” (a sudden, drastic change in expenses following a loss of benefits). Children who are determined eligible through the graduated phase-out provision should receive a full eligibility period (a minimum of 12 months).

Considering Child Development and Continuity of Care

The regulations require states to consider children's development and learning and continuity of care when authorizing child care. The preamble to the regulations gives examples of how this provision may be implemented, which include designing child care services to include child development services, such as coordination with Head Start or state prekindergarten. States can use this provision as an opportunity to help families connect with resources they need for their children, including nutrition, health, early intervention, and other assistance and services.

FAMILY COPAYMENT POLICIES

Key Provisions in the Law and Regulations

- The reauthorization law maintains existing language on sliding fee scales and the existing definition of sliding fee scales as a system of cost sharing by a family based on the family's income. The law adds language stating that cost sharing must not be a barrier to families' receiving child care assistance.
- The regulations revise the federal benchmark for affordable parent fees from the previous 10 percent to a more sustainable seven percent of family income.
- States are allowed to waive copayments for families living below the poverty level and for children who receive protective services or other priority categories established by the state.
- States can only increase copayments at redeterminations or during graduated phase-out periods for families with incomes above the initial income eligibility level. States

may decrease copayments during the eligibility period if a change warrants.

Implementation Considerations

The language in the law was a clear signal to states that they should not set copayment levels so high that they will discourage families from applying for or continuing to receive child care assistance. This policy may be particularly important to monitor within the context of reauthorization implementation and the costs entailed—costs that states may be tempted to pass on to providers and families, which would exacerbate barriers to access.

With the final rule, states should reexamine their copayment policies to determine whether the cost burden is manageable for families receiving child care assistance. Even at current levels, many states' copayments are far too high. For example, more than half (26) of the states require families with incomes at 150 percent of poverty and receiving child care assistance to pay a higher portion of their income in copayments than the nationwide average amount that families who pay for child care spend on child care (7.2 percent of income),¹⁶ the new federal benchmark for affordability. States should consider lowering their copayments for all families and waiving fees for families with incomes below the poverty level or other priority populations.

ADDITIONAL RESOURCES

Child Care Subsidy Policies and Simplification

- NWLC, *Red Light, Green Light: State Child Care Assistance Policies 2016*, <https://nwlc.org/wp-content/uploads/2016/10/NWLC-State-Child-Care-Assistance-Policies-2016-final.pdf>.
- CLASP and Urban Institute, *Confronting the Child Care Eligibility Maze: Simplifying and Aligning Child Care with Other Work Supports*, <http://www.clasp.org/resources-and-publications/publication-1/WSS-CC-Paper.pdf>.
- Urban Institute, *Designing Subsidy Systems to Meet the Needs of Families*, <http://www.urban.org/research/publication/designing-subsidy-systems-meet-needs-families>.

Special Populations

- CLASP, *Better for Babies: a Study of State Infant and Toddler Child Care Policies*, <http://www.clasp.org/resources-and-publications/files/BetterforBabies2.pdf>.
- CLASP, *Charting Progress for Babies in Child Care: Build Supply of Quality Care*, <http://www.clasp.org/babiesinchildcare/recommendations/their-families-to-have-access-to-quality-options-for-their-care/build-supply-of-quality-care>.
- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, *Policies/Resources for Expanding ECE Services for Homeless Children & Families*, <https://www.acf.hhs.gov/occ/resource/policies-resources-for-expanding-ece-services-for-homeless-children>.
- National Association for the Education of Homeless Children and Youth, <http://naehcy.org/sites/default/files/dl/CCDF%20Homelessness%20Guide%20final%20Oct%202015.pdf>.
- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, *Information Memorandum: Child Welfare and Child Care Partnerships*, "Child Welfare and Child Care Partnerships: Partnering with Families Involved in Child Care Subsidy Programs," <http://www.acf.hhs.gov/programs/occ/resource/im-child-welfare>.
- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, *Information Memorandum: Refugee Resettlement and Child Care Partnerships*, "Refugee Resettlement and Child Care Partnerships: Partnering to Increase Refugee Families' Access to High-Quality Child Care," <http://www.acf.hhs.gov/programs/occ/resource/im-refugee-resettlement>.

Direct Contracts

- CLASP, *Ensuring Quality Care for Low-Income Babies: Contracting Directly with Providers to Expand and Improve Infant and Toddler Care*,

<http://www.clasp.org/resources-and-publications/files/0422.pdf>.

Nonstandard Hours and Low-Wage Work

- NWLC, *Set Up To Fail: When Low-Wage Work Jeopardizes Parents' and Children's Success*, <http://nwlc.org/resources/set-up-to-fail-when-low-wage-work-jeopardizes-parents-and-childrens-success/>.

- CLASP, *Scrambling for Stability: The Challenges of Job Schedule Volatility and Child Care*, <http://www.clasp.org/resources-and-publications/publication-1/2014-03-27-Scrambling-for-Stability-The-Challenges-of-Job-Schedule-Volat-.pdf>.
- NWLC, *Strategies for Supporting Family, Friend, and Neighbor Care Providers*, <http://nwlc.org/resources/strategies-for-supporting-family-friend-and-neighbor-care-providers/>.

- 1 U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, *Child Care and Development Fund Statistics*, "Table 2 - Percent of Children Served by Payment Method," FY 2015 Preliminary Data, <http://www.acf.hhs.gov/occ/resource/fy-2015-preliminary-data-table-2>.
- 2 Hannah Matthews and Rachel Schumacher, *Ensuring Quality Care for Low Income Babies*, CLASP, 2008, <http://www.clasp.org/resources-and-publications/files/0422.pdf>.
- 3 CLASP, "Massachusetts: Family Child Care System Contracts," *Charting Progress for Babies in Child Care Project*, 2011, <http://www.clasp.org/babiesinchildcare/state/massachusetts-family-child-care-system-contracts>.
- 4 Karen Schulman and Helen Blank, *Red Light Green Light: State Child Care Assistance Policies 2016*, NWLC, 2016, <https://nwlc.org/wp-content/uploads/2016/10/NWLC-State-Child-Care-Assistance-Policies-2016-final.pdf>.
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Provider Payment Rates, Policies, and Practices

Recognizing that the success of state child care assistance programs relies on a robust and diverse population of high-quality child care providers, the CCDBG law and regulations encourage an improved financial and business relationship between state lead agencies and individual child care providers in the subsidy system. Specifically, the law and regulations target more regular and reliable assessment of provider payment rates, policies, and practices. In reviewing their child care assistance systems, states should look at their provider payment policies and practices with an eye toward building the supply of high-quality child care, strengthening the fiscal stability of providers in the subsidy system, and maintaining the diversity of child care options for families by ensuring that policies and practices are equitable across provider types.

Key Provisions in the Law and Regulations **Rate Setting**

As under the previous legislation, the reauthorization law requires states to demonstrate that their payment rates for child care providers serving families receiving child care assistance ensure equal access to child care services comparable to those provided to other families. The regulations clarify that, to meet this standard, states must set base payment rates at least at a level sufficient for child care providers to meet health, safety, quality, and staffing requirements included in the law and regulations and take into consideration the cost of providing higher-quality child care services.

The final rule requires states, in their plans, to demonstrate that they are meeting this equal access requirement by providing a summary of data and facts that show:

- How a choice of the full range of providers is made available, the extent to which child care providers participate in the child care assistance program, and any barriers to providers' participation.
- How base payment rates enable providers to meet health, safety, quality, and staffing requirements included in the law and regulations.
- How payment rates for higher-quality care, as determined using a quality rating and improvement system or other system of quality indicators, relate to the estimated cost of care at each level of quality.
- A rationale for the state's decision on whether to allow providers to charge (beyond the required parent copayment) the difference between the state payment rate and the provider's regular private rate, whether state payment rates are sufficient to provide access to child care without the additional fees, and the extent to which providers charge such additional fees, if allowed.
- How and on what factors the state differentiates payment rates.

In addition, the preamble to the final rule maintains the 75th percentile of market rates as a benchmark for assessing whether states' payment rates adequately ensure equal access.

The reauthorization law and regulations specify that, to meet the requirements regarding payment rates, states must develop and conduct a

statistically valid and reliable survey of market rates for child care that reflects variations in the cost of child care services by geographic area, type of provider, and age of child, or use an alternative methodology, such as a cost estimation model. The law requires that the market rate survey or alternative methodology must be developed by the state's Lead Agency in consultation with the State Advisory Council on Early Childhood Education and Care (or similar coordinating body), local program administrators, resource and referral agencies, and other appropriate entities, and the regulations require that organizations representing child care caregivers, teachers, and directors must be consulted as well.

According to the law, each state must:

- Develop and conduct the market rate survey or alternative methodology every three years, within two years of submitting the state plan in which the study is referenced. The regulations specify that the alternative methodology (if used as a replacement, not a supplement, for the market rate survey) must be approved in advance by the Administration for Children and Families (ACF).
- Report on the results of the market rate survey or alternative methodology and make the results widely available (including by posting it on the internet). The regulations require states to release the report within 30 days of completion. In addition to providing the results of the market rate survey or alternative methodology and the estimated cost required to meet the equal access requirements, the report must include the state's response to stakeholder views and comments.
- Describe how it will set provider payment rates across provider types in accordance with the market rate survey or alternative methodology, and taking into consideration the cost of providing higher-quality child care services, without, to the extent practicable, reducing the number of families receiving child care assistance. The regulations specify that state payment rates must be set based on the most recent market rate survey or alternative methodology.

According to the regulations, each state's market rate survey/alternative methodology must track data on:

- Variations in child care costs by geographic location, category of provider, and age of child.
- The extent to which child care providers are participating in the child care assistance program and any barriers to participation, including barriers related to payment rates and practices.
- The frequency with which child care providers charge families more than the required copayment in instances where the provider's fee for private-paying parents exceeds the state payment rate, and the amount providers charge in such cases.

The reauthorization law and regulations also clarify that states are not barred from differentiating payment rates based on a provider's geographic location; a child's age or particular needs (such as the needs of children with disabilities, children served by child protective services, and children experiencing homelessness); whether a provider offers care during non-traditional hours; and a provider's quality level. However, the regulations prohibit states from differentiating payment rates based on a family's eligibility status, such as qualifying based on receipt of Temporary Assistance for Needy Families (TANF).

Payment Practices

Under the law, states must certify that payment practices for providers receiving CCDBG assistance reflect generally accepted payment practices for child care providers in their state or service area that serve children who do not receive CCDBG assistance. The regulations require that states describe in their state plans how their payment practices allow for stable funding for providers and encourage child care providers to serve children receiving CCDBG assistance.

The law also requires that, to the extent practicable, states must implement enrollment and eligibility

policies that support the fixed costs of providing child care services by delinking provider payment rates from an eligible child's occasional absences due to holidays or unforeseen circumstances (such as illness). The regulations indicate that states can meet this requirement by: paying based on a child's enrollment rather than attendance; providing full payment if a child attends at least 85 percent of the authorized time; providing full payment if a child is absent for five or fewer days in a month; or an alternative approach that the state justifies in its plan.

States must also describe how they will provide for timely payment for services. The regulations specify that states can meet this requirement by paying prospectively prior to the delivery of services, or by paying within no more than 21 calendar days of the receipt of a complete invoice for services.

In addition, the regulations require states to take several other steps to align their payment practices for child care providers serving families receiving child care assistance with payment practices for those providers serving families that do not receive assistance. States must, for families receiving CCDBG assistance:

- Pay on a part-time or full-time basis rather than paying for hours of service or smaller increments of time (unless the state provides evidence that the practice of paying on a part- or full-time basis is not generally accepted in the state or service area).
- Pay for reasonable mandatory registration fees that the provider charges to private-paying parents (unless the state provides evidence that such practices are not generally accepted in the state or service area).
- Ensure child care providers receive payment for any services in accordance with a written payment agreement or authorization for services that includes, at a minimum, information regarding provider payment policies, including rates, schedules, any fees charged to providers, and the dispute resolution process.
- Ensure child care providers receive prompt notice of changes to a family's eligibility status that may affect payment, and that the notice is sent to providers no later than the day the state becomes aware that the change will occur.
- Include timely appeal and resolution processes for any payment inaccuracies and disputes.

Implementation Considerations

Rate Setting

These provisions address an issue that is essential to families' access to high-quality child care: payment rates for providers. The reauthorization provides an opportunity for all states to look closely at their rates to determine how they can improve them to increase families' access to high-quality options, one of the primary goals of this legislation. Rates are fundamental in determining whether providers have the resources they need to support high-quality care—resources for salaries sufficient to attract and retain qualified staff, for equipment and materials to create a good learning environment, and for other expenses. Low rates can make it particularly difficult for providers in low-income communities that have limited resources to support high-quality care. Rates also have a major impact on high-quality providers' willingness to serve low-income families and their children, so setting rates at more appropriate levels can increase the capacity and variety of programs available to families.¹ Yet, currently, state rates are far too low. In 2016, only three states set their payment rates at the federally recommended level, the 75th percentile of current market rates, which is the level designed to give families access to 75 percent of the providers in their community.² The remaining states had rates that were below the recommended level—in many cases, substantially below this level. For example, in February 2016, 31 states had payment rates for center care for a four-year-old that were at least 20 percent below the 75th percentile of current market rates.³

It is essential for states to regularly update their rates—the preamble to the regulations recommends that states consider annual rate increases—to keep pace with the rising cost of providing care and remain competitive with rates in the private market.

The reauthorization legislation makes a few specific changes to policies for setting payment rates. Previously, states were required to conduct market rate surveys every two years; the reauthorization only requires a market rate survey once every three years in line with the change in the state plan period from two to three years. However, states should not interpret this change to mean that they only need to increase their payment rates once every three years. It is essential for states to regularly update their rates—the preamble to the regulations recommends that states consider annual rate increases—to keep pace with the rising cost of providing care and remain competitive with rates in the private market.

The legislation permits states to set provider payment rates using a methodology other than a market rate survey. Cost modeling is one alternative approach being used in some states and referenced in the legislation. Rather than surveying the prices charged for child care, cost modeling estimates the cost of providing care at varying levels of quality based on the resources a provider needs to remain financially solvent. States that plan to use an alternative methodology as a replacement for the market rate survey must receive advance approval; in the preamble to the regulations, ACF indicated that it planned to provide non-regulatory guidance regarding the process for proposing an alternative methodology, including criteria and a timeline for approval.

If states choose to adopt a different approach, it is important to proceed cautiously. States using an alternative method should examine how the results produced by this method compare to results from prior market surveys, with adjustments for inflation. By using the previous market rate survey as a benchmark, states can ensure that the alternative method does not result in a reduction in payment rates. The preamble to the regulations indicates that any alternative methodology or market rate survey that results in stagnant or reduced payment rates will result in increased scrutiny by ACF in its review, and that the state will have to explain how this result improves access to higher-quality child care.

Regardless of whether states use a market rate survey or an alternative method, states are required by the regulations to use the data they collect and analyze to set payment rates. States should also make certain that base rates are set at a level that will ensure all providers have the resources and incentives to provide healthy, safe care to all children receiving child care assistance. To ensure adequate base rates, states should determine the cost of every element involved in providing healthy and safe care. These elements include provider-to-child ratios and group sizes that meet state requirements, qualified providers who have completed required training, safe facilities that comply with licensing rules, outdoor play spaces, learning materials such as books and toys, and other components critical to children's health, safety, and development. In determining the base payment rates necessary to support healthy, safe care, states should consider not only the first-order costs entailed in doing so, but the secondary costs as well. For example, states should account for not only the fees that providers must pay for training, but the costs for substitutes to cover for providers while they are attending the training.

In addition to costing out healthy, safe care, states should analyze the findings from their market rate survey on the extent to which providers are participating in the child care assistance program

and the frequency with which child care providers charge families the difference between the provider's private-pay rate and the state rate to assess whether their base rates are too low to incentivize providers to offer care to families receiving child care assistance or leave these families to cover a large portion of the costs. States should then adjust their rates accordingly so that enough providers participate to offer families sufficient child care options and so that the rates cover a provider's entire private-pay rate.

A commitment to regular payment rate increases to reflect regular increases in the costs of providing care is important. Sufficient resources will be needed to ensure that states, as directed by the law, are able to increase rates without compromising the number of children served.

Setting Differential Rates

The reauthorization law specifies that states may differentiate rates based on various characteristics of care. Most states already differentiate payment rates based on certain factors, such as the provider's location, the child's age, or the quality of care—for example, states often have higher rates for care for providers in high-cost areas, younger children, higher-quality care, and/or providers offering care during evenings, overnight, and weekends. These higher rates may reflect higher market prices for a particular type of care, the need to pay higher rates as an incentive to offer care that is in particularly short supply, or the additional costs of providing a certain type of care. For example, rates for infant care are typically higher because care for very young children—who need extensive individualized attention—entails better provider-to-child ratios than care for older children (according to early childhood experts' recommendations and most states' licensing requirements), and as a result is more expensive to provide. Higher rates for higher-quality care are also important to encourage providers to improve their quality and to cover the additional costs involved in doing so—including costs to hire and retain

credentialed teachers, buy new toys, books, and other learning materials, and upgrade facilities.

While differentiating rates can serve important purposes, it is essential first for states to set adequate base rates. If base rates are low, a small differential—or even a large one—will still leave providers without the resources they need to offer a high-quality early learning experience for the children in their care and without an incentive to serve families receiving assistance. For example, while 38 states had higher payment rates for higher-quality providers in 2016, many of them had such inadequate base rates that, in more than three-quarters of these states, even the higher rates were still below the federally recommended level.⁴

Sufficient resources will be needed to ensure that states, as directed by the law, are able to increase rates without compromising the number of children served.

Payment Practices

Under current policy in most states, provider payment practices for subsidized care look very different from generally accepted payment practices for private-paying parents who typically pay their provider a set fee based on their child's enrollment, often a month in advance of when services are provided. In the subsidy system, however, there is often a significant lag between when care is provided and when a provider is paid, and payments are often tied very closely to the exact days, or hours, a child attends child care. As a result, gaps in attendance—which can occur frequently or for an extended period due, for example, to a child's illness—often leave providers with gaps in revenue, making it difficult for them to meet the fixed costs (rent, utilities, salaries) of running a business.

Strictly linking provider payments in the child care assistance program to a child's attendance therefore has negative consequences for providers, who must absorb the income loss associated with absences. And it has negative effects for families receiving child care assistance—especially families with infants (who tend to get sick often as their immune systems develop) or children with chronic illnesses that cause them to have regular absences—as providers may be reluctant to serve them if the providers will not be paid for absent days. Restrictive payment policies may also create a disincentive for child care providers to accept children whose parents have volatile work schedules, as the child's attendance and subsequent payment may be unpredictable. By revising their payment policies, states can incentivize providers to enroll families receiving child care assistance—which, in turn, can improve the stability of child care arrangements for families receiving assistance, benefiting the child's development and the parent's ability to work.

States should take full advantage of the opportunity presented by the reauthorization to explore ways to make their payment practices align more closely with generally accepted payment practices in the private market. The strategies outlined in the regulations as required or recommended for achieving this goal—paying providers based on enrollment (rather than

attendance), paying for absent days, covering registration fees charged to private-paying parents, preparing providers for changes to subsidy payments, and making timely payments—all benefit providers who need stable income to maintain their businesses and families who need reliable care to ensure the well-being of their children.

ADDITIONAL RESOURCES

- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, *QRIS Cost Estimation Model and Resource Guide*, <https://childcareta.acf.hhs.gov/story/qris-cost-estimation-model-and-resource-guide>.
- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care, *Provider Cost of Quality Calculator*, <https://www.ecequalitycalculator.com/Login.aspx?ReturnUrl=%2f>.
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- 2 Karen Schulman and Helen Blank, *Red Light Green Light: State Child Care Assistance Policies 2016*, NWLC, 2016, <https://nwlc.org/wp-content/uploads/2016/10/NWLC-State-Child-Care-Assistance-Policies-2016-final.pdf> (9, 15-16). Oregon set its reimbursement rates at the 75th percentile of current market rates as of February 2016. In addition, West Virginia increased its reimbursement rates to the 75th percentile of current market rates in March 2016, and South Dakota increased its reimbursement rates to the 75th percentile of current market rates in June 2016.
- 3 Schulman and Blank, *Red Light Green Light* (10).
- 4 Schulman and Blank, *Red Light Green Light* (10).

Conclusion

States have critical choices to make about priorities and resources as they move forward with CCDBG implementation. Keeping children's healthy development and families' economic security at the center of each policy decision can help advance the promises of CCDBG reauthorization—continuity and stability for families; improved health and safety for children; and supported, high-quality providers and programs—even in the face of challenging times and limited resources. As outlined in this guide, advocates, policymakers, administrators, and others are all important stakeholders in safeguarding and carrying out the vision of a stronger CCDBG that better supports children and families.



11 Dupont Circle, Suite 800
Washington, DC 20036
202.588.5180 | fax 202.588.5185
www.nwlc.org



1200 18th Street NW Suite 200
Washington, D.C., 20036
Phone: 202.906.8000
Fax: 202.842.2885

STRONG LICENSING: THE FOUNDATION FOR A QUALITY EARLY CARE AND EDUCATION SYSTEM

Research-based Preliminary Principles and Suggestions to Strengthen
Requirements and Enforcement for Licensed Child Care

By Amie Lapp Payne, Ph.D. | Child & Family Solutions Consulting



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403 Marquis Avenue, Suite 200 | Lexington, KY 40502 | (859) 514-1921 | <http://naralicensing.org>



May 2011

Acknowledgments

This paper, which describes key principles and characteristics of strong licensing programs, was developed with the advice of licensing and early care and education experts who have dedicated their careers to improving the lives and care conditions of our most vulnerable citizens. These experts included individuals within and outside of NARA's Board of Directors. The individuals outside of NARA were asked to be a part of the Norris Class Project's Advisory Committee. We are deeply indebted to those individuals for volunteering their time, expertise, and talents to this Norris Class Project and for reviewing drafts of this paper. Finally, we value each individual who supports strong licensing as an essential strategy to protect and nurture a significant number of young children while promoting their optimal development in out-of-home care.

Helen Blank

National Women's Law Center
(NWLC)

Julie Shuell

National Child Care
Information
Center (NCCIC)

Linda Smith

National Association of
Resource and Referral
Agencies (NACCRRA)

Davida McDonald

National Association for the
Education of Young Children
(NAEYC)

Dr. Eric Karolak

Early Care and Education
Coalition (ECEC)

Dr. Gerrit Westervelt

The BUILD Initiative

Linda Geigle

National Association of Family
Child Care (NAFCC)

Dr. Richard Fiene

Pennsylvania State
University

Dr. Sharon Lynn Kagan

Teachers College, Columbia
University
Child Study Center, Yale
University

NARA REPRESENTATIVES

Pauline Koch, Executive Director
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Carolynne Stevens,

NARA Vice President of
Professional Development

Rachel Demma

National Governor's
Association (NGA)

Dr. Amie Lapp Payne

Project Consultant

NARA remains forever grateful to the late Professor Norris E. Class . . . for his lifelong commitment to protecting and serving vulnerable populations, for his legacy of regulatory knowledge, and for his enduring gift to NARA, the inspiration to honor his memory through the fund that supported the development of this paper.

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INTRODUCTORY SUMMARY AND COMMENTARY

Licensing significantly impacts the quality of care children receive. The caliber of the licensing program determines the nature of its impact.

With more than 11 million children in out-of-home child care programs, many of which are licensed by states, child care licensing requirements¹ and enforcement must be strong and dependable. Licensed child care requirements and their effective enforcement are one of the more critical and strategic sets of program standards states have to protect and nurture young children while promoting their optimal development (NACCRA, 2010; see NARA & NCCIC, 2009).

Our nation and its families are experiencing profound, ongoing shifts that suggest licensed child care programs may be more important now than ever. These changes include: the marked growth in employed mothers; the increased understanding of the long-term significance of brain development in the first five years of life and, in turn, on children's subsequent school readiness; the rapid transition to a technology-driven, knowledge-based economy; and, the implications of all these changes for our nation's current and projected demographic and economic conditions.

Parents need to know that they can count on state licensing programs to monitor and enforce quality child care that is licensed to protect their children while promoting children's learning and development, particularly before they enter kindergarten. However, a lack of specific federal requirements or guidelines for child care quality compliance, intensified by the enforcement challenges currently facing state licensing programs, results in considerable variation of child care quality across states.

Strengthening licensing requirements and their enforcement is one of the more efficient ways available to achieve a positive impact on a substantial proportion of children in out-of-home care. Because licensing requirements are legally enforceable, and because so many young children participate in licensed child care prior to entering kindergarten, strengthening licensing requirements and enforcement has the potential to reach each state's children in licensed care in consistent ways – and to do so in a relatively short period of time.

¹ States often use the terms “rule” or “standard” when referring to a requirement or regulation that must be met to receive or retain a license. Although those terms will sometimes be used, the term “requirement” will most often appear; it is clearer, especially for those outside the field. “Standard” is a context-dependent term, e.g., may only mean “commonly accepted,” or may refer to approval criteria used in voluntary (non-enforceable) systems such as Quality Rating Improvement Systems (QRIS), accreditation, etc. In licensing, however, both “rules” and “standards” are enforceable – but they are constructed and enforced differently. A regulation constructed as a “standard” requires the use of judgment, interpretation, or context for enforcement, e.g., to determine when a toy is “safe,” or when a classroom is “clean,” or has “developmentally appropriate materials.” Many requirements actually *must* be constructed as standards because they deal with a non-exact mix of characteristics that exist along a positive-to-negative range of effects, e.g., safe, clean and orderly rooms must not undermine children's need for active exploration. In contrast, a regulation constructed as a “rule” is more precise, conveys no intentional leeway, and needs little or no interpretation, e.g., requiring safety covers on electrical outlets when not in use, or prescribing a formula to calculate the depth of resilient surfacing on playgrounds. Regulations must use both types of construction to protect children from the variety of risks associated with care-activities and situations. Licensing agencies use interpretation guides and other strategies to achieve consistent enforcement of both types of requirements, especially standards, and provide similar guidance to licensees.

Understanding what constitutes licensed child care sets the stage for understanding how licensing protects – or fails to protect – children. Licensed care varies considerably both within and across states, for example, in types and settings, by how many children are in care, by program requirements, and by enforcement effectiveness. While the requirements vary, issues common to licensing, including why licensing is important for school readiness and the nature of variations that exist in state licensing standards, do not. This paper addresses the principles and practices that should guide the formulation, revision, and enforcement of child care program requirements.

PROGRAM REQUIREMENTS AND THEIR ENFORCEMENT MATTER

Clear guidance now exists for states to improve their child care licensing services. The principles for improving the efficacy of protection requirements and their enforcement are research-based, steeped in best practices, and consistent with what is working well in state licensing programs. These principles should guide states as they begin to examine and narrow the gap between their existing licensing requirements and higher quality, voluntary program standards set through other mechanisms in Early Care and Education (ECE) systems, such as quality rating and improvement systems and early learning standards.

Effective, high quality licensing consists of at least three distinct components: a strong enabling statute, strong program requirements, and strong enforcement. To address quality care and education for children adequately, states must take a multi-faceted approach to establishing effective licensing programs with both the authority and the capacity to promulgate and enforce quality-focused requirements. At a minimum, such facets should be guided by key principles and characteristics for a strong licensing law, for strong child care program requirements, and for strong licensing agency operations and enforcement. These principles are summarized below and described in more depth later in the paper.

THE LICENSING STATUTE

The licensing statute, enacted by the state legislature, establishes the scope of facilities subject to licensure and the scope of authority, responsibilities, and enforcement methods for the licensing agency. The characteristics of strong statutes include but are not limited to:

- No exemptions or definitional exclusions for regularly operating settings that offer supervision or care.
- Clear authority and provisions to investigate and to close illegal operations.
- Appeal rights and processes that apply to adverse enforcement actions.
- Initial and recurring background clearances for caregivers; that is, fingerprint-based national and state records checks for convictions and founded abuse/neglect/cruelty.
- Authority and direction in enforcement activities, such as issuances and complaint response, which may also include frequency, intervals/duration, and/or response times in key activities.

- A basis to use a full continuum of enforcement options, with agency discretion to secure compliance using a range of positive and adverse interventions, from instruction to injunction.

THE LICENSING REQUIREMENTS

The body of requirements (often referred to as “standards”) adopted by the licensing agency establishes the scope and quality of regulatory prescriptions and proscriptions that, collectively, create facilities’ physical, social, learning, and organizational environments.² Indicators of strength include but are not limited to the use of:

- Scheduled reviews of regulations every three to four years, plus event-triggered reviews required to respond to urgent demands.
- Broad public outreach and consultation in drafting and revising regulations.
- Requirements that are kept research-based, current, and designed to respond to known public risks and to the strengths and weaknesses in the industry’s prevailing conditions.
- Requirements that reflect the understanding that the benefits of early learning stem directly from the nature of children’s relationships with their adult caregivers. Caregivers must know how children learn and be able to foster their optimal development.
- A body of requirements designed with a holistic focus on child well-being. Collectively, the body of requirements creates a safe environment that promotes healthy physical, social, emotional, and cognitive development.
- Attention to operational reasonableness and cost considerations, including provisions for phasing in new requirements if necessary.
- Sound interpretation guidelines and procedures manuals, updated as necessary, to help both providers and inspectors apply the requirements correctly, fairly, and consistently.

THE LICENSING AGENCY

The licensing agency must be structured, staffed, and managed to ensure proper performance of all functions and tasks implicit in and incidental to sound administration of the licensing law and regulations, for example, operational and enforcement policies and practices, provider and community engagement, and similar key performance areas. Strength indicators reflecting best practices for regulatory agency performance include but are not limited to:

² As indicated below, licensing agencies lack authority to adopt regulations directly or unilaterally. In the administrative procedures statutes, states establish methods that govern the adoption of regulations, which may be further defined in governors’ executive orders. These specify minimum requirements for public notification and input opportunities and for external reviews and approvals addressing both content and legal issues. Required approvals typically include governmental agencies/boards designated because of relevant expertise or authority, legislative oversight committees, and elected officials, such as governor and office of the attorney general. Although the licensing agency lacks adoption authority, it is responsible for assessing and justifying changes needed, for proposing and negotiating changes, and for coordinating the state’s requirements for lawful adoption and promulgation.

- Adequate funding and executive/legislative support to operate the agency according to law, policy, and regulatory best practices.
- Adequate staffing to support routine monitoring of facilities twice annually, increasing to four or more times annually as needed until satisfactory compliance is stable or the facility is closed. The workload standard for inspectors should be 50-60, calculated by a best-practice method that considers local conditions.
- Effective management and leadership focused on program planning and on management systems and procedures to achieve reciprocal reinforcement among all components and functions. Management uses research and evaluation to drive program compliance and quality improvement. Methods ensure that actions are correct, timely, thorough, objective, and consistent across the agency. The agency uses a systematic, risk-based enforcement decision method.
- Acquisition and retention of suitably educated, well-qualified regulatory and support services personnel, with initial and ongoing training in regulatory theory and practice provided.
- Systematic methods to achieve an agency-wide culture built on data-driven continuous learning, a shared vision of performance excellence, and a comprehensive continuous quality improvement function steered by sound measurements.
- Effective provider support services designed to promote providers' knowledge, compliance, and accountability; the services emphasize compliance-related technical assistance and workforce development.
- Communication and collaboration systems that maintain coordination with the agency's many stakeholder groups, including key legislative committees. Facility compliance reports are Internet-available, as are agency performance reports and other pertinent resources for providers, consumers, and other stakeholder groups.
- Direct linkages to legal counsel and well-defined systems of administrative appeals that protect the rights of licensees and care-consumers.

Using these principles, states will be able to identify strengths, weaknesses, and inconsistencies within their licensing programs. Policy makers and licensing administrators must think holistically about licensing principles and characteristics to ensure that they guide the formulation and enforcement of child care regulatory requirements in a systematic and intentional manner. Together, these principles provide a means for each state to assess its licensing program's readiness to construct a strong foundation for quality care throughout the early care and education system.

Despite the disturbing unevenness in current quality and rigor, it is noteworthy that all states have concluded that child care meets the public-protection test that precedes any proper decision to regulate products and services. In fact, research and experience have steadily expanded appreciation of the need to address both immediate and developmental risks that were not recognized when child care licensing began more than a century ago.

Adopting federal requirements (or “national standards”) for child care quality compliance would magnify the benefits of quality child care immeasurably – and not only by providing children and families with equal opportunities for development and protection throughout the nation. Significant benefits and cost reductions also would accrue in such functions and tasks as research, program/system assessments to improve planning and funding decisions, and workforce development. Additionally, properly designed national requirements and enforcement methods could lead to operational efficiencies at both state and national levels by reducing redundant efforts, for example in developing requirements, resource documents, and training materials.

Finally, a frequently overlooked outcome is that stronger regulation benefits providers. More than is characteristic of many other types of regulation, human care regulation always has been mindful of the special nature of care-giving – and well aware that caregivers must be nurtured before the industry can nurture the nation’s young. Licensing agencies are keenly attuned to the residual effects of an industry rooted in a history of an unpaid or underpaid and under-educated female workforce. Both directly and collaboratively, every strong licensing agency engages in strengthening the industry – walking a carefully drawn line between positive enforcement methods (to motivate and to enhance the skills of suitable caregivers) and adverse enforcement methods (to weed out facilities that pose too great a risk to the public).

The National Association for Regulatory Administration (NARA) presents these child care licensing principles for consideration. The hope is that these principles will be used by states – and perhaps the nation – to help review, revise, promulgate, and enforce an integrated set of model regulatory policies and practices that could boost the quality of children’s health, safety, and development throughout their early learning experiences in licensed care. NARA supports a vision of effective licensing programs reinforced by increased administrative and financial support and fully prepared to protect and promote children’s development. Ultimately, building a strong nation is achieved by developing capable children.

STRONG LICENSING: THE FOUNDATION FOR A QUALITY EARLY CARE AND EDUCATION SYSTEM

WHAT IS LICENSED CHILD CARE?

The purpose of this paper is to establish the pivotal role child care licensing plays in protecting, nurturing, and promoting the development of young children in out-of-home care. Specifically, we must be clear about what child care licensing requirements are and are not; to whom they apply; who provides licensed child care; and, what current child care licensing issues are. Only then can we understand how strengthening licensing requirements – including their enforcement – supports voluntary approaches to raising the quality of child care (such as early learning standards and quality rating and improvement systems).

METHODOLOGY

To determine the content to include for this paper and its resulting *Preliminary Child Care Licensing Principles (Principles)*, NARA hired a child development consultant, formed a National Advisory Committee for the project, and reviewed a number of research and policy papers focused on what child care licensing does to protect children's health and safety effectively while promoting their optimal development. Because states and child care providers typically refer to a variety of well-known resources when researching quality child care program requirements and enforcement, NARA examined these same resources, among others, when researching and recommending its *Principles* (See Section V, *Policy Analysis and Strategies: Preliminary Child Care Licensing Principles*).

CHILD CARE LICENSING REQUIREMENTS

To protect children in licensed child care, states adopt requirements that providers must meet to obtain and retain licensure. The drafting and adoption process is prescribed in law and is exacting, requiring public involvement and comment opportunities as well as reviews by legislative and administrative authorities. The child care licensing office within each state monitors compliance with its requirements. Both program requirements and monitoring methods vary widely from state to state. Program requirements prescribe: what each state considers citizenry-supported essential elements of quality that should be in place to protect children's health and safety (see National Conference of State Legislatures, NCSL, 1999); how a program operates; what qualifications and skills practitioners (or caregivers) must have; and (in most cases), what kinds of early learning activities and

experiences are regularly available to children in the licensed child care environment (Morgan & LeMoine, 2004; LeMoine & Morgan, 2004; see NARA & NCCIC, 2009).

Accordingly, just because a program is licensed does not mean that it provides quality care. If states fail to adopt (and to enforce) quality program requirements, licensed programs likely will not provide quality care. Child development researchers often have defined quality in terms of a program's ability to protect children's health and safety and to educate young children – contributing to the development of the whole child. Program requirements that enable such quality care include trained teachers who have necessary child development knowledge, skills, and competencies to engage children in, and promote their love of learning (Morgan & LeMoine, 2004; Ramey & Ramey, 2000; Shonkoff & Phillips, 2000). In other words, quality programs concurrently address all aspects of child development (NICHD, 2000, 2001; Ramey, 2000). These multiple domains of development include: physical and motor development; social and emotional development; approaches toward learning; language, literacy and communication skills; and cognitive skills (Kagan, Scott-Little, & Frelow, 2003; National Educational Goals Panel, 1991). States that do not require quality programming to address children's development fail to protect children adequately against risks to their health and safety, as well as to their overall developmental well-being.

It remains the case then, that there are significant inconsistencies in the quality of states' licensing requirements and enforcement practices, and it has long been documented that the vast majority of licensed care available is not good quality (see Cost, Quality, & Child Outcomes Study Team, 1995; see Fiene et al., 2002). Many states are trying out a variety of strategies throughout their licensing processes to improve the quality of their licensed programs – even in the midst of our nation's current economic crisis (*see Appendix B: State Strategies to Improve Licensing Policies and Practices*). However, the quality of licensed care is currently a “mixed bag.” Uneven quality in early care and education programs has been documented repeatedly in evaluation studies (see Goffin & Washington, 2007; Early et al., 2006). Seminal research documents that only 15 percent or less of child care centers provide good-quality care, as rated by trained observers (Cost, Quality, & Child Outcomes Study Team, 1995), and current National Association of Child Care Resource and Referral Agencies (NACCRRA) ratings of state licensing program requirements and enforcement practices, compared to best practices, seem to confirm such findings.

BRIEF HISTORY OF POLICY

It is important to note that there are no *mandatory* federal standards governing the quality of licensed care, and the only existing law relative to child care licensing program standards is the Child Care and Development Block Grant (CCDBG) federal funding requirement. CCDBG mandates only that programs not required to be licensed or registered must at least meet the state's basic health and safety standards.

Historically, child care was seen solely as a work support. Now, the term “child care licensing program requirements” not only addresses protection against immediate harm to children’s safety and healthy, but also the level of quality children must have while in non-parental care to protect them against cumulative developmental risks to reaching their full potential (National Association for Regulatory Administration, NARA & National Child Care Information Center, NCCIC, 2009; see Shonkoff & Phillips, 2000). However, our country has not been able to apply what we know to what we do to provide, on a consistent basis, quality care that is licensed. This failure stems, in large part, from the belief that upfront financial costs of care meeting higher quality program requirements are more expensive. Because most states do not, or believe they cannot, provide enough help to parents to pay for high quality care; the concern is that higher quality program requirements may push families out of the licensed child care market entirely. Still, parents want and need quality care for their children and states’ laws typically mandate their licensing programs to require child care providers to provide care that protects children while promoting their overall well-being.

WHY STRONG LICENSING MAY IMPROVE SCHOOL READINESS

The vast majority of children’s overall development takes place within the first five years of life; with 85 percent of brain development having occurred by the time children reach age three. Understanding how critical the early years are for children’s success in school and in life has resulted in widespread agreement about the importance of quality early learning experiences. Research has consistently demonstrated that quality early learning programs are beneficial for children’s school readiness. Children experience developmental consequences as a result of their early learning experiences, and these consequences can be positive or negative for their brain development (Frede, 1995; Shore, 1997; Shonkoff & Phillips, 2000). Research indicates that children who enjoy high quality care – particularly during the first four years of life – are more likely to be better prepared for school upon entrance to kindergarten and also more likely to experience long-term educational success (Schweinhart, 2004; see Vandell & Pierce, 2003).

The presence or absence of quality licensing program requirements and enforcement in licensed care settings significantly impacts children. Strong licensing not only answers the question of “how well” children are protected against risks to their health, safety, and overall development but also “for how many.” Licensing is the only set of legally enforceable requirements in place to safeguard children in out-of-home care through regular monitoring and enforcement of compliance with program requirements while children are away from their parents. Because so many parents with young children work outside of the home, licensed care can have a significant impact on millions of children.

Many children, however, are cared for in unlicensed settings without such protections in place. Although there is a chance that such settings may offer care that keeps some children healthy and safe, there simply is no way to ensure – or to require – that the quality of care being offered matches that provided in licensed settings. In addition, there is no way to monitor or enforce the presence or absence of quality indicators in unregulated care settings (Cost, Quality, & Outcomes Study, 1995).

Also, violation records of licensed facilities are available to parents seeking the best provider for their children whereas unlicensed care would have no such records available. That is, unregulated human care businesses are not subject to oversight – or to investigation – unless a specific complaint alleges conduct that rises to the level of abuse/neglect/endangerment or operational matters covered under other general laws.

The enforcement of licensing program requirements has the potential to keep children safe and developing in healthy, positive ways – effectively setting the conditions for school readiness and greater success in life. Though it is not possible to measure the number of incidents, accidents, and cumulative risks to children prevented by licensed care, it is possible to recognize the many measures states put into place to keep children safe. From conducting background checks on caregivers who work with children to implementing preventative program standards that reduce the transmission of disease, injury, and death, the protections offered by quality licensing program requirements ensure children’s safety and well-being and also increase the likelihood that they will experience quality care (Shonkoff & Phillips, 2000; Zigler, 2010). Knowing they have a place to go where they can trust adults to meet their needs, develop relationships with others, explore the world around them, and satisfy their curiosity to promote their love of learning is an immeasurable benefit to children as they not only prepare for kindergarten, but also prepare to succeed in life (Schweinhart, 2004; NICHD, 1996).

Research has continuously documented the benefits of children’s quality early experiences with their subsequent preparedness—or lack of preparedness—for successful experiences in formal schooling. Without strong program requirements and enforcement, children’s preparation for school is weakened. Children, especially children at risk, who have not had adequate supports and opportunities throughout their early learning experiences to appropriately stimulate their development, may need remedial education and many other publicly-funded supports – which costs the state more time and more money, and costs children a portion of their limited time in which to reach their full potential (Rolnick & Grunewald, 2003).

Overall, states can improve the likelihood of children’s readiness for school by making at least three conscious choices to actively protect and promote children’s optimal development in licensed, non-parental care: (1) proposing and promulgating strong, quality-focused, evidence-based licensing requirements; (2) adequately monitoring and enforcing compliance with such quality program requirements; and (3) reducing or eliminating statutory exclusions and exemptions from licensure that currently apply to many child care settings that have assumed the same care and supervision responsibilities as licensed settings. By making the choice to adopt and implement these policies, states can create a solid foundation upon which to build a thriving early care and education system.

WHO IS IN LICENSED CHILD CARE?

Child care is in high demand, largely due to the proportion of young children whose mothers work outside the home. In 2004, 62.2 percent of mothers with children under the age of six were working (US Bureau of Labor and Statistics, 2005). In 2010, roughly 44 percent of young children (i.e., 11 million out of approximately 25.1 million children ages birth through 11 years) were in out-of-home care (see NACCRRA, 2010; www.childstats.gov/americaschildren/tables/pop1.asp). In 2007, child care slots were available to children in licensed care for roughly 40 percent of young children (i.e., more than 9.5 million child care slots for approximately 23.9 million children ages birth through age 11 years; see NARA & NCCIC, 2009; www.childstats.gov). These child care slots were available in a total of 325,289 licensed facilities within the United States, representing care provided in a variety of settings.

Most states license care in child care centers, family child care and group family care homes, for-profit businesses, and not-for profits. However, some states exempt particular child care programs from licensing. Making licensed child care available in a variety of settings (e.g., child care centers and family child care homes) increases its accessibility to a diverse group of parents while increasing the likelihood that, with adequate licensing program requirements and enforcement in place, the care is safe and healthy and provides their children with quality early learning experiences.

LICENSED CHILD CARE CENTERS

All states' laws and child care center licensing regulations define the type of center-based facility that is required to be licensed. Although each state's definition of child care centers varies, many elements are commonly included among many states. Examples of elements common to state definitions of child care centers include: minimum number of children in a facility (37 states); services provided for fewer than 24 hours per day per child (35); services provided on an ongoing basis (24); ages of children in a facility (minimum/maximum) (21); services provided for payment or compensation (19); and provider and children are not related by blood, marriage, and/or adoption, and children are not from one family (i.e., are not siblings) (17) (NARA & NCCIC, 2009).

FAMILY CHILD CARE HOMES

States' laws and regulations also define home-based facilities that are required to be licensed. These most often refer to child care that is provided in the home of the non-relative adult caretaker. There are two types of licensed family child care homes: (1) small family child care homes; and (2) large or group family child care homes. Although not all states use the same terminology to describe child care that is provided in a child care provider's home, the classification of family child care (FCC) is

typically based on the number of children receiving care and/or employees providing care in a particular family child care home (NARA & NCCCIC, 2009).

Small family child care homes. *Small family child care homes* typically share a number of common elements across various state definitions. Most often, small FCCs are child care programs located in the provider's residence that usually include one provider and a small number of children. Examples of other elements common to small FCCs include: FCC provider is the holder of the license (22 states); and services are provided in the residence of the provider/licensee (17) (NARA & NCCCIC, 2009).

Large/group family child care homes. A child care program, located in the provider's residence, and that typically includes one provider, an assistant, and a large number of children is often considered a *large or group FCC home*. A total of 39 states include large/group homes in their regulations either by licensing or by registration or certification. However, 12 states do not have this category in their licensed facilities.

For example, many states define large/group FCC homes as the care of 7-12 children, where 18 states specify seven children as the minimum number of children allowed and 20 states specify 12 children as the maximum number allowed.³ However, seven states do not specify minimum numbers of children in their large/group FCC home definitions and one state does not have a maximum number of children allowed (NARA & NCCCIC, 2009).

Licensing thresholds. All state child care licensing regulations define the levels of center-based facilities or family child care homes that are required to be licensed. Each state has a minimum number of children in care (that is, the threshold) that determines when a license is required.

When it comes to care provided in *FCC homes*, most states require licensure, however states vary considerably in the number of children FCC providers can have in care before they must become licensed. While some states require all FCC providers to be regulated as soon as they are providing care for one child, several states exempt providers caring for up to five children, and a handful of states exempt providers caring for an even larger number of children (Schulman & Blank, 2007):

- Ten states require all non-relative family child care providers to meet licensing or regulation requirements as soon as they are caring for one child (Alabama, Connecticut, Delaware, District of Columbia, Kansas, Maryland, Massachusetts, Michigan, Oklahoma, and Washington) (USDHHS, NCCCIC, 2006).
- Five states exempt FCC providers caring for one child or the children of only one family (California, Colorado, Florida, Minnesota, and South Carolina).

³ States may have policies and procedures that could allow licensure in a residence for more children than their stated FCC maximums – but only if the home is defined and licensed under *child care center* regulations. To serve a larger number in a residence, however, often requires some structural modification to meet more stringent building and fire safety codes that apply to centers. Hence, what is administratively possible may not be feasible when the modification costs are identified.

- Eight states exempt FCC providers caring for up to two children (Georgia, Hawaii, Maine, Montana, New York, North Carolina, Vermont*, and Wyoming**).
- Eleven states exempt FCC providers caring for up to three children (Illinois ***, Kentucky, Nebraska, New Hampshire, North Dakota, Oregon***, Pennsylvania, Rhode Island, Texas, West Virginia, and Wisconsin).
- Seven states exempt FCC providers caring for up to four children (Alaska, Indiana, Iowa, Mississippi, New Jersey, and Virginia).
- Three states exempt home-based providers caring for up to six children (Idaho, Louisiana, and Ohio).
- South Dakota exempts home-based providers caring for up to twelve children.

Note: * Vermont also exempts providers caring for children from two families, regardless of how many total children from those families are in their care. ** Wyoming also exempts providers caring for children from a single family, regardless of how many total children from that family are in their care. ***Illinois and Oregon also exempt providers caring for children from a single family, regardless of how many total children from that family are in their care.

LICENSING EXEMPTIONS

Some states legally exempt certain programs or providers from licensure. In fact, there are at least 15 different *center-based* facilities/program types exempt from licensure across all states. For example, 26 states exempt facilities with small numbers of children in care (e.g., FCC) from being licensed, while 17 states exempt programs that offer religious instruction, 12 states exempt facilities operated by religious organizations, and 11 states exempt preschool programs operated by private schools or school systems (see NARA & NCCIC, 2009).

Exempting facilities of any kind from licensure – whether based upon religious affiliation or on geographical or programmatic factors – creates serious gaps in child care protection. Without being licensed, child care programs lack the regulation and enforcement protections necessary to reduce risks to children. Exemptions, if providers are not required to meet at least health and safety program standards, can jeopardize the immediate well being of children. Because licensing requirements are mandatory for licensed child care programs, and so many young children participate in licensed child care prior to kindergarten entry, strengthening licensing requirements and enforcement has the capacity and the potential to reach each state’s licensed programs caring for young children in consistent ways over a relatively short period of time. Overall, strengthening licensing requirements and enforcement across all 50 states and requiring regulation of *all* child care facilities is an efficient and responsible way to ensure safe, quality child care for millions of children.

WHAT ARE THE ISSUES? IMPROVING CHILD CARE LICENSING PROGRAMS

WHY CHANGE IS NEEDED

To make sound social policy decisions regarding the regulation of child care, the first step, and the driving purpose of this paper, is to understand that the extent to which decisions that states make have life-long effects for young children. Moreover, policy leaders and citizens in general must also grasp the broader implications of these effects. Failure to create opportunities for young children's optimal development, which adversely affects brain development and academic achievement, means children may be missing the stimulation necessary to reach their full potential. Research repeatedly confirms that licensing requirements and enforcement affect the quality of care and developmental stimulation children experience in out-of-home care environments.

As the preceding section discussed, state legislatures make the first critical decisions that affect the quality of care for children when they determine what child care shall be exempt from regulation. States' subsequent decisions about the nature of licensing requirements and enforcement practices obviously will not matter for children who are served in unlicensed care.

For children who are served in licensed care, however, it is important first to understand what *kinds* of care-program requirements are selected and how much those licensing requirements and their associated enforcement protect (or fail to protect) children.

WHAT GETS DETERMINED: QUALITY INDICATORS

To reach a feasible set of licensing requirements that will support the level of quality care necessary to protect children while promoting their development, providers and other constituents must provide input, together with the state, as to how best to make proposed program requirements work for all affected parties. The resulting licensing requirements for care programs, then, are the consensus of what gets selected.

States have access to model standards through a number of organizations that focus on optimal development for young children. Current resources, such as Caring For Our Children (CFOC) and publications from organizations such as the National Association of Child Care Resource and Referral Agencies (NACCRRA), and from accreditation bodies such as the National Association for the Education of Young Children (NAEYC) and the National Association for Family Child Care (NAFCC), all provide guidelines to help states understand what makes up higher quality program standards and to strengthen licensing requirements. Some states use these resources to help them meet such evidence-based recommendations. However, states vary greatly in their financial ability and/or political willingness to refer to and/or to incorporate these higher quality guidelines and to strengthen the quality of licensing requirements.

For licensed child care, including child care centers and family child care homes, program requirements include child care program elements that are common among licensing requirements. Sound licensing program requirements should be clearly written, reasonable to implement, relevant to risks children would otherwise encounter, and developed by a citizen-based democratic process (such as the Model Administrative Procedures Act, APA). When licensing requirements are based upon research and best practices linked to children's safety, well-being, and/or school readiness, these can be referred to as quality indicators. Quality indicators promote the types of interactions between adults and children, and between children and their peers, that support young children's learning and development (*see Vandell & Wolfe, 2000; see Pianta, 1997*) and protect children from immediate risks to their health and safety. What gets selected as a licensing requirement is important – it affects the quality of care that either protects or fails to protect children against risks associated with their health, safety, and readiness for school.

Key quality indicators. Quality indicators exist for program and practitioner (care-giver) regulations. Indicators for program requirements such as child-staff ratio, group size, and playground requirements, and for practitioner requirements such as staff qualifications and training are just a few examples of non-exhaustive, key indicators consistently identified in the research that promote children's health, safety, and overall well-being (Fiene, 2002; CFOC, 2002).

PROGRAM REQUIREMENTS

Child-staff ratios and group size. Best practice recommendations for selection of licensing requirements governing child-staff ratios state, “no more than three (CFOC, 2002)-to-four infants (six weeks to 15 months old) should be cared for by a caregiver in a child care center at any time” (NAEYC, NACCRRA, 2009;). Lower *child-to-staff ratios* (fewer children per staff member) and smaller *group sizes* (total number of children in a specified group for a given space) have been associated with lower disease transmission (Collet, Burtin, Kramer, Bossard & Ducruet, 1994; Bredekamp, 1990); increased monitoring of healthy and safe practices (Hayes, Palmer, & Zaslow, 1990); improved care giving behavior and safety conditions (severity and frequency of complaints or reports of abuse and neglect) (Russell & Clifford, 1987); and significantly more caregiver time interacting with the children in their care – such as comforting, responding, instructing, questioning, and praising. (NICHD Early Child Care Research Network, 1996; Ruopp, Travers, Glantz, & Coelen, 1979). Teachers with fewer children in their care engage in more verbal communication with children and this has been associated with greater language development in children (Palmerus, 1996). Children in smaller groups and in care situations with fewer children per teacher also have been shown to be more cooperative and compliant, and to exhibit greater innovation and more social competence than children in larger groups (Clarke-Stewart, Gruber, & Fitzgerald, 1994). Overall, the smaller the total number of children caregivers are responsible for at one time, the more positive and individual attention children get from their caregivers, and such attention promotes more positive outcomes for children.

Space requirements. Best practice research recommends that each child has at least 35 square feet of usable space in a child care environment, whether in a child care center or a family child care home (CFOC, 2002; Prescott & David, 1976), and most states meet this requirement. The amount of indoor space available per child in out-of-home child care environments has been associated with positive and negative child outcomes. When adequate space is organized to promote developmentally appropriate skills, children are better able to make good use of their learning time through their play and work (Kruvant, Redish, & Dodge, 1976). In contrast, children who are crowded in inadequate spaces are at increased risk of developing upper respiratory infections and of injury from simultaneous activity (Fleming, Cochi, Hightower et al., 1987; CFOC).

Educational materials. In general, all children need a variety of materials to support quality educational experiences within each developmental domain. Most states require that licensed child care providers, whether child care centers or family child care homes, have a certain type and/or quantity of child equipment and/or materials available for children's activities. This typically means materials such as fine motor/manipulatives; books and literacy; dramatic play/pretend; art supplies/creative activities; gross motor equipment (both indoors and outdoors); music; science/experimental/math (counting/sorting); and sensory.

Having such an array of educational materials to work with is necessary for children no matter which type of care they are in, although requirements and recommendations for specific types and quantities of materials may differ for child care centers and family child care homes. For example, for child care centers, NACCRRA recommends that child care programs have educational activities and materials to promote six developmental domains: social, physical, language/literacy, cognitive/intellectual, emotional and cultural (2009).

For family child care homes, the NAFCC accrediting body requires educational materials for each age group of children in family child care. For infants, toddlers, preschoolers, and school-age children this means that children in each age group will have toys and materials that support large and small motor development; language and literacy development; art; science; and, mathematics.

Health and safety: Immunizations. There are a number of different quality indicators to protect children's health and/or safety. However, this paper will use two examples to illustrate best practices necessary for adequate protection of children in the areas of basic health and safety: Immunizations and Sudden Infant Death Syndrome (SIDS). Best practices for child immunizations are to follow the latest version of the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Pediatrics (AAP) immunization schedule (CFOC, 2004). In addition, all licensed child care programs should require that children be immunized prior to attendance (NACCRRA, 2010). Research has continuously demonstrated that immunizations are one of the most effective ways to reduce the spread of infectious diseases among young children (Fiene, 2004; see Bond & Lester, 1999; Ferson, 1997; Middleton, 1995). This is important as the majority of

research on infectious diseases in children using out-of-home child care shows that children in preschool or long hours in child care centers are more likely to experience more frequent infections and more sick days than young children who are cared for at home or in a family child care home (Ferson, 1997). To minimize these risks, all young children should be appropriately immunized.

Health and safety: Sudden Infant Death Syndrome (SIDS) Reduction. Recent research has consistently shown that the supine (back) position presents the least risk of SIDS for infants (Task Force on Infant Sleep Position and Sudden Infant Death Syndrome, 2000). For example, infants who are back-sleepers at home, but are put to sleep on their stomachs (prone position) in child care settings have a higher risk of SIDS (Moon, Patel, & Shaefer, 2000). Best practices (CFOC, 2002) recommend that unless a child has a note from a physician specifying otherwise, infants shall be placed in a supine (back) position for sleeping to lower the risks of Sudden Infant Death Syndrome (SIDS). In addition, soft surfaces and gas-trapping objects such as pillows, quilts, sheepskins, soft bumpers or waterbeds shall not be placed under or with an infant for sleeping. Despite a number of child deaths across the nation, only about half of states that license child care centers and/or family child care homes (small and/or large) require measures in their licensed family child care homes that reduce the likelihood of SIDS, (NACCRRRA, 2010; see Table 1). Putting into place the respective health and safety program requirements that correlate with best practices to reduce disease, injury, and death mitigates the risks of these occurring in out-of-home child care environments (Wrigley & Dreby, 2005).

Playground safety: Surfacing requirements. As another quality indicator, playground equipment and materials provide an outdoor environment that is rich in opportunities for children's development – but also full of chances for injuries to occur if adequate protections are not part of playground design and regular upkeep requirements. Materials put underneath playground equipment to absorb children's falls are known as *resilient surfacing*. To protect children against injuries associated with falls from playground equipment, states must first require such program standards for playground surfacing. Best practices recommend that the depth of these materials should be proportionate to the critical height value of the playground equipment as tested by the National Program for Playground Safety (NPPS, 2000; Consumer Product Safety Commission, CPSC, 2004). Research has consistently demonstrated that the most common injuries in child care occur on playgrounds (Briss, Sacks, Addiss, Kresnow, & O'Neill, 1994; NPPS, 2000). These injuries are typically due to falls from climbing equipment and lack of adequate resilient surfacing. In a national study examining the risk of injury associated with child care center attendance, approximately one out of every five of playground injuries resulted from falls from climbing equipment, and more than half of fractures and concussions were caused by these same types of falls. Overall, the most important risk factor for injuries is the height of climbing equipment and lack of adequate resilient surfacing, which also demands regular raking and replenishment to maintain the required depth during usage.

PRACTITIONER REQUIREMENTS

Practitioner regulations include requirements such as having completed a certain number of training hours, specific training credentials (such as Child Development Associate, CDA), and teacher certification (such as Early Childhood Education Bachelor's degree). Requirements can vary widely. To qualify as a teacher in a licensed child care program may be as minimal as having a negative result on a tuberculosis test, being at least 18 years old, and having a state driver's license (but no pre-service qualifications or high school diploma or its equivalent) (see NARA & NCCIC, 2009). Alternatively, more rigorous practitioner standards, such as those used in nationally accredited programs, and for certain positions (such as center Directors) in states with quality licensing requirements, may require a degree in child development or early childhood education (for example, Bachelor, Associate), as well as additional childhood specific teacher certification. No state requires child care teachers to have a college degree and, as of 2008, this is reportedly true for specialized training in early childhood as well (Barnett, Epstein, Friedman, Boyd, & Hustedt, 2008). This weakness is understandable, given the financial challenges within ECE systems (such as the cost of providing and obtaining child care and the cost of adequate compensation for teachers). Teachers should be required – and supported – to obtain specialized training in ECE, however, in view of the important role child care teachers play in helping to shape children's ability to reach their full potential during their most critical periods of development (see Appendix A: Early Care and Education Systems Development).

Staff qualifications and training. Staff qualifications and training are important indicators for quality practitioner and care requirements. Caregivers with formal education or specialized training at the college level have been shown to engage in more positive behaviors toward children. For example, caregivers with a college degree or with college-level, specialized training behave less harshly and more sensitively, display less detachment and are less punitive, and engage in more positive interactions with children in their care (Fiene, 2002). Specifically, caregivers with such qualifications and training display more warmth, enthusiasm, and developmentally appropriate communication with children, and they are more involved with and interested in them while also being less hostile or threatening toward, or harshly critical of, children (Arnett, 1989; Whitebook, Howes, & Phillips, 1989). In addition, the more education caregivers have, the more likely they are to have children in their care who are more socially competent and compliant (presumably at least in part as a result of their care), (Clarke-Stewart, Gruber, & Fitzgerald, 1994). Children with caregivers who have more education also score higher on developmental assessments of preschoolers, including their knowledge of information such as shapes, sizes, and parts of the body as well as measures of intellectual ability including language comprehension, verbal fluency, and memory (Clarke-Stewart, Gruber, & Ainsley, 1984).

Beyond children's developmental benefits, staff training programs have also been shown to decrease the likelihood of immediate physical harm to children's health and safety. Specifically, targeted staff

training reduces the number of accidental injuries in child care centers (Ulione, 1997) and increases staff ability to identify signs and symptoms of childhood illnesses and to employ infection control, further preventing child and staff illnesses and injuries, and to provide basic first aid for children (Ulione, 1997). Thus, the more child development education and training caregivers have, the more likely they are to promote children's overall well-being and to protect children's health and safety.

WHAT GETS DETERMINED: EFFECTIVE CHILD CARE LICENSING PROGRAMS

Above and beyond the statutes that authorize state agencies to promulgate the scope and quality of requirements by which child care programs (and practitioners) must operate, state child care licensing agencies must effectively monitor and enforce such requirements. Well designed, appropriately staffed regulatory programs protect the public and promote the availability of quality care when they are equipped to use a comprehensive array of strategies and interventions ranging from monitoring and supporting licensees to improve their care of children to closing unsafe programs (NARA, 2009).

Effective licensing programs put such practices into place and can be recognized by such characteristics as: (1) strong administrative support from executive and legislative branches of government; (2) adequate funding; (3) sound licensing requirements; (4) legally sound enforcement procedures; (5) strong provider support; (6) sound consumer education; and (7) collaboration and coordination with each part of the larger early care and education system.

Administrative support and adequate funding. Strong administrative support empowers licensing programs with strong licensing laws, with political will, and with quality requirements and means of enforcement to take necessary legal actions that adequately protect children and set the conditions for quality child care that is licensed. Such support can also provide necessary funding to appropriately staff licensing programs with well-trained and educated staff who are skilled in observation and documentation (monitoring), and who can interpret and apply licensing requirements consistently. An adequate staffing complement of professionals who are well-prepared in regulatory theory and practices will also include necessary coverage for such specialized functions as staff/provider training and policy management and for readily accessible back-up expertise in areas such as health, research, and performance improvement oversight.

Licensing requirements. Sound licensing requirements (that is, requirements designed to match quality indicators, as previously discussed) are key to establishing the threshold for quality child care. However, parents and the public cannot be assured that quality care is actually being provided to children in licensed care without strong provider support services and adequate enforcement techniques in place to be sure that providers are meeting these program requirements.

ENFORCEMENT PROCEDURES

Monitoring. Licensing staff can help providers achieve and maintain compliance with program requirements when legally sound monitoring and enforcement procedures are in place and when they are able to implement strong support and technical assistance programs. Licensing typically uses at least three categories of techniques to enforce licensing program requirements: (1) monitoring; (2) technical assistance; and (3) sanctions. Licensing program requirements are enforced through *monitoring* which takes place during licensing inspections (compliance evaluation visits). During these inspections, licensing staff observe and record what they see to determine whether providers are meeting state licensing program requirements (NARA & NCCIC, 2009). Licensors also inspect facilities as a follow up if the state receives complaints about them; if violations are found, then licensors work with providers to create a corrective action plan.

Problems exist across the nation with the frequency of licensing inspections. For example, in California all licensed care environments – including child care centers and family child care homes – are required to be inspected only once every five years. When facilities are not being inspected on a frequent basis, there is a lower likelihood of implementing program requirements – and a lower likelihood of detecting and correcting non-compliances before they pose a serious risk to children’s health and safety (see Wrigley & Dreby, 2005). Research shows that states with adequate licensing enforcement supports in place, such as more frequent inspections (for example, best practices recommend a minimum of licensing inspections at least once per year; four times per year including inspections by health and fire departments, NACCRRA, 2009; 2010), seem to do better than would be expected by the strength of their regulations alone (see Phillips, Mekos, Scarr, McCartney, & Abbott-Shim, 2000). By doing so, states can assure accountability for programs as well as for the practitioners that operate within such programs.

Differential monitoring. One method some states are using as a strategy to increase the frequency of monitoring inspections for licensed programs is referred to as differential monitoring. Specifically, differential monitoring (also known as “risk assessment monitoring” or “risk based monitoring,” NARA & NCCIC, 2009) is a monitoring technique whereby the frequency of inspections a licensed facility receives varies according to the facility’s compliance history with program requirements. Facilities that exhibit a low level of compliance are inspected more frequently. Typically, states using, or planning to use, differential monitoring are trying to identify and realize licensing efficiencies and to improve consistent enforcement throughout their business processes. Although controversial, the use of differential monitoring as an effective method to improve licensing efficiencies and consistency is growing in its popularity and is currently being considered and/or used by a number of states (see Table 2).

State example: California. Most recently, California has developed a model for differential monitoring of its licensed child care facilities and is currently proposing adoption by the legislature (NACCRRRA National Military Advisory Group Presentation by Gloria Merk, State of California, June, 2010). Once proposed policies are approved, anticipated field testing to assess the feasibility and effectiveness of this approach is scheduled to begin as early as July 2011 (see http://www.myccl.ca.gov/default.asp?b=New_Directions). Given the lack of adequate staffing resources and the extremely reduced funding under which the State of California is operating, the Community Care Licensing (CCLD)'s current Frequency of Inspection Protocol is to conduct compliance inspections of all facilities at least once every five years, and to conduct an annual random sample of 30 percent of facilities. However, due to the ongoing fiscal crisis in California, CCLD has lost 30 percent of the staffing resources necessary to complete the mandated inspections.

To increase health and safety protections for those in its care, without incurring additional staff expenses, CCLD proposes to increase the current frequency of inspections by implementing a new Frequency of Inspection Protocol using a Licensing Indicator System (LIS), which is a differential monitoring approach, called the Health and Safety Compliance Review System. California purports that this newly proposed system will provide CCLD with a reliable method for moving forward with continuous quality improvement and technical assistance, compliance, and enforcement activities with a particular emphasis on increased frequency of inspection for licensed facilities.

Technical assistance. In addition to conducting evaluation inspections while monitoring child care providers, child care licensing staff also support child care providers by offering *technical assistance*. Licensors provide technical assistance to help providers understand and meet the licensing requirements for which they are responsible; to share information about child care safety and health, quality, and child development; to be available for provider questions; and to provide access to information about other state-and locally-funded and administered programs that support child care facilities.

Sanctions. When providers are either unable or unwilling to achieve compliance with licensing requirements within a risk-reasonable amount of time, sanctions are necessary. Sanctions are legally enforceable penalties licensing agencies impose on facilities that fail (typically repeatedly) to meet licensing requirements. Collectively, they constitute options to intervene into unsafe child care situations. They include such actions as: a warning notice/letter; mandated training or other corrective action; fines; reduction in operating capacity; and, closing programs through non-renewal or revocation of the license. A license conveys permission to operate, which is contingent on providing care that complies with requirements intended to ensure that the program is safe and beneficial for children. Imposing consequences on unsafe programs ensures that licensed facilities will come into compliance with state program requirements or will forfeit their license (NARA & NCCIC, 2009).

COMMUNITY EDUCATION AND ENGAGEMENT

Consumer education. Consistently educating consumers on the various roles that licensing staff and programs, providers, parents, and the community play is also important. Consumers must understand “what licensing is” and how various community members play different roles as “the eyes and ears” in helping state child care licensing programs adequately protect children while promoting their development. In addition, licensing programs must educate consumers about their right to publicly accessible, non-confidential regulatory information. This includes internet-based information such as complaints filed against licensed child care providers and compliance histories for licensees.

ECE System participation. Finally, actively participating in early care and education systems helps licensing programs align policies and services with those of their partners where appropriate. For example, strong collaboration among ECE partners and with state licensing programs as either a leader or an integral partner is necessary to develop and promote a system of incentives to recognize or reward child care providers that consistently comply with mandatory as well as voluntary quality program standards. Effective partnerships are likely to increase the chances that such voluntary quality enhancements as quality rating systems and accreditation will be well-publicized, well-understood, and will provide viable options for licensed child care providers willing to implement such program standards.

The characteristics described above constitute the basics for effective child care licensing programs. In contrast, when licensing programs lack these components – are not well-designed, or do not have adequate staff in place to ensure proper practice – children’s safety and well-being can be greatly compromised. As a case in point, failure to properly enforce background check program requirements, in one tragic instance, led to the death of a three-month-old infant in the care of a family child care provider licensed in Georgia who had previously been charged with Child Protective Services violations (NACCRA, 2010). Establishing adequate requirements fortified through training and by agency policies and workloads that ensure sound enforcement – such as monitoring whether licensed providers have been cleared through thorough criminal background checks – equips licensing staff with an array of strategies that could help protect against tragedies such as child death, sexual abuse, and abuse and neglect (see Blank, 1994; Phillips, 1986). The risks of poor quality program standards and enforcement not only may include cumulative detriments to children’s overall developmental potential, but may also put children’s health, safety, and potentially their lives at risk.

In sum, the strength of quality program standards – especially when it comes to child care licensing requirements – often depends upon the capacity and ability to hold programs accountable by adequately monitoring and enforcing those program requirements as well (see Griffin & Fiene, 1995; NACCRA 2009; 2010). Moreover, when licensed programs are not monitored, states have difficulties enforcing their regulations and revoking the licenses of individuals who should not have the privilege of operating state-licensed child care programs (see Gormley, 1997). To have effective

licensing programs, states must design strong quality licensing requirements and have adequate administrative support and staffing to accomplish frequent and appropriate enforcement of those requirements.

STATE VARIATIONS IN LICENSING PROVISIONS

Considerable variation exists among intents of state legislatures for licensed child care program requirements. These intents range from consumer protection to health and safety, to child development, to education, to family employment support, to unique state goals. There are likely a number of different reasons for the variation and inconsistencies in state licensing program standards. The reasons may include issues such as: political barriers within executive and legislative branches; failure to conduct regularly scheduled periodic reviews of regulations or a lack of support for agency regulatory recommendations; resistance to “cost drivers” such as child-staff ratios, group size, and/or space requirements that some providers, state child care council members, and/or legislators are either unable or unwilling to support; and, philosophical differences such as discomfort with the concept of regulation or in acknowledging the abundance of research documenting the need for quality care in children’s earliest years of development (e.g., see http://www.dss.virginia.gov/files/division/olra/cdcc/meeting/minutes/2004/2004-02-12_minutes.pdf and <http://jlarc.state.va.us/Meetings/September04/DayCare.pdf>).

State licensing provisions vary widely—for various reasons, children may not be adequately protected as a result. Despite such wide variation across child care licensing programs throughout the nation, it is common for states to strive for consistency in implementing, monitoring, and enforcing child care licensing practices within their own states. States that are trying to meet best practices may benefit from collaborating with their peers in other states whose regulatory program strategies have been effective under given political and economic conditions in supporting quality program standards and enforcement. In addition, it would serve our nation to establish and implement federal guidelines that require consistent, quality program standards and practices across *every* state so that *all* children—regardless of which state they live in—have the opportunity to access out of home care that adequately protects and promotes their full potential. [SEE APPENDICES AND TABLES FOR STATE EXAMPLES.]

COSTS

States may be asking themselves, “How good is good enough?” (*See Appendix B: Examining Existing Program Standards*). Although some low-and no-cost strategies may exist to help states close the gap between their current licensing programs and how much better they want them to be in the near future (*see Appendix C: State Strategies to Improve Licensing Policies and Practices*), it is clear that there are often costs associated with quality improvements. Due to the financial costs of putting some of these improvements into place, it is equally important that states ask themselves, “What are

the tradeoffs and the long term costs of inaction?” Even during a time when states across our entire nation are experiencing severe cutbacks to staffing and to programs, it is imperative that states focus on core, quality licensing program standards and enforcements to adequately protect children against risks to their health, safety, and well-being.

SUPPORT

State child care licensing programs must have strong support from executive and legislative branches of government at federal and state levels to successfully carry out their mandated responsibilities to protect, safeguard, and nurture children (Pope, 1997). Ensuring that state licensing programs have adequate administrative and financial supports is essential for licensing programs to be effective and to put quality program standards and enforcements into place. The federal government should put child care requirements in place emphasizing the importance of child care licensing and quality improvements. In addition, states must have the political will to craft and apply strong licensing laws with well resourced systems that allow consistent application and enforcement of program standards across all licensed child care programs.

OTHER APPROACHES TO STRENGTHENING QUALITY

CHILDREN’S EARLY LEARNING STANDARDS

Although strengthening licensing requirements and enforcement is likely one of the more effective and efficient ways to boost the quality of care children experiences, other quality enhancement efforts that are connected to state licensing programs may positively influence children’s early learning experiences as well. These include children’s early learning standards (i.e., early learning guidelines) and quality rating systems (i.e., quality rating and improvement systems, QRIS). Children’s early learning standards are concerned with what children need to know and be able to do, typically, by the time they enter kindergarten (Ackerman & Sansanelli, 2010; Kagan & Rigby, 2003). Many states with early learning standards for preschoolers also have early learning standards in place for infants and toddlers. Early learning standards are important as they are used in concert with licensed child care program requirements to improve the quality of children’s education experiences (Neuman & Roskos, 2005; Scott-Little, Kagan, & Frelow, 2003).

State early learning standards and licensing requirements both help practitioners promote young children’s development and yet, although complementary, each of these sets of standards is distinct. In licensing requirements, the primary emphasis is preventing immediate risks to children’s health and safety and preventing cumulative risks to their overall development and well-being. However, the emphasis in most state early learning standards is first and foremost on helping children develop

language and thinking skills. Although different domains of development are addressed through early learning standards, and these may promote children's health and well-being, most states emphasize language and cognitive domains whereas standards within domains of learning and development, such as physical fitness and relationships, are less often emphasized (Scott-Little, Kagan, & Frelow, 2006; see Grolund, 2006).

Most notably, early learning standards are different from licensing requirements because of their *voluntary* nature. Most often, meeting state early learning standards is voluntary and program and practitioner compliance with these standards will not be monitored or enforced with state mandates to protect children against harm. Licensing requirements and enforcement set the foundation for early learning standards to be put into effective practice.

QUALITY RATING AND IMPROVEMENT SYSTEMS

Quality Rating and Improvement Systems (QRIS) comprise another strategy states are using to enhance the quality of care for children and that is rooted in licensing. States began using quality rating systems as a strategy to invest in child care quality mechanisms that have the potential for systemic improvements to child care services. QRIS rates child care programs based on increasing quality program standards. As one of the forerunners of QRIS, North Carolina is considered the model state for how to build QRIS into a licensing system and is one of several states using a rated license as a strategy to incorporate the QRIS star rating directly into the participating program's child care license. In addition, although not necessarily using rated licenses, 23 states require licensure for child care centers to enroll in the first tier of their QRIS, and 19 states have this same licensure requirement for family child care home eligibility.

(See: <http://nccic.acf.hhs.gov/qrresourceguide/index.cfm?do=qrabout>).

The growth of QRIS across states is due, at least in part, to the appealing "ladder design" where programs that voluntarily participate are gradually able to improve over time. The challenge for QRIS is that when states build quality enhancements upon foundations where licensing requirements and/or enforcement are weak, the intended benefits may not be realized. An effective QRIS requires strong quality licensing requirements and enforcement practices, additional licensing and monitoring staff, plus ample program improvement resources for child care programs, to assist providers with meeting higher sets of program standards (see Groginsky, Robinson, & Smith, 1999; GAO-02-897).

POLICY ANALYSIS and STRATEGIES: PRELIMINARY CHILD CARE LICENSING PRINCIPLES

It is clear that quality care that is licensed must be founded on at least two chief components: strong program requirements and strong enforcement. By proposing at least a preliminary set of child care licensing principles for consideration, NARA, which is accepted by the field as the repository for

expertise regarding child care licensing, aims to provide policy makers, licensing staff, and other persons working on behalf of children with a rich, concentrated, ready-to-use resource to guide their work in developing and implementing quality child care licensing regulations, operating processes, and best practices. The licensing principles presented are overarching in nature, and based upon an analysis of evidence-based research, recommended best practices, and examples provided by states that are steadily making improvements to licensing requirements and enforcement. Through licensing regulations, states must effectively communicate what their expectations are for licensed early learning experiences for children – experiences that merely keep children safe and healthy are necessary but not sufficient.

PRINCIPLES FOR CONSIDERATION

To address quality licensing requirements for children adequately, states must take a multi-faceted approach to establishing effective licensing programs with the capacity to promulgate, implement, and enforce quality licensing policies and practices. Three major components – the statute, the regulations, and licensing agency practices – must all work together to support that mission because of the nature of their reciprocal effects on one another. The principles and characteristics of a strong, effective licensing program should include, but not be limited to, those described below.

THE LICENSING STATUTE

The licensing statute, enacted by the legislature, establishes the scope of facilities subject to licensure as well as the scope of authority, responsibilities, and enforcement methods for the licensing agency to administer the law. The provisions of that and other applicable law bind a licensing agency. It is legally obliged to perform duties and responsibilities included in its enabling statute and must conform its regulations and practices to what the law either expressly requires or permits by legally principled interpretation of the law's more broadly stated duties and responsibilities.

The characteristics of a strong licensing statute include but are not limited to:

- No exemptions or definitional exclusions for regularly operating settings that offer supervision/care.
- Clear authority and provisions to investigate and to close illegal operations.
- Appeal rights and processes that apply to adverse enforcement actions.
- Initial and recurring background clearances for caregivers; i.e., fingerprint-based national and state records checks for convictions and founded abuse/neglect/cruelty.
- Authority and direction in enforcement activities such as issuances and complaint response, which may also include frequency, intervals/duration, response times in key activities.

- A basis to use a full continuum of enforcement options, with agency discretion to secure compliance using a range of positive and adverse interventions, from instruction to injunction.

THE LICENSING REQUIREMENTS

The formulation of licensing requirements encompasses not only the content and effectiveness of those requirements but also the use of an open, broadly participative, and transparent process for their development and eventual implementation. The process, which may use an external facilitator, should help convey the message that the licensing requirements are primarily to benefit children, which, in turn, benefits the society at large (both immediately and across children's life-spans), rather than being over-focused, for example, on providers, parents, or licensors. The body of rules and requirements adopted within the statute's intent by the licensing agency establishes the scope and quality of regulatory prescriptions and proscriptions that, collectively, create facilities' physical and social environments. Indicators of strength include but are not limited to the use of:

- *Scheduled reviews of rules every three to four years*, plus event-triggered reviews required to respond to urgent demands.
- *Broad public outreach and consultation in drafting and revising regulations.* The goals of the process are to gather good ideas and information; to create a shared understanding of the needs and issues; to broaden ownership of the resulting regulations across the entire stakeholder community; and, to establish vehicles to keep providers and other stakeholders informed throughout the adoption and eventual implementation phases of the process. The appropriate legislative committees and gubernatorial oversight arm should be kept informed of agency operations as a routine matter but should be kept closely informed of policy options and intentions related to a review and revision of licensing regulations.
- *Regulations that are kept research-based, current, and designed to respond to known public risks and to the strengths and weaknesses in the industry's prevailing conditions.* Regulations should be written with careful attention to organization, clarity, internal consistency, and coordination with other applicable laws/regulations. The document should follow the state's prescribed style⁴ and be easy for readers to understand. Each requirement is a directive and therefore must be enforceable; that is, sufficiently clear and specific for inspectors (and licensees) to determine when it has been met.
- *Requirements that reflect the understanding that the benefits of early learning stem directly from the nature of children's relationships with their caregivers.* Caregivers must know how children learn and be able to foster their optimal development. To accomplish this, the requirements will

⁴ States generally have a Registrar of Regulations to oversee the regulatory development process and to maintain both the state's official *Register of Regulations* and a prescribed "style manual" to help agencies produce clear, consistently well-formatted and well-organized documents that providers and the general public will find easy to use and understand. Requirements must be clear, succinct statements of what is to be done (or not done), when, where, how, by whom. Regulations do not provide the rationale, which instead may be included in the agency's Interpretation Manual when warranted. However, a clearly organized, fully-indexed regulatory document with well-selected section titles and headers does promote an intuitive grasp of the purpose of each requirement while making it easier for users to locate needed information quickly.

also address caregiver and supervisory qualifications in terms of education, demonstrated competencies, and ongoing training access.

- *A body of requirements designed with a holistic focus on child well-being.* Collectively, the body of requirements must work together to create an environment that is safe, healthy, and actively promotes (age/stage/individualized) optimal development across all domains. In addition to protection from immediate health and safety risks associated with children and care-environments, the requirements should ensure activities and interactions that promote: physical well-being and motor development; social and emotional development; motivation and positive approaches toward learning; development of language and communication skills; and development of cognitive/reasoning skills and general knowledge. To promote the reassurance of a sense of unity and continuity for children between home and facility, the regulation should require and invite parental involvement, communication, and parental access to their children's care giving environments.
- *Attention to operational reasonableness and cost considerations*, such as: emphasis on no- or low-cost improvements; including provisions for phasing in new requirements if necessary; and providing, or locating resources in facilities that need to implement improvements or regulatory upgrades.
- *Sound interpretation guides and procedures manuals*, updated as necessary, to help both providers and inspectors to apply the requirements correctly, fairly, and consistently.

THE LICENSING AGENCY

The licensing agency must be structured, staffed, and managed to ensure proper performance of all functions and tasks implicit in and incidental to sound administration of the licensing law and regulations, e.g., operational and enforcement policies and practices, provider and community engagement, and similar key performance areas. The agency's information management system is key to effective and efficient performance in nearly all agency-performed functions. In the context of this paper, note that an up-to-date, accurate electronic database and supporting technology, integrated with other key agencies and with other parts of the early care and education system, are vital linking vehicles to facilitate broad-based assessments, planning, and communication. Strength indicators reflecting best practices for regulatory agency performance include but are not limited to:

- *Adequate funding and executive/legislative support* to operate the agency according to law, policy, and regulatory best practices.
- *Adequate staffing* to support routine monitoring of facilities twice annually (and not less than annually within a rigorous differential monitoring system), increasing to four or more times annually as needed until satisfactory compliance is stable or the facility is closed. The workload standard should be calculated to account for local variables but the average workload for inspectors should not exceed 50-60 facilities.

- *Effective management and leadership* focused on program planning, on management systems and procedures to achieve reciprocal benefits from and among all components and functions, and on research and evaluation to drive program compliance and quality improvement. Methods ensure that actions are correct, timely, thorough, objective, and consistent across the agency; agency uses a systematic, risk-based enforcement decision method.
- *Acquisition and retention of suitably educated, well-qualified regulatory and support services personnel.* Ongoing training in regulatory theory and practice is provided.
- *Systematic methods* to achieve an agency-wide culture built on data-driven continuous learning, a shared vision of performance excellence, and a comprehensive continuous quality improvement function steered by regular assessment, responsive planning, and sound measurements.
- *Effective provider support services* designed to promote providers' knowledge, motivation, compliance, and accountability; the services emphasize compliance-related technical assistance and workforce development.
- *Communication and collaboration systems that maintain coordination with the agency's many stakeholders;* agency performance/activity reports and facility compliance reports are web-available. One goal of the communication and collaboration function is to promote an understanding of the ways in which licensing requirements and their enforcement are the foundation for the community of stakeholders' strivings toward quality supports for optimal development during the powerful window-of-opportunity available in children's early years.
- *Direct linkages to legal counsel and well-defined systems of administrative appeals* that protect the rights of licensees and care-consumers.

AN EXPANDED EXAMINATION OF THE LICENSING ENFORCEMENT FUNCTION

The preceding sections provided an overview of the broad principles and underpinnings of the licensing enforcement function as glimpsed through the three major components of licensing: law, regulatory requirements, and agency administration. Enforcement, however, needs a fuller treatment. Essentially, enforcement is what makes the protection that society promises vulnerable people real and viable. It threads through the entire fabric of a licensing program yet is often the least understood function in licensing, which is, itself, a little-understood governmental responsibility.

Consequently, licensing enforcement is sometimes not only irrationally feared by providers and lawmakers but also resisted – often unconsciously – by some licensors, who typically come from “helping professions” rather than “law enforcement” backgrounds. Moreover, the very nature of human care licensing leads to a logical preference for positive enforcement; that is, achieving compliance through teaching and technical assistance. Experience shows that most providers *want* to “do right by children,” even those who prove not to have the essential skills and resources to be entrusted with their care.

Licensors also know that being able to help providers start and maintain a quality childcare program is a win-win:

- For children and families;
- For providers who get the benefit of considerable coaching and assistance to succeed – and with reduced liability exposure;
- For the economy that gets the benefit of a new business;
- For employers of working parents;
- For schools and other social services that will need to do less remediation as children emerge strong and capable; and,
- For the future economy when those children apply success-directed capabilities, attitudes and skills they developed in their early learning years.

By way of review, this is the broad sketch of enforcement incorporated in the three components:

- *Enforcement begins with Constitutional and statutory law.* There, the rights of citizens and property owners are established, as are the responsibilities and powers vested in a governmental (regulatory) agency to ensure that the legitimate interests of other affected people are also protected. The law also provides licensees with due process and appeal rights in the agency's exercise of regulatory authority.
- *The theme of enforcement (to balance, clarify, and find nexus in those potentially conflicted private/public and consumer/provider interests) continues in the process of establishing regulations.* To gain sufficient support for adoption, a proposed regulation must withstand debate in public hearings and reviews by the legal and administrative bodies assigned that function for the state. To be valid – and able to withstand any subsequent challenges on appeals – a regulation not only must conform to law and reason but also be enforceable in the practical sense (clear, specific, measurable, etc.).
- *Finally, the agency's methods of compliance determination and enforcement must be able to withstand any claim that it has applied a requirement improperly, unfairly, unequally, arbitrarily, etc.* This demand gives rise to many agency functions and responsibilities in such areas as staff development and performance expectations, provider assistance, consumer education, and public access to all of its information that is not specifically restricted by privacy and confidentiality laws. The agency is obliged to inform all parties of their rights and options as well as their responsibilities throughout the licensing process but especially in the event of adverse findings and resulting actions taken against a license/application.

Clearly, whatever authority a licensing agency has is carefully bounded by very familiar legal principles and ethics. Whatever it proposes to do and whatever actions it takes are open to public

scrutiny. And, any adverse action the agency takes against a license⁵ or application is subject to review and ruling by either an administrative law judge (hearing officer) or, in the case of a provider alleged to be operating illegally, a judge in a court of competent jurisdiction.

Continuing to a closer examination of the enforcement function, an agency that is adequately staffed, trained, and funded provides the infrastructure necessary to put strong, quality-directed licensing requirements in place and to appropriately enforce them (see Koch, Collins, & Azer, 2005). A number of well-integrated activities are necessary to enforce licensing requirements that protect the health, safety, and well-being of children (see *NARA Recommended Best Practices for Human Care Regulatory Agencies*, 2009, available at www.naralicensing.org). The preliminary principles and suggestions offered below focus on a subset of seven critical enforcement activities: staff education and training; workload management; enforcement management; compliance monitoring inspections; differential monitoring; provider support and technical assistance; and sanctions (see *Appendix D: Definitions of Enforcement Aspects*).

EXPANDED ENFORCEMENT PRINCIPLES AND SUGGESTIONS FOR CONSIDERATION

Staff Education and Training

1. Ensure licensing staff requirements address staff education and training, as well as knowledge and competencies necessary for licensing staff to perform the enforcement function effectively. Require of all licensors:
 - At least a Bachelor's degree education.
 - Initial and ongoing annual training according to the agency's training plan and individuals' needs-assessments. Content areas include, but are not limited to: licensing theory and practice, the needs of relevant populations in care, facility characteristics, data usage, regulatory writing, etc. Staffs have ongoing responsibility to read and be able to apply new or revised policies and procedures that may not require formal instruction. The agency provides close licensor supervision and regular opportunities for case presentations to promote consistency in methods, practices, and decision-making.
 - Specific job roles in the agency (e.g., supervisors, policy and training specialists, office support staffs, etc.) also have access to appropriately well-developed annual training services because all positions ultimately contribute to the agency's performance, including its enforcement performance.

⁵ Although the recipient of a sanction may feel personally attacked, regulatory theory is quite clear that the agency is taking adverse action against the license (or application), *not* against the licensee or applicant. The agency is assessing compliance, not "judging" the licensee as a person; the concepts of guilt or innocence are not applicable, as they would be in criminal law. This aspect of maintaining the objective/impersonal nature of the "regulatory stance" is explained more fully under the header, "Sanctions."

2. Create a culture of learning through knowledge sharing for licensing staff and licensees
 - Training services meet high standards of quality in adult education design and delivery.
 - Staff development and provider training programs are well planned, monitored and evaluated, respond to identified needs (i.e., existing and emergent), and are integrated into all agency and unit operating plans.

Workload Management

1. Establish and examine:
 - Effective staff-to-facility workload standards
 - Periodically review how the state's unique licensing situation affects key workload variables⁶ that determine the amount of time necessary to adequately monitor and enforce provider compliance with program standards and offer ample technical assistance

Example variables:

- Travel required to and from each facility
 - Number of regulated facilities and the proportion of new to established facilities
 - Number of low-compliance facilities requiring heavier monitoring/assistance and the number being prepared for major sanctions or in active appeal status
 - Number and rate of new and renewal licenses
 - Number and complexity of regulations being applied
2. Limit inspector caseloads to recommended levels if the thorough analysis mentioned above is not established and maintained.

Example: No more than 50 facilities per staff member (NACCRRRA, 2009; 2010; NARA⁷, 2010)

3. Efficient licensing inspections:

Examples:

- Use electronic licensing forms and automated technology solutions
- Use a well-developed risk-based enforcement management system that includes indicators/triggers for increased (differential) monitoring and adverse action
- Consider when the use of an inspection team may be more efficient or effective than a single inspector, such as large facilities or serious/complex complaints

⁶ NARA published a paper on workload assessment methodology, authored by Harold Gazan in 1999, and has listed additional variables in the reader version of its "Recommended Best Practices." Both documents are available at www.naralicensing.org.

⁷ In its *Recommended Best Practices*, NARA recommends that agencies use the calculation method to ensure that workloads are manageable for local conditions. Absent that data, NARA has observed that most agencies without immediately identifiable, problematic peculiarities in local characteristics can usually perform essential tasks acceptably if workloads do not exceed an average range of 50-60 facilities across the complement of inspectors.

Enforcement Management

1. Ensure that enforcement performance methods and expectations are in effect:
 - Maintain close monitoring and regular management review for high-risk cases
 - High risk cases include, but are not limited to:
 - Facilities on enforcement watch due to compliance deficits
 - Forcible closure cases operating during appeals
 - Facilities operating on substandard licenses or on settlement agreements
 - Facilities being sold or closed
2. Specify, in procedures and protocols, triggers for more frequent inspections or contacts for:
 - Facilities with significant compliance issues
 - Facilities that are in or emerging from a sanction
 - Facilities that are undergoing significant changes

Example: Changes in management, structure, or other changes in the business environment, including changes in the care population that could logically destabilize facility operations or portend adverse effects on consumer care
3. Regularly update policies and procedures resources for consistent application and enforcement of the requirements.
4. Establish for each set of licensing requirements, and train/require staff to refer to interpretive guidelines, that clearly state:
 - Intent of each requirement
 - Method to assess compliance with the requirement
 - Threshold of compliance, used to determine whether to cite the facility as *non-compliant*
 - Revise or reinforce the process with:
 - Up-dates as new or altered interpretative guidance is developed, for example, in response to experience with requirements or as new products or methods come on the care scene and raise questions about the applicability of, or options to comply with, a requirement
 - Peer review and presentation of cases
 - Reviews of compliance data for logic and consistency

COMPLIANCE MONITORING INSPECTIONS

Recognize that licensure, monitoring inspections, and enforcement are the most effective ways state licensing programs can ensure children's safety and well-being in licensed child care settings.

1. Frequently monitor programs for compliance with program standards:

- NACCRRRA recommends at least four times per year including health, safety, and fire departments (NACCRRRA, 2009; 2010a; 2010b)
- NARA recommends at least two licensing specific inspections per year (not including inspections by other agencies), with provision for not less than one per year for high compliance facilities if the agency uses an effective differential (risk-based) monitoring system, (NARA Best Practices, 2009)

Example: Agency makes more frequent inspections than would otherwise be required when licensees have problems complying with licensing program standards

- Include unannounced visits
- Ensure licensing decisions and actions are timely, fair, objective, thorough, and recognizably consistent from person to person, and from office to office
- Develop and use available tools that will promote consistency without leading to inflexibility and rigidity that can arise when consistency is confused with uniformity, however.

Example: The agency should have authority to grant stipulated variances to its regulations (or outright waivers, although these should be used even more rarely). Many compliance complications providers experience can be addressed with creative technical assistance. If not, the agency should have a carefully designed process to receive and evaluate a facility's request to meet the *intent* of the requirement by alternative means, subject to the sole approval of the agency director. If used, the agency must establish a data system to track granted deviations to evaluate such variables as consistency, results, need (including changes in the conditions that prompted granting the variance), etc. Well-designed and carefully managed flexibility can be necessary to respond to unique conditions. Supplying conscientious, consistent responses can help to dispel the myths about regulatory rigidity and its ill effects on consumers and businesses.

- Regularly examine and improve review and inspection tools and protocols
- To examine and improve consistency, develop a structured case review system with a mix of methods and reviewers; for example, supervisor, peers in same and different offices, and a mix of case and inspection types (e.g., new facility, regular monitoring, complaint response, etc.)

2. Increase communication with parents and with providers:
 - Make inspection and complaint reports available online (NACCRRRA, 2009a; 2010a); also post parent-focused information about the licensing process
 - Hold regular provider meetings (e.g., 2-4 annually) with time for open dialogue as well as short training or information sessions
3. Consider Differential (Risk-Based) Monitoring methods; use data to:
 - Examine associations between and among specific program requirements, violations, compliance histories and relative risk for licensed facilities, then tailor the scope or frequency of inspections for greater attention to those requirements and facilities. It requires extensive analysis of facility characteristics/profiles to develop a suitable method. The agency must avoid methods that cannot be fully defended as justified and unbiased – and would be well-advised to request a review of its intended policy by legal staff.
 - Perform ongoing assessment of the results not only to identify needed refinements but also because of the inherent risks in this method. The truism “what gets checked is what gets done” applies – and experience shows that many facilities slip into serious non-compliance without the regular reinforcement of inspections and associated coaching. A sound and creative design may overcome some of the inherent pitfalls, but continued evaluation of results is essential.
4. Provider Support and Technical Assistance – Give providers the technical assistance and support necessary to help them understand and meet licensing requirements but in ways that avoid creating dependency on the inspector to find problems or solutions:
 - Share information about child care safety and health, quality, and child development.
 - Connect them with local resources.
 - Monitor their facilities to help make sure they are meeting state licensing requirements.
 - Follow up promptly if the agency gets complaints about licensed facilities and work with them to create plans to come into sustained compliance if the complaint is founded.
 - Be available for their questions.
 - Take action to ensure children are in a safe and healthy environment in accordance with respective state laws and requirements, including those administered by other agencies (see <http://www.del.wa.gov/publications/licensing/docs/ProviderHandbook.pdf>)
 - Provide access to information about other state- and locally-funded and administered programs that support child care facilities.

Example: Licensors can help providers understand why it is necessary to replace, refurbish, or remove window cord blinds (a child entanglement and strangulation hazard), how to do so, and where to get necessary supplies (see http://www.del.wa.gov/publications/licensing/docs/WindowCoverings_QandA.pdf).

Example: Licensors may direct providers to phone numbers, meetings, brochures, and websites about how to access grants to help offset costs of quality improvements such as, but not limited to, child care playground equipment, furniture, and reading materials (e.g., see http://ncchildcare.dhhs.state.nc.us/providers/pv_providres.asp or www.ncsmartstart.org).

SANCTIONS

A license is a covenant between the licensee and the state (representing the people's interests), and both parties are legally and ethically obliged to keep their bargains, commitments, and promises. It is incorrect to view a sanction as "punishment" or as an accusation that the sanctioned provider is a "bad" or "guilty" person. A sanction is simply one of two things: either an action to try to restore (enforce) the terms of the original bargain or an action to terminate a bargain that was not fulfilled.

Inherent in the agency's authority to issue a license is its responsibility to monitor programs to ensure that sanctions are:

- Issued when compliance is not maintained
- Selected according to a systematic risk-assessment model

[Note: The agency is also responsible for managing a process to investigate and suppress illegal operations. Suppression is not a regulatory sanction. It is enforcement of the licensing law, not the regulations. However, for reasons of convenience and expertise, the function is typically assigned to the licensing agency rather than to local law enforcement. Unlike sanctions, suppression cases go directly before a court without an administrative hearing. The sole issue is that the agency has found the facility subject to licensure but operating without a license; the quality of care being offered is not being adjudicated.]

As permitted within statutory provisions and as governed by agency policies, the agency should establish a structured continuum of enforcement to position its use of sanctions (sometimes referred to as a "progressive enforcement system"). The continuum consists of three levels: prevention, intermediate sanctions, and forcible closure sanctions.

Teaching-based, prevention-focused enforcement strategies typically are not viewed as sanctions but instead as (non-appealable) requirements adopted by the agency in its procedural regulations; that is, the licensee need only be generally informed of the agency's rules and operational practices. Some examples are:

- Require posting of all inspection reports and sanction notifications in the facility where current consumers and personnel can readily see them. (This is in addition to cumulatively posting the same or similar information on the Internet.)
- Require applicants or new licensees to take training offered by the agency or to undertake self-study of requirements, with agency confirmation of correct understanding.
- Inspect new facilities frequently and allow more on-site time for technical assistance.
- Require licensee to acknowledge receipt of violation reports and to submit a specific corrective action plan for all but very minor lapses that are easily corrected (often while the inspector is on-site) and that are not indicative of a systemic weakness.
- Use the process to teach the provider to see and address precursor conditions, patterns, and causal relationships in violations as well as to emphasize management accountability.
- Teach the cause-targeted corrective action planning method to prevent recurrence of same or similar violations.

Intermediate sanctions aimed at motivation or deterrence are usually appealable, although the statute may leave the agency sole-discretion in some matters (for example, type/duration of license to issue) or specify an internal-only review if incorporated in a procedural regulation (usually concluded by an agency head decision after prior review by personnel not involved in the original decision). In general, and even if not directly required by the statute, the agency should offer licensees the essence of the legal “right to be heard” in order to access a remedy that is within the administrative agency’s authority to grant, for example, a supervisory review of a finding the licensee disputes. This is both proper within administrative law and is an important demonstration of the agency’s commitment to such fundamental democratic values as fairness, objectivity, and the right to due process. Some tools to consider are:

- A risk-based system or method to guide selection from the available array of intermediate sanctions according to the extent of risk inherent in violating a given requirement.
- A point-system for violations that ties to ranges in monetary penalties, based at least in part on a theory of negating fiscal gains from allowing conditions that underlie violations, such as insufficient or insufficiently trained personnel or dangerously outworn equipment. The system should include a point-range where the risk-level is unacceptable and only termination of the license is considered. (Violation risks can be point-weighted along such variables as severity, speed-to-impact, numbers of children impacted, whether violations are narrowly focused or so widespread as to suggest management breakdown, pattern of repetition, inability to sustain compliance, etc.)
- Another intermediate option might be issuance of a provisional/probationary status license; that is, a short-term “impaired status” license that will be followed by termination unless the facility qualifies for a regular license. This gives notice to the provider and customers that conditions are unsatisfactory and, absent prompt correction, forcible closure action will soon follow. (Depending on the law, a provisional/probationary license, per se, might not be appealable (if issued when a

regular license is expiring, or might only qualify for a truncated administrative review/appeal of particular violations.)

- A temporary reduction in capacity until a serious condition is remedied if doing so would reduce risk to an acceptable level while the operator pursues full correction)

Forcible closure sanctions are always subject to formal appeal provisions because the licensee has acquired, and is threatened with loss of, a property right represented in the license. The sanctions do, however, include some gradations that the agency may consider in light of the level of risk and the time normally required to execute them. (Recall that the suppression of illegal operations is not a sanction.)

- The agency may refuse renewal of an expiring license
- The agency may revoke a license during its effective dates.
- The agency may seek an emergency suspension/closure action, which will require access to an expedited process for any appeal of the requested suspension as well as the permanent closure case that would follow. The agency must be prepared to prove that the risk to children is both very high and imminent, such that it would be imprudent to allow the facility to remain in operation during a normal appeal process.

[Note: In the course of forcible closure actions, the licensee may offer a “settlement agreement” in lieu of closure. The agency (usually through its attorney) may (but is not obliged to) entertain the offer, to negotiate more acceptable conditions, or to accept an offer. The agency must evaluate the immediacy of risk to children as well as the capability and sincerity of the licensee in deciding whether to accept or to decline. Settlement agreements normally connote some degree of acknowledgment by the licensee of serious non-compliance and commit the licensee to strong efforts to achieve full compliance quickly; that is, settlement agreements often go well beyond what is ordinarily required in the regulations. They also commit the agency to follow up with close oversight of performance and additional inspections to confirm sustained success.]

SOME CAUTIONARY NOTES ON PROGRESSIVE ENFORCEMENT SYSTEMS

- The agency must ensure that both licensees and licensors fully understand that the use of a continuum of progressively severe responses does not commit the agency to use them step-wise. A single incident may give evidence of a failure in judgment and responsibility so egregious that the agency cannot responsibly consider intermediate sanctions. A licensing agency has both the right and the responsibility to move directly to forcible closure action when providers are unable or unwilling to comply with requirements designed to protect the health, safety, and developmental well-being of children.

- Similarly, the system must be designed (and communicated) as a way to structure the process for more consistent exercise of professional judgment and decision-making at the organizational level. However, it is not intended, nor is it feasible, to try to replace professional judgment with a rigid formula. For example, if violations are weighted to determine amounts for fiscal sanctions, point-ranges should tie to penalty-brackets. This will increase decision-consistency and transparency while also allowing the decision-makers some (narrowed) latitude to take into account the different case circumstances typically found in real-life cases: history, attitudes, patterns, contributing circumstances, etc.

CONCLUSIONS

This paper recognizes strong licensing programs as offering one of the more critical and strategic sets of legally enforceable child care program requirements states have to adequately protect and nurture a significant number of young children while promoting their optimal development in out-of-home care. Converging events have posed dramatic challenges and opportunities that have not been conceptualized or addressed adequately at either national or state levels. With respect to child care regulatory practices, some key forces in motion are:

- Rapid growth in the demand for child care as maternal employment surged.
- An undetermined number of children in care that is either unregulated or is regulated by a method even less robust and reliable than licensure.
- Few states staffed or otherwise empowered to promulgate and enforce strong licensing requirements.
- Expanded knowledge, not yet fully applied, from accelerated research in brain development. Particularly relevant are findings related to the influence of adult interaction during the first five years and, specifically, the strong link between early brain development and readiness to succeed in school and in later life. Repeated findings are that the quality of children's child care experiences is generally well below that needed for school-readiness and optimal development.

Parents need to know that they can rely on state licensing programs to monitor and enforce quality child care that is licensed to protect their young children while promoting their learning and development, particularly for the many young children in out-of-home child care settings before entering kindergarten. However, the lack of specific federal program requirements or guidelines for child care quality compliance, combined with the enforcement challenges state licensing programs currently face, results in considerable variation and deficits across states.

Clear guidance is offered here for states' consideration of how to improve the quality of their program requirements and enforcement for licensed child care. The principles presented suggest that

states use a multi-faceted approach to establish effective licensing programs with strong program quality requirements and strong enforcement. The principles and suggestions presented are based on research, recommended practices, and current examples of what is working well in state licensing programs. These principles should serve as a resource to states as they seek to examine and narrow the gap between existing mandatory program requirements and higher quality but voluntary program standards, such as state early learning standards and quality rating systems, throughout ECE systems. Specifically, states will be able to identify strengths, weaknesses, and inconsistencies within their licensing programs. In addition, this work should help policy makers and licensing administrators consider licensing program requirements and enforcement principles that can guide child care regulatory operations in a systematic manner, rather than investing in a collection of incremental initiatives that further fragment and weaken attempts to improve the overall quality of early learning experiences for children.

The hope is that these principles will be used to help review, revise, promulgate, and enforce an integrated set of model regulatory policies and practices that aim to boost the quality of children's health, safety, and development throughout their early learning experiences in licensed care.

Moreover, arguments presented in this paper support a vision of effective licensing programs, buttressed by increased administrative and financial support, that are capable of implementing stronger licensing requirements and enforcement. If the nation stops short of that vision, it will not adequately protect and promote the development of the children who embody all our national hopes of achievement and leadership required for the demanding future that will soon pass into their hands.

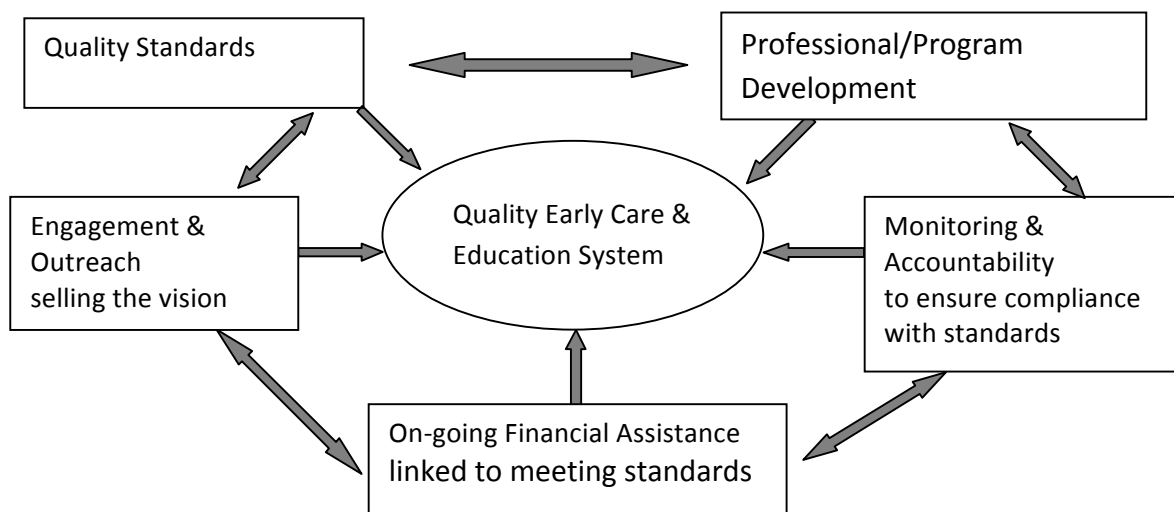
APPENDICES

APPENDIX A: EARLY CARE AND EDUCATION SYSTEMS DEVELOPMENT

One significant early learning policy question that state leaders continue to grapple with is how best to “move the needle” on increasing the quality of care, especially for the most vulnerable children, while leveraging federal and state dollars to make a measurable impact on child outcomes – and to do so before they reach kindergarten. While considering how best to create a menu of services including policy mandates as well as policy incentives, several states have taken a systems approach to tackle this issue, and many have relied upon Mitchell and Stoney’s “Alliance model” of a quality early care and education system (2005). The model includes many inter-related pieces necessary to strengthen the entire ECE system. Specifically, states have used this approach as a guide to help them align existing subsystems and to identify gaps in funding and services.

All of the pieces of the model are, of course essential to building a quality ECE system.

Figure 1: QUALITY EARLY CARE AND EDUCATION SYSTEM



Adapted from Mitchell & Stoney, 2005; Alliance for Early Childhood Finance: A Model Early Care and Education System Design

Two state examples using components within the Alliance model to improve their ECE system quality are Pennsylvania and North Carolina. To guide its work on early childhood system reform, the Pennsylvania BUILD initiative used the Alliance model. The team began by detailing each of the pieces of the model: Quality Standards; Professional/Program Development; Monitoring and Accountability; Financial Assistance; and Engagement and Outreach. For the Quality Standards piece, they outlined all of the program and practitioner standards that were used by any part of the early care and education system in any part of the state. They followed the same process for each of the

remaining pieces of the model, identifying each subsystem throughout (e.g., Professional/Program Development; Monitoring and Accountability; etc). In addition, when identifying all forms of financial assistance, the team also included information regarding whether that assistance was explicitly linked to compliance with quality program standards (e.g., licensing). The team followed this exercise by working on how they would implement a coordinated, quality ECE system, ensuring alignment within each piece of the model. One example is their latest approach to Professional/Program Development, “Keys to Quality,” which is purposely linked to the Pennsylvania quality rating system (Keystone Stars) (Mitchell & Stoney, 2005). These are, of course, inextricably tied to child care licensing program standards, which also underwent improvements.

Since 2006, Pennsylvania (PA) has strengthened its Quality Standards – and this intentionally includes its licensing program standards and oversight. By creating a diverse and inclusive workgroup of stakeholders, (e.g., providers, parents, advocates, contractors) and agency partners (e.g., other Commonwealth agencies as well as staff within the Department of Public Welfare) and working with legislative committees throughout the development process, Pennsylvania was able to successfully amend regulations for child care centers, group child care homes, and family child care homes in 2008. In addition, state administrators worked hard to ensure thorough communication and support about new policy mandates with its partners across the early care and education system who typically implement policy incentives including training, technical assistance, the subsidy program, provider organizations and professional development. For example, three critical partners in reinforcing quality licensing program standards are the Pennsylvania Key, that facilitates professional development opportunities and a variety of services for child care providers, Regional Keys that oversee the Keystone STARS quality program (Pennsylvania’s Quality Rating System), and Child Care Information Service Agencies that communicate with providers who participate in the child care subsidy program and provider organizations (personal communication with Jennifer Lau, State of Pennsylvania, July 6, 2010). Pennsylvania’s system reform work has resulted in an innovative mix of policy mandates as well as policy incentives that have increased its overall quality in licensing (NACCRRRA 2007 and 2009; NARA & NCCIC, 2009) as well as throughout its early care and education system (Bruner & Wright, 2009).

North Carolina used the model to design its system and subsequently evaluated the effects of its Professional/Program Development and Financial Assistance mechanisms to ensure they were adequately supporting child care programs striving to improve their licensing quality through participation in the improved quality system. In North Carolina, these Support functions are referred to as “Smart Start activities.” Smart Start activities include enhanced subsidies for higher child care quality or higher teacher education; license upgrades; technical assistance; quality improvement and facility grants; teacher education scholarships; and teacher salary supplements. Researchers found that the quality of licensed child care significantly increased from 1994 to 1999. In fact, twice as many centers in 1999 compared to 1994 scored in the “good to excellent” quality range. Not surprisingly the number of teachers (i.e., caregivers) participating in programs to obtain more education increased as well as the number of teachers having some college coursework. In addition,

the percentage of centers licensed at higher levels and the percentage of nationally accredited centers increased. Another important finding was that tiered reimbursement levels were positively related to participation in Smart Start. That is, the greater a program's participation in Smart Start support activities, the greater financial reimbursement they received for providing care for low-income children who receive subsidies. Finally, median teacher turnover remained steady at 17-20 percent, and group sizes and teacher-child ratios have remained fairly constant. An unexpected finding was that extensive previous participation in Smart Start did not guarantee that a center's current quality was high (GAO-02-897). Smart Start activities in North Carolina were largely successful at increasing overall child care quality in participating programs but ongoing systemic support was necessary to sustain increased quality. Through its innovative approach, not only has North Carolina improved the quality of care—and especially licensed care for children who receive subsidies— but it also has created an awareness of quality among parents, likely increasing the demand for such quality as well.

Overall, states such as Pennsylvania and North Carolina have used this model as a guide to help them examine each piece of their ECE system. Upon doing so, they were able to successfully improve segments of the system while integrating such pieces in a way that is strengthening the quality of their early care and education systems as a whole.

APPENDIX B: EXAMINING EXISTING PROGRAM REQUIREMENTS

One thing all states must do is create and enforce licensing requirements as the threshold of essential quality that each of their licensed programs must meet. States, and even cities, can successfully accomplish this task by asking how far away the quality of their existing licensing program standards and enforcement are from recommended best practices or “how good is good enough?” Once states have successfully answered these questions, they can then take action to narrow the gap between what they currently have in place what they need to put into place to protect and promote the development of children in quality child care settings that are licensed.

In-Depth Case Study: New York City. On a large-scale local level, New York City recently asked itself a set of similar questions. Largely due to accidents and child deaths, negative press, and pressure from families, new State and City laws were designed to protect children in care (Citizens Committee for Children of New York, CCC, 2004). In a report examining the monitoring and oversight of programs in New York City, Citizens Committee for Children of New York convened a Taskforce on the Quality Oversight of Child Care (i.e., Taskforce). The CCC Taskforce developed a questionnaire and asked center-based and family child care providers about their experiences with their local child care licensing agency. Seven areas were of key interest: licensing and oversight, staff screening, staff recruitment, qualifications and training, child health, facilities, and materials. In particular, the Taskforce was interested in health and safety regulations, provider experiences with compliance, the nature and availability of the local licensing agency’s technical assistance, provider and staff access to training and professional development activities, and whether additional provider support was necessary. The goal of the Taskforce was to make recommendations about how agencies in cities and states across the nation can strengthen the ability of licensed child care center and family child care home providers to offer quality child care (CCC, 2004).

The CCC’s study showed that providers reported inspections that were often delayed, and programs often operated with expired licenses while waiting for required paperwork and/or inspections. On a program level, providers reported that monitoring visits were inconsistent in terms of what individual licensors inspected but that each visit was thorough. Family child care providers reported that licensing visits often left them confused about licensors’ interpretations of child care program standards, and these same providers requested increased access to information and technical assistance to clarify these discrepancies. When it came to training, the study found that existing providers and staff had actually acquired more than the minimum level of mandatory training and wanted additional professional opportunities. Notably, however, providers expressed concern about whether they could afford to support staff (or themselves) with additional training opportunities due to costs, as difficulty recruiting and retaining qualified staff was a common theme. Child care center providers and staff consistently reported that a lack of funds presented challenges across a number of areas, including the ability to afford necessary materials and repairs. Finally, information technology was a concern as the City licensing agency’s outdated database of programs and providers risked putting additional strain on program funding. To this end, family child care providers reported being

worried about delayed payments from the City for child care provided to children who receive child care subsidies, and also about the provider's own eligibility to receive federal subsidies via the Child and Adult Care Food Program (CACFP) (CCC, 2004).

These findings suggested the need to strengthen oversight and technical assistance provided by the City's licensing agency. Specifically, recommendations to strengthen the Bureau of Day Care's infrastructure included recommendations to hire additional staff (i.e., reduce number of cases per licenser) and to use existing staff in better, more efficient ways. Implementing these recommended changes should enable the licensing agency to conduct timely inspections, keep registrations and licenses current, and provide technical assistance as necessary. Further, CCC recommended that the agency develop a time-sensitive, comprehensive quality improvement plan to improve the oversight and monitoring of child care programs, including elements associated with enforcement performance management, work process improvement and a staffing plan to successfully implement mandates specified in the most recent law, the Quality Child Care and Protection Act. Improved coordination within and between government agencies is also necessary to better execute shared monitoring responsibilities across multiple agencies. Finally, financing impacting child care quality must be accomplished through systemic investments at City and State levels, as results of an underfunded system (i.e., low wages and high staff turnover) have a negative impact on child care quality in New York City (CCC, 2004).

Studies such as this underscore the importance of strong child care regulations—including oversight and monitoring—to ensure child care quality in out of home settings. In sum, by equipping licensing programs with the administrative and financial support they need to be effective, states—and even cities—are beginning to significantly improve the strength and quality of their child care licensing program standards and enforcement.

APPENDIX C: STATE STRATEGIES FOR IMPROVING LICENSING POLICIES AND PRACTICES

Despite challenges states may face while trying to promulgate, implement, and enforce quality licensing program standards, a number of states have used innovative methods to successfully augment their regulatory processes in an effort to strengthen their program standards and enforcement practices, elevating the overall quality of their ECE systems. Leveraging the participatory APA process (previously described in this section) to include methods such as the use of data-based projected impacts, consensus-based approaches, and intentional communication with partners are proving to be successful strategies for proposing and promulgating rules governing strong licensing program standards. At the same time, using phased-in time frames and, at times, grandfathering approaches appear to make approval of proposed program standards and their subsequent implementation successful. Methods to successfully monitor and enforce such strong program standards include differential monitoring (e.g., use of risk assessment tools), as well as obtaining legal authority to exercise a wider variety of progressive adverse enforcement actions.

Although not every state using such methods necessarily ranks in the current “top 10” in the nation for its overall ratings in licensing requirements and oversight of either child care center or family child care homes, some states are near the top of the list and other states also have been working hard to notably improve their overall policy and practice score ratings, steadily increasing the quality of child care they license as a result (see NACCRRA, 2007; 2008; 2009; 2010). For example, states such as New Jersey, Pennsylvania, Tennessee, and Washington have used a variety of effective techniques to bolster their licensing programs over the past few years, whether for one specific type of licensed care, a combination of care types, or all licensed care. In addition, the state of California is currently proposing significant improvements to its licensing program standards and enforcement practices for all licensed child care facilities. The state of Ohio has also recently recognized the need to strengthen its regulatory system as the foundation upon which to continue building its Bureau of Child Care and Development programs that support licensed child care quality and school readiness, and plans to do so by strengthening licensing enforcement standards and practices, as well as by increasing communication with providers and with parents.

STATE STRATEGIES TO STRENGTHEN LICENSING REQUIREMENTS AND ENFORCEMENT

Note – In the examples that follow, states received a zero from NACCRRA because they do not inspect or visit family child care homes prior to issuing a license. The score these states otherwise would have received, if applicable, is listed below the zero.

State	Policy strategies	Practice strategies																		
New Jersey Overall NACCRRA ratings & rankings: Child Care Center <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2007</td><td>50%</td><td>22</td></tr> <tr> <td>2009</td><td>57%</td><td>28</td></tr> </table> Family Child Care * <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2008</td><td>0%</td><td>52</td></tr> <tr> <td>2010</td><td>0%</td><td>52</td></tr> </table> Note: voluntary licensing only		Rating	Ranking	2007	50%	22	2009	57%	28		Rating	Ranking	2008	0%	52	2010	0%	52	• Provider surveys to create data-based, estimated projected cost impacts • Statewide presentations & technical assistance workshops before adoption & after implementation of newly adopted regulations	• Communication with providers about changes & effective dates prior to implementation
	Rating	Ranking																		
2007	50%	22																		
2009	57%	28																		
	Rating	Ranking																		
2008	0%	52																		
2010	0%	52																		

State	Policy Strategies	Practice Strategies																		
Washington Overall NACCRRRA ratings & rankings: Child Care Center <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2007</td><td>59%</td><td>4</td></tr> <tr> <td>2009</td><td>65%</td><td>9</td></tr> </table> Family Child Care <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2008</td><td>74%</td><td>2</td></tr> <tr> <td>2010</td><td>74%</td><td>3</td></tr> </table>		Rating	Ranking	2007	59%	4	2009	65%	9		Rating	Ranking	2008	74%	2	2010	74%	3	- Consensus-based, partnership approach (i.e., via Negotiated Rule Making) to formulate proposed program standards prior to adoption; use of facilitator - Selection of mainly low- or no-cost program standards to amend	- Written communication, interpretive guide & training to increase consistency of licensor & provider interpretation of regulations - Electronic licensing forms to increase licensing efficiencies
	Rating	Ranking																		
2007	59%	4																		
2009	65%	9																		
	Rating	Ranking																		
2008	74%	2																		
2010	74%	3																		

Washington is finalizing its proposed, consensus-based regulations. As of July 2010 these have not yet been implemented.

State	Policy Strategies	Practice Strategies																		
Tennessee Overall NACCRRRA ratings & rankings: Child Care Center <table> <tr> <th></th><th>Rating</th><th>Ranking</th></tr> <tr> <td>2007</td><td>55%</td><td>7</td></tr> <tr> <td>2009</td><td>71%</td><td>3</td></tr> </table> Family Child Care <table> <tr> <th></th><th>Rating</th><th>Ranking</th></tr> <tr> <td>2008</td><td>34%</td><td>23</td></tr> <tr> <td>2010</td><td>43%</td><td>14</td></tr> </table>		Rating	Ranking	2007	55%	7	2009	71%	3		Rating	Ranking	2008	34%	23	2010	43%	14	Consensus-based, partnership approach to formulate proposed program standards prior to adoption	- Increased frequency of monitoring visits - Intensive, ongoing training for staff, providers, & partners to increase consistency of understanding & implementation - Differential monitoring - Case review (e.g., quality improvement) process - Bonus payments for compliance with increased quality - Phased-in implementation for cost-incurring, increased quality program standards - Technical assistance for providers to generate low- or no-cost compliance solutions
	Rating	Ranking																		
2007	55%	7																		
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Pennsylvania Overall NACCRRA ratings & rankings: Child Care Center <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2007</td><td>53%</td><td>15</td></tr> <tr> <td>2009</td><td>61%</td><td>16</td></tr> </table> Family Child Care <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2008</td><td>0% (27)</td><td>45</td></tr> <tr> <td>2010</td><td>0% (25)</td><td>42</td></tr> </table>		Rating	Ranking	2007	53%	15	2009	61%	16		Rating	Ranking	2008	0% (27)	45	2010	0% (25)	42	- Consensus-based, partnership approach to formulate proposed program standards prior to adoption - Intentional, ongoing communication with legislative committees regarding intentions - Selection of low- or no-cost program standards to amend	- Grandfathering provisions & phased-in approaches to minimize cost impact - Data-based list serves to electronically communicate with all providers
	Rating	Ranking																		
2007	53%	15																		
2009	61%	16																		
	Rating	Ranking																		
2008	0% (27)	45																		
2010	0% (25)	42																		

State	Policy Strategies	Practice Strategies																		
California Overall NACCRRA ratings & rankings: Child Care Center <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2007</td><td>36%</td><td>47</td></tr> <tr> <td>2009</td><td>41%</td><td>48</td></tr> </table> Family Child Care <table> <tr> <td></td><td>Rating</td><td>Ranking</td></tr> <tr> <td>2008</td><td>42%</td><td>15</td></tr> <tr> <td>2010</td><td>37%</td><td>23</td></tr> </table>		Rating	Ranking	2007	36%	47	2009	41%	48		Rating	Ranking	2008	42%	15	2010	37%	23	Development of more efficient inspections: Licensing Indicator System, “Health & Safety Compliance Review” tools & practices	- Differential monitoring - Increased frequency of monitoring (i.e., compliance) inspections
	Rating	Ranking																		
2007	36%	47																		
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	Rating	Ranking																		
2008	42%	15																		
2010	37%	23																		

California is proposing these strategies for adoption and approval by the state legislature; June 2010.

WHAT IS WORKING? QUESTIONS FOR EXEMPLARY STATE STRATEGIES

To better understand what is working for these states and the specific policy and practice strategies they used to strengthen their licensing program requirements and/or enforcement, NARA recently reached out to a number of state licensing administrators included in this sub-sample of states using such exemplary strategies.

State administrators were contacted by telephone and/or email in June of 2010 and sent a set of 10 questions addressing three overarching, licensing focus areas: policy, enforcement, and costs.

Answers pertained to: a specific set of licensed programs (e.g., only child care centers); a combination of programs (e.g., child care centers and small family child care homes); or all licensed facilities (e.g., child care centers, family child care homes, and group homes). Licensing and/or quality improvement staff and administrators used the questionnaire to share their perspectives about what is working for them in their states and why. The items included in the questionnaire follow:

Policy

- What are the incremental steps you have taken to strengthen your licensing program standards (rules, requirements, regulations) and any other applicable policies? How did you do it?
- What are the lessons that you learned?
- What, if anything, do you wish you had done differently?
- Which aspects of the licensing system were the most difficult to change? Why?
- Which aspects of the licensing system were the most difficult to get up to speed/up to scale (statewide)? Why?

Enforcement

- What are some ideas to approach oversight aspect of these program standards? That is, how will you (or have you) implemented these new, stronger program requirements?
- Is your implementation of these new, stronger program regulations different than it was before you were able to strengthen them? If so, how?
- Are you using a unique approach, such as a “risk assessment strategy” (or differential monitoring) to enforce these program requirements?
- If so, what does that look like in your state?

Cost

- Certain structural program requirements, such as teacher-child ratio and group size, are typically considered “high cost drivers” for providers. If you strengthened any program requirements with projected cost impacts, how were you able to do this?
- Did your program requirements and enforcement improvement include any low-cost or no-cost strategies?
- If so, what were these and how did you implement them?

New Jersey

New Jersey’s Department of Children and Families, Office of Licensing, for example, recently strengthened its licensing requirements for child care centers. To do so, the state took incremental steps including the following: soliciting and receiving recommendations from licensing staff; sending surveys to child care centers to assess their anticipated impact of the some of the proposed changes; inviting affected constituents (i.e., providers) to participate in an Ad Hoc workgroup; and conducting statewide presentations and technical assistance workshops prior to the adoption, and after implementation, of the new regulations. New Jersey learned that using this process to approach the development, proposal, and promulgation of strong licensing program requirements was successful and intends to repeat this process in the future (email communication with Gary Sefchik, State of New Jersey, June 30, 2010).

Staff in New Jersey recognized that the overall increase of more stringent requirements such as credentialed staffing and staff development for licensed child care centers was the most difficult to change due to the high rate of staff turnover within and across centers and the anticipated financial impact on them. This was also the licensing requirement that was most difficult to get up to scale statewide, and this was particularly the case as it pertained to center directors.

With regard to enforcement, New Jersey’s ideas to implement these new, stronger program requirements included notification of all licensed centers of the ensuing changes and effective dates. However, no changes were made to the way in which New Jersey approached its oversight or implementation of the new program requirements. That is, compliance violations observed during monitoring inspections were cited accordingly. The State of New Jersey does not currently use any differential monitoring techniques but inspects centers every three years at the time of the center’s renewal and conducts investigations when allegations are made about possible noncompliance with licensing requirement. (For more information, please see: www.state.nj.us/dcf/divisions/licensing/).

Strategies to adequately address improvements to program requirements that are associated with costs included the use of constituent surveys. New Jersey contacted potentially affected constituents

and asked them to provide detailed information pertaining to the staff-to-child ratios they currently had in place in their licensed child care centers. The state then compiled and examined the data and, as a result, determined the previously estimated cost impact would not be as severe as anticipated since many centers already voluntarily maintained or exceeded the proposed staff-to-child ratios prior to the proposed strong requirement being mandated. Finally, to ensure that providers would have adequate access to information and support without incurring additional and potentially unnecessary expenses, licensing staff conducted statewide presentations and technical assistance workshops prior to and after implementing the new regulations.

Washington

Washington State has been steadily working with its partners to improve licensing program requirements for family child care homes. From January of 2007 through December of 2009, the Washington State Department of Early Learning (DEL) engaged in a legislatively-mandated, consensus-based process (called a negotiated rule making process, NRM) to draft these proposed program requirements. NRM is a process intended to solicit broad input from parents, child care providers, health and safety experts, licensing staff, and other interested stakeholders (e.g., family child care union representatives; advocates) about issues that affect the health, safety, and quality of the family home child care environment. The NRM process will lead Washington to requirements that are easily understood so that both licensors and providers will have clear ideas about what is expected to successfully comply with the program requirements

(See <http://www.del.wa.gov/laws/development/negotiated.aspx>).

To proceed with the NRM process, DEL identified 30 key participants who met every six to eight weeks to complete the foundational work necessary to draft proposed regulations affecting licensed family child care homes. Each participant also was part of a sub-committee that met at least two times each month. The NRM team determined that the recommendations would be divided into 13 topic areas and also established a framework of guiding principles for the process. The framework had a child-centered focus, meaning all decisions were based on the question, “What is best for children in family home child care settings?” The sub-committees took a topic and determined which regulations were needed based upon an examination of current Washington regulations, comparisons with other states’ rules, evidence-based research, discussion, and input from subject matter experts (email communication with Robert McLellan, State of Washington, July 6, 2010).

Washington reports having learned that when taking on a new approach to rule writing, involving a consensus-based approach, participants can expect all members to bring their own experiences and individual passions to the work. To stay focused on the timelines and final product, Washington used an experienced facilitator who helped with the consensus-based process. The facilitator helped move

along discussions if and when they stalled; or redirected the group on the child-centered focus if the conversation strayed.

In terms of recommendations for how states in similar situations might do things differently, Washington would have fully prepared meeting protocol and expectations prior to the beginning of the NRM process. Building these protocols and expectations as part of the process resulted in a substantial amount of time being spent on “housekeeping” issues, which take away from the initial effectiveness and efficiency of the group in developing recommendations for the proposed requirements. To fully prepare meeting protocols, DEL would have begun the process by placing stronger emphasis on program requirements that would *not* be on the table for negotiations. Specifically, these would have included regulations that globally spanned different categories of child care licenses such as: background checks, enforcement action, and any language contained within a statute that directs specific action or compliance.

The NRM approach was a completely new rule-writing approach for Washington and, as a result, proved to be difficult. DEL used its existing rules as a resource, and decided *not* to simply rewrite and revise each one – effectively challenging the process of past rule revisions. However, given the comprehensive examinations of the program requirements that the NRM team and each sub-committee conducted, it proved to be successful in the end.

Some aspects of the NRM process proved to be more difficult than others in terms of getting up to speed. For example, defining licensed versus unlicensed space and the impact of such definitions was particularly challenging. There was also tremendous discussion on safety around bodies of water and what should be regulated. Each of these topics of discussion was enlivened due to the great impact it would have on licensed family child care providers. In addition, the discussion on bodies of water was particularly passionate because of the link between recent child deaths and bodies of water near licensed providers in Washington State.

Ideas to approach oversight aspects of these new, stronger program regulations include training, communication, and an interpretative guide. DEL will conduct intensive training for its licensors as well as its licensed family child care home providers. Following adoption of the final requirements in 2010, Washington also will communicate with providers and develop a written interpretative guide to provide a common ground for the routine interpretation of the regulations for both the licensors and the providers. DEL believes these implementation strategies will strengthen licensing practices for all parties, beyond what simply putting the regulations into effect could accomplish.

Washington currently makes use of standard approaches to enforcement, with in-depth family child care home renewals occurring every three years, and monitoring visits occurring at least every year for child care centers, and every 18 months for family child care homes. Enforcement of program requirements is based upon indicator checklists. However, Washington is currently moving toward developing and implementing licensing efficiencies through the use of electronic licensing forms. DEL is also exploring incremental implementation of non-expiring licenses, risk-based modeling, weighted

regulations, and differential enhanced monitoring. Differential enhanced monitoring is monitoring that does not drop below a minimum threshold but provides additional monitoring, technical assistance, and coaching to sites that perform below requirements identified in the risk-based model.

DEL also considered cost when revising its licensing program requirements and practices. The majority of the work completed in Washington's NRM process involved mainly cost-neutral approaches for both the family child care provider and for the state. Washington law requires an economic impact study to be completed for rules that contain "high cost" drivers. To date, some of the areas that may require such a study include: pre-service training requirements, water well testing requirements, and septic testing requirements. (*Note:* As of July, 2010, Washington is currently moving toward formal adoption of these proposed rules but has not yet completed the public hearing process).

Tennessee

Tennessee addressed policy changes to its licensing program by responding to unsafe situations that led to child deaths by changes in legislation and by incorporating best practices into its program standards for child care centers as well as small and large family child care homes (email communication with Barbara Wall, State of Tennessee, July 14, 2010). After receiving training and consultation many years ago from a NARA consultant, the late Norris Class, licensing staff began to better understand and recognize their critical role as licensors in protecting the health, safety, and well-being of children. With an explosion of the demand for child care as a result of Welfare Reform and complementary child care subsidy usage, a critical need emerged to exercise stronger and more consistent enforcement of regulations that providers needed to meet to better protect, nurture, and educate children in their care.

Massive changes to child care laws in Tennessee passed through legislation in 2000, paving the way for stronger licensing requirements and procedures. Changes brought about in that law include: the implementation of criminal background checks; rated licensing requirements and report cards; more stringent staff-to-child ratios; additional monitoring by licensing staff; more comprehensive enforcement options; required annual environment assessments; increased licensing fees; and, insurance requirements. At the same time this legislation passed, new bonus payments were offered to providers serving subsidized children, with incrementally higher bonus payments made based upon the program's quality rating (see http://tennessee.gov/humanserv/adfam/cc_main.html).

Since that time, Tennessee has used a consensus-based approach to develop, propose, and promulgate its licensing requirements. Licensing staff report that their lessons learned include the multiple benefits of including providers and other state and community partners into the process of developing licensing requirements. Bringing Tennessee providers and partners into the process not

only allows for input from their unique perspectives but also allows for joint ownership of the program requirements that will govern their businesses. The partnership approach promotes better understanding of the “why” behind the rules and their connections to the health, safety, and well-being of children. Including all partners in the promulgation of licensing rules early and in a meaningful, intensive way also benefits the state and its ability to identify problems or unintended consequences in a timely manner.

APPENDIX D: IN-DEPTH STATE EXAMPLES

Tennessee

Keys to strengthening licensing standards and practices in Tennessee included the following:

Action Steps

- Increased the number of licensing supervisors and licensing evaluators statewide
- Reduced caseload per licensing evaluator
- Increased number of required monitoring visits per year
- Developed criteria for a required licensing report card with input from providers, other government agencies, community and state partners, child advocates, child care resource and referral agencies, and licensing staff
- Promulgated new rules
- Began environmental assessment of each required child care facility (i.e., agency) annually
- Developed a statewide child care resource and referral network for providers
- Developed training for providers that was at no cost to the provider
- Increased accountability throughout the licensing process, including provider “ownership” of required standards

Lessons Learned

- Change takes time and comes about slowly
- Perseverance and repeated attempts are necessary
- Balance is required for any change affecting licensed child care. Although proposed changes are set to increase child safety (or decrease child risk) and implement best practices, costs to the provider are a significant piece of the overall equation. Balancing quality with feasibility is challenging and what is in the best interest of the child may not always be what is financially feasible for providers
- Increased number of required monitoring visits per year
- Consistent statewide implementation is very difficult
- Be prepared to be viewed as “the enforcer” as opposed to “the friend”
- Lawmakers and the lawmaking process are complex

Keys to strengthening licensing standards and practices in Tennessee included the following:

Ideas to Approach Oversight

- Conducting frequent monitoring visits is the only way to ensure on-going compliance and to take advantage of opportunities to provide technical assistance.
- Educating and training staff, partners, and providers is key. Staff and partners need to be trained to increase understanding; staff also needs to be trained to consistently interpret and enforce requirements statewide; providers need to understand the reasons for requirements and how to meet them. Intensive training is provided on an ongoing basis, not only for new providers but also as refresher courses.
- State administrator(s) develops policy and procedures for statewide implementation

- Program supervisors coordinate training and work on interpretations
- Licensing administrators and/or supervisors meet frequently with licensors to learn how implementation is going and to make suggestions for improvement (e.g., quality improvement process)

Unique Approaches to Enforce Requirements

- Scheduling monitoring visits based on variation in quality ratings is proving to be successful. Licensed providers (i.e., agencies) with higher quality ratings require fewer monitoring visits per year.
- Developing a case review (e.g., quality improvement) process for use by licensing staff, in conjunction with legal staff, will increase the state's ability to more closely examine licensed child care programs whose compliance (or lack thereof) may warrant legal enforcement action.

Strategies to strengthen standards with projected cost impacts

- Implement a bonus payment system.
- Tennessee uses a bonus payment system for certificate (i.e., assisted child care) payments. The bonus is dependent upon the star rating achieved by the licensed child care provider (i.e., agency). Provider quality ratings include licensing compliance in quality components. The bonus is in addition to child care subsidy reimbursement payments.
- Invest heavily in low- or no-cost technical assistance, training, and educational opportunities for licensed child care providers.
- Use a phased-in implementation approach for more stringent requirements.
- Tennessee used a three-year, phased-in implementation period for stronger staff-to-child ratios
- Tennessee used a long-term, phased-in approach to bring licensed programs into compliance with newly adopted transportation requirements, as these were high cost items for providers.
- Work with licensed providers to assist them in developing low- or no-cost solutions to satisfactorily comply with licensing requirements. This is usually done on an individual, case-by-case basis looking at the specific needs of an individual program.

Pennsylvania

The Commonwealth of Pennsylvania has recently taken action to strengthen its licensed child care programs as well. In 2008, the Office of Child Development and Early Learning (OCDEL) amended the child care facility regulations for child care centers, group child care homes, and family child care homes.

On a policy level, Pennsylvania used its existing process to amend these program regulations as prescribed by law. OCDEL used a consensus-based approach to develop proposed regulations. Specifically, the state formed a workgroup made up of representative stakeholders interested in child care facilities that included advocacy groups and organizations, contractors, providers, parents, other Commonwealth agencies, and their partners within the Department of Public Welfare. The stakeholder group was intimately involved in developing the content of the amendments. Staff also relied heavily upon recognized research and expertise demonstrating the benefits of adopting and

implementing (and the risks of failing to implement) particular program requirements for children's safety, health, and well-being and shared these resources with its stakeholders. Throughout this process, OCDEL briefed the staff and chairs of respective Legislative Committees about their intention to amend the regulations and provided regular updates to these committee representatives as the process continued.

Pennsylvania learned to make every effort to include and involve stakeholders early in the process. In addition, staff learned how critical communication is to working through the regulation amendment process. Prior to 2008, the language of the statute had not been changed since 1981, and previous efforts to make necessary changes were unsuccessful. This was, understandably, frustrating for many individuals; the world of child care has changed immensely since that time and reflecting such changes in an updated and strengthened statute would be invaluable to parents, children, providers, and to the state. The challenges associated with making previous changes were political in nature and often pertained to differences in legislators' perspectives regarding child care and the appropriate degree of government oversight (email communication with Jennifer Lau, State of Pennsylvania, July 6, 2010).

Licensing system changes that proved to be most difficult, even after resolving political and legislative challenges to adopt and to promulgate newly strengthened child care program standards, were those that would likely be associated with higher costs to providers. This is especially true during economic challenges in the United States. Pennsylvania consistently commits to performing thorough fiscal analyses on any proposed regulatory changes. However, even for program requirements that may incur additional costs, it is necessary to raise the argument to protect children's safety. OCDEL tries to minimize expected cost impacts to providers by using grandfathering provisions, when appropriate, and by phasing-in implementation of such changes over time.

Due to the large number of facilities in Pennsylvania (8500 total), communicating with providers about changes to licensing requirements is likely the most difficult licensing policy change to get up to scale statewide. OCDEL developed list serves and now relies heavily on electronic communication to reach its licensed child care providers. In 2008, the task of training providers about the regulation changes involved more than 30 separate sessions in various locations across Pennsylvania and proved to be a large expense for the state with regard to staff time, travel, and respective costs. However, it was an investment in establishing clear communication with providers and helping them consistently understand how new licensing program requirements would be interpreted and implemented.

Pennsylvania continues to struggle, as many states do, with the issue of regulating faith-based facilities. Recent court cases affirmed the State's right to regulate all child care facilities. However, a petition for review is before the Pennsylvania State Supreme Court regarding an argument of religious liberty in relation to its regulatory authority. It is important to note that nothing in Pennsylvania statute or regulation prohibits religious teaching in child care facilities (see <http://www.dpw.state.pa.us/About/OCDEL/>).

In terms of enforcement, Pennsylvania believes that communication is key to enforcing program regulations. Providers must know about the regulation, and what it entails, to be able to comply with it. OCDEL uses a variety of means to communicate about the implementation and enforcement of program requirements. These include: training for providers; ongoing communication via list serves and newsletters; technical assistance provided by OCDEL staff when conducting inspections; and, required pre-operation orientation training for persons opening child care facilities (all types). In addition, Pennsylvania leverages its relationships with partners by making each of them aware of this same information so they can reinforce it with affected constituents as well. For example, partners typically include: the Pennsylvania Key that facilitates professional development opportunities and a variety of services for child care providers; Regional Keys that oversee the Keystone STARS quality program; Child Care Information Service Agencies that communicate with providers who participate in the child care subsidy program; and, provider organizations.

Implementation of Pennsylvania's new, stronger program requirements is also different from what it was beforehand. One key difference is existence of, and access to, additional resources. Pennsylvania had not issued amended regulations since 1992. The State now has many more resources available to more effectively implement and enforce licensing program standards. For example, using electronic communications and reaching out to providers through a broader array of agencies and supporting organizations significantly alters and improves implementation. Using such resources facilitates clearer and more frequent communication, better understanding, and greater consistency with providers and other constituents while enforcing licensing program requirements.

Pennsylvania uses different, and more, resources to implement its stronger licensing program requirements. However, it does not use approaches such as risk assessment strategies or differential monitoring to schedule and conduct licensing monitoring visits.

As it pertains to cost, some of the newly strengthened licensing requirements were associated with an estimated cost impact for providers. To offset such immediate costs, OCDEL used implementation strategies such as time-limited grandfathering clauses to bring currently licensed providers into compliance. For example, Pennsylvania was able to successfully pass and implement an improved regulations for protective (i.e., resilient) surfacing under outdoor embedded play equipment by putting into place a two-year, time-limited grandfathering provision for licensed facilities that were already operating in 2008. Over that two-year time limit, licensed providers were reminded repeatedly of the deadline for complying with the new requirement. Additionally, many newly strengthened program requirements selected for implementation were either low- or no-cost in nature.

Several of the newly strengthened program requirements were selected and approved for implementation due to their limited costs. Examples include: a new "back to sleep" requirement; strengthening the regulatory language relating to inclusion of children who have special needs; requiring a child service report every six months; improving language relating to other applicable laws

that impact child care facilities to make it more understandable and consistent; and requiring disposable gloves in each facility first aid kit.

Overall, each state included in this sub-sample of exemplary strategies to strengthen licensing program standards and enforcement comprehensively addressed issues throughout their respective licensing systems for one or more specific care types. New Jersey, Washington, Tennessee, and Pennsylvania used a variety of methods to improve their licensing requirements and enforcement processes while taking into account respective costs to providers. By building on these established strong methods and addressing additional areas and/or care types for improvement, states such as these can continue to strengthen early learning systems in their own jurisdictions as well as across our nation.

APPENDIX E: DEFINITIONS OF ENFORCEMENT ASPECTS

The enforcement of licensing regulations includes numerous elements to protect the health and safety of children (see NARA *Recommended Best Practices for Human Care Regulatory Agencies*, 2009). The preliminary principles included in this paper focus on a subset of seven aspects of enforcement: staff education and training; enforcement management; workload management; case review/quality improvement processes; monitoring compliance inspections; differential monitoring; provider support and technical assistance; and sanctions. These are defined below.

Staff education and training refers to the educational requirements licensing agencies put into place to ensure a qualified, competent licensing work force. It also includes the training supports put in place to provide licensing staff, as well as licensed providers, with opportunities to learn new information and/or to address any areas where deficiencies may be present.

Enforcement management pertains to enforcement performance standards, procedures, and protocols for licensors to achieve correct, consistent enforcement of their assigned providers and programs. It includes methods to identify and address inconsistencies and to confirm that provider compliance performance reflects consistent, correct interpretation and enforcement. Sound, systematic accountability methods must be in place to guide performance management. Enforcement management includes processes through which staff continuously examine high-risk cases to detect patterns of noncompliance, within and across licensed programs, and to assess whether such risks are associated with particular program standards and enforcement practices. Enforcement management systems include methods and triggers for such decisions as frequency/scope of inspections, type/duration of license issued, whether and how to sanction, etc. Staff also use data from these review findings to develop plans and processes designed to improve compliance for particular programs and for groups of programs with similar high-risk patterns.

Workload management refers to the use of methods necessary to balance the distribution of programs per licensor and to avoid such large caseloads that licensors cannot effectively apply sound methods of support and enforcement. Licensors in all offices are expected to apply consistent, fair, and effective interpretation and enforcement across all licensed facilities.

Compliance monitoring inspections refers to visits licensors make to licensed programs to inspect a facility and to assess compliance. During the inspection, licensors determine whether licensees are in compliance with the regulations for their program type.

Differential monitoring (also known as risk assessment monitoring or risk based monitoring) is a monitoring technique, i.e., is part of an enforcement management system. Its specific function is to determine the frequency or depth of monitoring based on an assessment of a facility's level of compliance with regulations. Facilities that have a number of citations for failure to meet licensing

program requirements exhibit a low level of compliance and, as a result, should receive more frequent inspections.

Provider support services and technical assistance are positive enforcement strategies and refer to the ways in which licensing staff provide licensed providers (or those who wish to become licensed) with ongoing information and practical supports. These may include, but not be limited to, answering specific questions, helping a licensee to develop options for problem-solving, and developing or making referrals to training opportunities to improve provider compliance and quality of care giving, including required pre-service training for applicants and new-licensees.

A **sanction** is an adverse enforcement action (i.e., a legally enforceable but appealable penalty), typically included among a menu of progressive enforcement action options. These range from intermediate sanctions (such as probation, restricted capacity, or fiscal penalties) to forcible closure actions (such as denial, non-renewal, or revocation of licensure). Licensing staff may impose sanctions when the licensee fails to comply (typically repeatedly) with licensing requirements.

ADDITIONAL TABLES FOR ANALYSIS

The tables below provide examples of quality indicators for program standards and enforcement across the nation. *Table 1: Examples of Quality Indicator Program Standards and Enforcement for Child Care Centers* demonstrates the wide variation that exists across state licensing program standards and enforcement, especially compared to what is considered by other organizations as best practice for licensed child care centers. *Table 2: Examples of Quality Indicator Program Standards and Enforcement for Family Child Care* also provides examples of state variations compared to best practices but focuses on family child care homes. *Table 3: Examples of Variations in State Licensing Strengths and Weaknesses* provides a few examples of strengths and weaknesses in child care licensing program standards and enforcement for child care centers from two states.

Table 1: Examples of Quality Indicator Program Standards and Enforcement for Child Care Centers - in 2007 from licensing agencies in each applicable state across the nation, Table 1 shows how many states meet or do not to meet best practices on quality indicators for program standards and enforcement practices applied to licensed child care centers (NARA & NCCIC, 2009). To demonstrate the degree to which states vary on key program standard indicators, example quality indicators are highlighted including: teacher-child ratio; indoor space; educational materials; health and safety (immunizations, SIDS); and playground safety (resilient surfacing). Two key enforcement practices were selected to show similarities and differences across all applicable states in the nation: frequency of inspections and background checks. In addition, program standards and enforcement practices that are common (or popular) among states are listed to show how close to or far from best practices states are on these indicators. Finally, other state practices are included as reference points of states that either exceed or struggle to meet common practices among states.

Quality Indicator	Best Practice	States Meet	States Do Not Meet	Common Practice	States Meet	Other State Practices
Ratio	Centers: <u>Infants</u> (Birth – 15 mos) 1 adult: 3 infants 1 adult: 4 infants	3/50 32/50		1 adult: 4 infants	32/50	*1 adult: 6 infants
Indoor Space	Centers: 35 Square Feet (SF) per child	42/50	7/50			*1/50 states: 40 SF/child
Educational Materials	Centers: Fine motor/manipulatives Books & literacy Dramatic play/pretend Art supplies/creative	30/38 29/38 28/38	8/38 9/38 10/38	Child equipment and/or materials requirements	38/38	

Quality Indicator	<i>Best Practice</i>	States Meet	States Do Not Meet	<i>Common Practice</i>	States Meet	Other State Practices
Educational Materials (continued)	activities	29/38	9/38			
	Gross motor equipment (indoor & outdoor)	31/38	7/38			
	Music	23/38	15/38			
	Science/Experimental/Math (counting/sorting)	20/38	18/38			
	Sensory	18/38	20/38			
Health & Safety: Immunizations	Requirement that children be immunized <i>Centers:</i>			Physicians can provide written statements to not have children immunized	35/50	Parents can provide written statements to not have children immunized 33/50
Health & Safety: SIDS	Requirements to place infants on their backs to sleep <i>Centers:</i>	28/50	22/50	Soft bedding/materials must not be used in cribs	20/50	Parents may authorize different sleep positions for infants 5/50
Playground Safety: Resilient Surfacing	Surfacing under playground equipment should be at a depth that is proportionate to the critical height value of the playground equipment as tested by NPPS <i>Centers:</i>	9/49	40	Requirements for surfaces underneath outdoor equipment	39/49*	
Frequency of Inspections	Requirement for <u>all</u> licensed child care programs to be inspected at least four times per year, including inspections by licensing, safety, health and fire departments <i>Centers:</i>	2/50	48/50	Requirement for all licensed child care programs to be inspected at least once per year.	26/50	Differential Monitoring as a strategy to stagger (&increase frequency of) regularly scheduled inspections. * *This technique is popular but is currently controversial. 13/50

Quality Indicator	<i>Best Practice</i>	States Meet	States Do Not Meet	<i>Common Practice</i>	States Meet	Other State Practices
Background Checks	Child care providers are required to undergo complete background checks, including state and federal checks of criminal history record using a fingerprint, child abuse registries and sex offender registries			State requires check of criminal history records Centers:	47/49	State requires checks of sex offender registries 13/49
Background Checks (Continued)	Centers:	2/49	47/49	State requires check of child abuse and neglect registries Centers: State requires checks of fingerprint records Centers:	41/49 29/49	

The number of total states for each category of licensed care depends upon the number of states that license that type of facility and/or specific quality indicators that are regulated and/or licensed for that type of facility. See NARA & NCCIC, 2009.

Table 2: Examples of Quality Indicator Program Standards and Enforcement Practices for Family Child Care - Table 2 also uses data from the 2007 Child Care Licensing Study (NARA & NCCIC, 2009), however it showcases examples of state variations in program standards and licensing enforcement for family child care homes. Best, common, and other state practices are highlighted in an attempt to demonstrate program standards and enforcement inconsistencies across states.

Quality Indicator	<i>Best Practice</i>	States Meet	States Do Not Meet	<i>Common Practice</i>	States Meet	Other State Practices
Ratio	<i>FCC homes:</i> The total number of children (whether related or not) in small family child care homes is limited based on the ages of children in care. - Count the provider's children less than 12 years of age - Limit the number of children to six (or eight if the additional two children were of school age).	11/52**	41/52	<i>Small FCC homes:</i> States do <u>not</u> have child-staff ratio requirements since there is typically only one provider in the home caring for a mixed-age group of children. Instead, states have requirements for the number of children allowed in a home when one provider is present.		
Ratio (Continued)	- Allow only two children less than 24 months of age when older children (over 2 years of age) are present - No more than three children if only infants & toddlers are in care.	21/52**	31/52			
		20/52**	32/52			
		20/52**	32/52	<i>Large FCC homes:</i> States have greatly varying child-staff ratio requirements, however not all states base these requirements on ages of children, because home providers typically care for mixed-age groups.		
		<i>Note: 12 states allow no more than <u>two</u> children if only infants & toddlers are in care, whereas an additional 8 states meet the benchmark for no more than three.</i>				
	<i>Small FCC homes:</i>					*17/44

Quality Indicator	Best Practice	States Meet	States Do Not Meet	Common Practice	States Meet	Other State Practices
Indoor Space	35 SF per child Large FCC homes: 35 SF per child	25/44 28/34	19/44 5/34	25 SF/child	2	states: no space requirements *1/34 states: 40 SF/child
Educational Materials	Small FCC Homes: Fine motor/manipulatives Books & literacy Dramatic play/pretend Art supplies/creative activities Gross motor equipment (indoor & outdoor) Music Science/Experimental/Math (counting/sorting)	16/25 16/25 13/25 13/25 15/25 9/25 4/25	9/25 9/25 12/25 12/25 10/25 16/25 21/25	Child equipment and/or materials requirements	25/25	
Educational Materials (Continued)	Large FCC Homes: Fine motor/manipulatives Books & literacy Dramatic play/pretend Art supplies/creative activities Gross motor equipment (indoor & outdoor) Music Science/Experimental/Math (counting/sorting) Sensory	16/23 16/23 15/23 15/23 14/23 12/23 7/23 6/23	7/23 7/23 8/23 8/23 9/23 11/23 16/23 17/23	Child equipment and/or materials requirements	23/23	
Health & Safety: Immuniza-	Requirement that children be immunized			Physicians can provide written statements to not have children		Parents can provide written statements

Quality Indicator	Best Practice	States Meet	States Do Not Meet	Common Practice	States Meet	Other State Practices
tions	<i>Small FCC Homes:</i> <i>Large FCC Homes:</i>	43/44 39/39	1/44	immunized	25/44 23/39	to not have children immunized 24/44 25/39
Health & Safety: SIDS	Requirements to place infants on their backs to sleep <i>Small FCC Homes:</i> <i>Large FCC Homes:</i>	22/44 20/39	22/44 19/39	Soft bedding/materials must not be used in cribs	15/44 11/39	Parents may authorize different sleep positions for infants 3/44 1/39
Playground Safety: Resilient Surfacing	Surfacing under playground equipment should be at a depth that is proportionate to the critical height value of the playground equipment as tested by NPPS <i>Small FCC Homes:</i> <i>Large FCC Homes:</i>	2/34 2/34	32/34 32/34	Requirements for surfaces underneath outdoor equipment	23/34 26/34	
Frequency of Inspections	Requirement for <u>all</u> licensed child care programs to be inspected at least four times per year, including inspections by licensing, safety, health and fire departments <i>Small FCC homes:</i> <i>Large FCC homes:</i> <i>Small FCC homes:</i> <i>Large FCC homes:</i>	2/44 1/39	42/44 38/39	Requirement for all licensed child care programs to be inspected at least once per year.	15/44 14/39	Differential Monitoring as a strategy to stagger (and increase frequency of) regularly scheduled inspections. * <i>*This technique is popular but is currently considered controversial.</i> 9/44 10/39
Background	Child care providers are			State requires		State

Quality Indicator	Best Practice	States Meet	States Do Not Meet	Common Practice	States Meet	Other State Practices
Checks	required to undergo complete background checks, including state and federal checks of criminal history record using a fingerprint, child abuse registries and sex offender registries			check of criminal history records		requires checks of sex offender registries
	Small FCC homes: Large FCC homes: <i>*Requires fingerprints in complete background checks, but not necessarily for both state and federal records</i>	3/44* 3/39*	41/44 36/39	Small FCC homes: Large FCC homes: State requires check of child abuse and neglect registries Small FCC homes: Large FCC homes: State requires checks of fingerprint records Small FCC homes: Large FCC homes:	43/44 37/39 38/44 34/39 25/44 24/39	13/44 12/39
Background Checks (Continued)						

The number of total states for each category of licensed care depends upon the number of states that license that type of facility and/or specific quality indicators that are regulated and/or licensed for that type of facility. *See NARA & NCCIC, 2009; and **NACCRRRA 2010; 2010.

Table 3: Examples of Variations in State Licensing Strengths and Weaknesses --Based on NACCRRRA state overall rankings and rating scores in licensing regulations and oversight, it is clear that some states may be strong in either licensing program standards or enforcement, while other states may be weak in both areas and, without adequate funding and support, rarely is it the case that any state is strong in both areas. In Table 3, Maine and Oklahoma were selected as state examples due to their relatively high (compared to the other states in the nation) ranking in one area yet relatively low ranking in another area. Similarly, their overall ratings reflect their proportionate scores on strength of regulatory oversight (i.e., monitoring and enforcement) and strength of regulations. These state examples demonstrate that it is possible to have strong quality program standards in place yet lack the proper supports to adequately enforce them. On the other hand, states can have very strong enforcement in place yet lack quality program standards with which providers must comply. Although each state has a number of different child care licensing program characteristics that may be considered strengths or weaknesses among different types of care, only those that were considered as key program standards or enforcement practices used in licensed child care centers were highlighted. For child care center licensing program standards these include: educational requirements for center staff; basic health and safety requirements; and provisions for parent involvement, communication, and visits. For regulatory enforcement these include: adequate monitoring; qualifications for licensing staff; and online inspection and complaint reports.

State	Examples of Strengths or Weaknesses	Ranking & Rating*	Program Standards or Enforcement Examples**
Maine	Strength: Child Care Center Licensing Program Standards	16/52 High 66% overall strength of center regulations scores	Educational requirements for center staff: Child care center teachers must have experience with young children before they assume their roles in classrooms, and teachers must also undergo 30 clock hours of training each year. Basic health & safety requirements: Infants are buffered against SIDS by standards to refrain from using any soft bedding in cribs, placing infants on their backs to sleep, and allowing only physicians to authorize other sleep positions. Provisions for parent involvement, communication, & visits: Has requirement for parent involvement and communication, and allows parental visits
	Weakness: Regulatory Enforcement	50/52 Low 14% overall strength of regulatory oversight in centers	Adequate monitoring: Child care center programs are only inspected at the time of re-licensing and once during the licensing period. Licensor caseloads are not feasible. Licensors have, on average, a total of 179 cases each. This is compared to best practice recommendations of

State	Examples of Strengths or Weaknesses	Ranking & Rating*	Program Standards or Enforcement Examples**
			1:50 (NACCRRRA) or 1:75 (Government Accountability Office, GAO). Qualifications for licensing staff: There is no requirement for licensors to have an associate's degree education. Online inspection & complaint reports: Reports of routine inspections conducted at all licensed child care programs & reports of those conducted because of complaints are not available online.
Oklahoma	Strength: Regulatory Enforcement	1/52 High 90% overall strength of regulatory oversight in centers	Adequate monitoring: Licenses all of its child care centers (i.e., there are no exemptions) and family child care homes. Inspects child care centers three times each year. Has a licensing caseload ratio of 1:50. Qualifications for licensing staff: Licensors are required to have a bachelor's degree education and 40 clock hours of ongoing annual training. Online inspection & complaint reports: Reports of routine inspections conducted at all licensed child care programs & reports of those conducted because of complaints are available online.
	Weakness: Child Care Center Licensing Program Standards	21/52 Low 61% overall strength of center regulations scores	Educational requirements for center staff: Child care center teachers are not required to have completed a high school education. Teachers are only required to have completed the 10th grade and to be enrolled in a GED program to education young children in their care. Assistant teacher aides have not high school grade completion requirements, must only be enrolled in high school or a GED program, and are not required to complete any pre-service qualifications prior to working with children in their care. Center staff are required to complete only 12 hours of annual training.

*Based on NACCRRRA ratings, 2009 ** See NARA & NCCIC, 2009

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AUTHOR

Amie Lapp Payne, Ph.D., is the President of Child and Family Solutions Consulting, through which she provides expertise to clients on policy strategies to effectively develop, promote, and realize increased quality of program and performance standards and enforcement practices in child care environments and state administrations.

Dr. Payne holds degrees in child development from Auburn and Florida State Universities' Colleges of Human Sciences, specializes in childcare quality, and public policy and completed her internship in psycho-social care for chronically and terminally ill children at Duke University Medical Center. Her previous research, and that of her colleagues, continues to be on the cutting edge, examining the quality of relationships between preschool children and their teachers and documenting the psycho-physiological consequences and benefits associated with the varying levels of quality that children experience in early care and education

Although trained as a child development researcher, Dr. Payne has: cared for infants and toddlers; taught preschool and kindergarten in inner-city neighborhoods; directed a rural, non-profit child care center; and, worked with parents across these settings. She has also worked with stakeholders and state legislatures. Her focus was to promote an understanding that the use of research-based policies and licensing regulations establishes quality early care and education environments, which, in turn, create important benefits for young children and their families – and for the public.

Most recently, Dr. Payne has been living out what she has learned regarding child development, this time in parenthood. She is the proud mother of baby twins Cameron and Kaelyn Payne, born on October 9, 2010.

In addition to her new role as Mother, she provides consultation services for clients on national and state levels. Before beginning her national consultation, Dr. Payne served as the Deputy Director of the Washington State Department of Early Learning (DEL) where she oversaw all DEL programs and policy work: its three Service Areas across the state; the Quality Division; the Systems, Partnerships and Collaboration Division; and the Parent Support and Programs Division.

Prior to DEL, she served as the Executive Director of the Washington State Association of Head Start and Early Childhood Education Assistance Program (ECEAP) and as a consultant to the Governor's Office on current early learning initiatives and developments in Washington State. Dr. Payne also has rich experiences in licensing regulation, including those she gained through her position as the Child Development Program Consultant at the Virginia Department of Social Services, which contribute to her keen understanding and ability to promote and to implement regulatory requirements. Dr. Payne has experience teaching, training, and working with a wide range of children and adults representing a variety of cultures, from infants at six weeks old, through graduate students up to 55 years of age, and many in between.

Through her rich and diverse education and experiences, she has been trained to effectively examine and communicate child development through research, teaching, and professional service. Dr. Payne's active engagement in local, state, and national leadership roles is another way in which she constantly strives to learn from others and to create new or enhance existing systems through which child development information, programs, and techniques can be accessed and applied for the benefit of all.

2017 Child Care Licensing Study



National Association for
Regulatory Administration

ACKNOWLEDGEMENTS

The National Association for Regulatory Administration (NARA) is an international professional organization dedicated to promoting excellence in human care regulation and licensing through leadership, education, collaboration, and services. NARA represents all human care licensing, including adult care, child care, and child welfare. NARA's researchers have been studying child care in the United States for over thirty-five years. NARA seeks to improve the overall quality of out-of-home child care by measuring the effectiveness of licensing policies and procedures and determining which regulations are best at protecting children from harm.

In 2001, NARA was approached by the Children's Foundation to collaborate on the *Child Care Licensing Study* assumed full responsibility for the research and publication of the studies in 2005. At that time, NARA formed a relationship with the Office of Child Care's National Center on Early Childhood Quality Assurance (formerly Child Care Quality Improvement) to produce research briefs based on the study.

The *2017 Child Care Licensing Study* is a study of the current state of licensing regulations in the United States. The *Child Care Licensing Study* is part of a series of studies used to verify and update the information about child care licensing.

NARA recognizes Clifford Schmidt, Kathryn Schmidt, and Tara Lynne Orlowski, M.Ed. and for their co-authorship of *2017 Child Care Licensing Study*.

NARA acknowledges the following individuals for their contributions:

- Sheri Fischer, The National Center on Early Childhood Quality Assurance
- Becky Fleming-Siebenaler, National Association for Regulatory Administration
- Deborah Russo, National Association for Regulatory Administration

This study was published under the following Board of Directors and Executive Director, who served as reviewers:

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STUDY DESIGN

In 2017, NARA sent a survey to all state child care licensing agencies via an online survey tool. The survey included 144 questions relating to regulatory implementation and operational procedures. Fifty states, the District of Columbia, and America Samoa responded to the survey. The data for each state was analyzed to obtain preliminary information about updates to the regulations since 2014, the last licensing study published by NARA.

DEFINITIONS

Abbreviated Compliance Inspection: An abbreviated inspection utilizing a select set of rules to be reviewed. The use of abbreviated inspections can be a time saving technique to focus regulatory efforts on facilities that require additional inspections or technical assistance. The forms or checklists used for abbreviated inspections may include those standards considered as most critical to children's safety and well-being standards that statistically indicate compliance with the entire set of standards. They also may be used as an indicator checklist to determine when a subsequent full compliance review is required.

Background Check: A process of searching for a history of criminal charges against individuals working in child care facilities.

Building Code Inspection: An inspection of child care facilities for compliance with the state's building construction codes and laws that assure buildings are safe for occupants. This inspection is in addition to those conducted by the licensing agency.

Child Care Centers: A provider licensed or otherwise authorized to provide child care services for fewer than 24 hours per day per child in a non-residential setting, unless care in excess of 24 hours is due to the nature of the parent(s)' work.

Conditional License: A license that is typically limited in some way, such as temporary, provisional, or probational based on the child care program not meeting the minimum regulatory standards. A conditional license can be disciplinary or non-disciplinary in nature.

Consent Agreement: An agreement between parties in a court action which solves a dispute. An example of consent agreement is a document stating that one party will stop the contested actions which will, in turn, resolve the lawsuit.

Criminal History Record (CHR): A compilation of an individual's identification, arrest, conviction (law), incarceration, legal status, sex offender registration, warrant information, and other relevant criminal history. In the United States, these compilations are maintained and updated on the local, state, and Federal levels by various law enforcement agencies.

Differential Monitoring: A method for determining the frequency of monitoring based on an assessment of a facility's level of complaint history and compliance with regulations. This process can be used to determine the number of inspections needed for a particular facility and the content of inspections. Differential monitoring includes Key Indicator Systems (KIS), which identify a subset of regulations from an existing set of regulations that statistically predict compliance with the entire set of regulations.

Emergency/Immediate Closure: Also known as emergency order, summary suspension, temporary closure Conditional License: When used as an enforcement action, also known as restricted license, suspension of specific services, provisional license

Environmental Health Inspection: An inspection of child care facilities conducted by the health department, or other entity, for compliance with the state's environmental health codes and laws. This inspection is in addition to those conducted by the licensing agency.

Fire Inspection: An inspection of child care facilities conducted by the state fire marshal, or other fire safety entity, for compliance with the state's fire safety codes and laws. This inspection is in addition to those conducted by the licensing agency.

Large/Group Family Child Care (FCC) Homes: Two or more individuals who provide child care services for fewer than 24 hours per day per child, in a private residence other than the child's residence, unless care in excess of 24 hours is due to the nature of the parent(s)' work.

QRIS: Quality Rating and Improvement System (QRIS) is a systemic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs.

Small Family Child Care (FCC) Homes: One individual who provides child care services for fewer than 24 hours per day, as the sole caregiver, in a private residence other than the child's residence, unless care in excess of 24 hours is due to the nature of the parent(s)'s work.

EXECUTIVE SUMMARY

Licensing is a process that establishes the requirements necessary to protect the health and safety of children in out-of-home-care. Strong licensing policies and regulations are key to help ensure the health and safety of our nation's children who spend time in out-of-home care. The potential for licensing to have a positive impact on children is very large given that there are more than 10.5 million slots in licensed child care programs of all types in the United States. States manage the licensing process through the application and enforcement of regulations. The protections offered by well-enforced, effective regulations are critical and broad in scope and impact the millions of children and their families who relied on state licensing agencies to monitor and enforce regulatory requirements in these settings. State child care licensing regulations and monitoring and enforcement policies help provide a baseline of protection for the health and safety of children in out-of-home care.

According to the U.S. Census Bureau, between 2014 and 2017 the number of children of child care age (0 to 12) in the United States rose slightly, from approximately 52.6 million to almost 52.8 million, a growth rate less than 0.3 percent. However, during that same time period, the number of licensed child care programs in the U.S. across all program types dropped by nearly 11 percent, or just over 27,000 programs in total; primarily in family child care homes. However, during the same time period, licensed capacity across all program types fell by approximately 0.1 percent.

Child care licensing line staff often have multiple roles and are rarely limited to inspecting just one type of facility or just child care programs. The number of line staff FTEs increased by approximately 400 between 2014 and 2017 with 29 states reporting increases and 5 states reporting no changes. Overall caseloads dropped with the average caseload of 100 per line staff in 2014 dropping to 88 in 2017. The median caseload dropped from 85 in 2014 to approximately 70 in 2017.

Between the *2014 Child Care Licensing Study* and *2017 Child Care Licensing Study*, the Child Care and Development Block Grant underwent reauthorization, which included several requirements related to child care regulation. Nearly every state has exemptions for certain types of programs though in nearly three-fourths of states, licensure is a requirement for receiving subsidy payments for some programs and only 14 states said licensure was not a prerequisite for receiving subsidy payments. Many states reported that the licensing requirements were different for exempt programs and that exempt centers and homes each had separate requirements. Just over half of the states reporting said that licensing agency staff was responsible for inspections of license exempt homes.

The broad trend between 2014 and 2017 saw a slight increase in the number of FCC homes that were required to be inspected prior to licensure. Inspections conducted prior to issuing a license are predominantly announced inspections with very little change seen between 2014 and 2017. The number of states conducting license inspections at least twice a year increased by two for centers and three for small FCC homes. There was no change for large/group FCC homes. There was a drop in the number of states reporting non-expiring licenses for all program types. This corresponded to an increase in the number of one, two, and three-year renewals for centers. The number of states conducting abbreviated inspections did not change between 2014 and 2017 though the number of states using them for initial licensing inspections and routine compliance dropped. One additional state reported using abbreviated inspections for license renewal.

Two more states reported using "Key Indicators" in 2017 versus 2014 to determine what requirements should be included in abbreviated inspections. An additional seven states reported having conducted risk assessments in 2017 versus 2014. Seven additional states also reported using weighting for all risk factors, three fewer states used only high-risk factors, and two additional states developed categories of requirements identified as high-risk. In 2017 there was a net gain of four states reported using differential monitoring. A net total of three additional states reported using differential monitoring for centers and five additional states reported using it for both large and small FCC homes.

States are increasingly using their licensing databases for multiple purposes including evaluating their own staffing and tracking inspection and enforcement actions against providers. Licensing databases are more interconnected with other state agencies more than ever before. The number of states using portable devices for inspections, and considering

other tools for licensing doubled, or nearly doubled in almost every area. Licensing databases are becoming increasingly interconnected with other state agencies.

States were much more likely to investigate complaints against license-exempt programs in 2017 than in 2014. There was a 10 percent increase in the total number of states reporting that they investigated all complaints against exempt facilities, and a 19 state increase reported in the number of investigations involving subsidy payments or federal/state funding.

Between 2014 and 2017 the number of states that made either a full inspection report or summary report available online increased by 9 states (18 percent). In both 2014 and 2017 nine states included all complaints online. The number of states reporting posting only substantiated complaints online increased from 20 to 32. The number of states that included enforcement actions as part of their online report grew from 21 to 34 states. In 2017, 60 percent of states reported that they provided guidance to the public to help understand the licensing reports they posted online. More than half the states reported having inspection reports available online within a week of inspection. Almost every state identifies and addresses illegally operating providers through complaints received by the public. In 2017, 90 percent of states reported that they encouraged illegally operating providers to become licensed.

In both 2014 and 2017, only one state required licensing staff to have a master's degree. In 2017, 65 percent of states reported a bachelor's degree as the minimum requirement, up one from 2014. In each year, only one state required an associate's degree. In 2014, two states allowed some college level coursework while no states reported that as a requirement in 2017. There was an increase of two states reporting "Other" which usually means some combination of experience and education equivalent to a bachelor's degree. In 2017, two additional states reported that the degree must be in early childhood education, child development, or a field related to the care and education of children, while two fewer states reported that licensing staff were required to have experience working in a setting with children. In 2017, 73% of states reported that annual training was a requirement. There was an increase across the board in the number of states requiring specific types of training as well, with the largest percentage increases in business administration, disaster and emergency planning, and fire safety. In 2017, the number of states reporting that community resources were a training source increased by 11 percent. There was also a slight increase in the number of states that reported using outside consultants or national conferences.

The number of states reporting that general revenue was a funding source for licensing agency hiring remained unchanged between 2014 and 2017. The number of states reporting that the Child Care and Development Fund was a source increased by two, and one additional state reported state block grants as a funding source.

The number of states that have incorporated "interrater reliability" training or evaluation for licensing staff saw a net increase from five in 2014 to eight in 2017 and an additional two states reported that they have developed interpretive guidelines for the licensing regulations. The number of states reporting that the licensing agency has policies for disaster and emergency response for licensing staff to follow increased from 70 to 80 percent.

When it comes to communicating with providers, in both 2014 and 2017 between 90 and 95 percent of states reported using a website, emails, and face-to-face meetings. Overall states were more likely to use a variety of methods in 2017. The number of states reporting that they used a provider newsletter grew by 11 states and the number of states using social media increased by eight.

In both 2014 and 2017 states relied primarily on *"Caring for Our Children: Health and Safety Standards"* for formulating rules and regulations for licensing child care facilities. States were much more likely to use Head Start standards and NARA research and practice publications in 2017 than in 2014.

Every state required background checks for centers in both 2014 and 2017 with all states including criminal history checks in 2017, up from 94 percent in 2014. The number of states requiring either state or federal fingerprint checks was up for all facility types. States requiring Child Abuse & Neglect (CAN) Registry checks for all staff in centers grew by eight percent and while it decreased for all staff in both FCC home types, there was a significant increase in the number of

states requiring CAN registry checks for staff having contact with children and volunteers. The number of states requiring sex offender registry checks for all program types grew by 10 to 12 percent. States were more likely to report conducting background checks annually in 2014 than in 2017.

Effective, robust licensing prevents harm to children. It mitigates the risk of injury or death from fire, building hazards, disease, and inadequate staff oversight, and helps to prevent the developmental delays that can result from the lack of healthy relationships with adults or developmentally inappropriate activities. There is still much research needed in order to determine which licensing policies and procedures are the most effective and which regulations are best at protecting children from harm. The data in this study will help inform the regulatory and early and school-age care and education field and hopefully spark researchers' interest in pursuing further analyses.

Note: Each of the major sections contains a Summary which includes a comparison between 2014 and 2017 license survey results. All inter-year analyses compare 50 states plus the District of Columbia. While a total of 53 states and territories including the District of Columbia responded to the survey in 2014, a different set of states and territories responded in 2017. In order to more accurately compare changes over time, the Summary analysis will examine and include in the analysis only those respondents who are included in both years. The 50 states and the District of Columbia will hereafter collectively be referred to as “states” for analysis purposes.

Each sub-section within a major section looks at results from only the 2017 survey. Fifty states plus the District of Columbia and American Samoa responded to the 2017 survey and their results are included in all sub-sections where applicable. Aggregate numbers from 2017 for the inter-year comparison will not necessarily be the same as those shown in the sub-sections since the complement of respondents in the analyses are different.

LICENSED PROGRAMS, CAPACITY, AND ENROLLMENT

Summary:

According to the U.S. Census Bureau, between 2014 and 2017 the number of children of child care age (0 to 12) in the United States rose slightly, from approximately 52.6 million to almost 52.8 million, a growth rate less than 0.3 percent. However, during that same time period, the number of licensed child care programs in the U.S. across all program types dropped by nearly 11 percent, or just over 27,000 programs in total. The decrease in the number of programs means that the average number of licensed programs per 1,000 children fell from 4.8 in 2014 to 4.3 in 2017. Only nine states showed an increase in the number of licensed programs.

Licensed capacity across all program types fell by just over 10,000 slots between 2014 and 2017, from 10.32 million to 10.31 million. The total decrease was approximately 0.1 percent. This represents a drop of less than 1 slot per 1,000 children of child care age. A total of 31 states had a reported increase in overall capacity.

Only eight states reported enrollment figures in 2017 and only five of those also had enrollment numbers reported in 2014. Of those five states, there was an overall drop of more than 305,000 in overall enrollment with two states showing an overall increase in enrollment.

Regulated Child Care Programs

State Abbreviation	State	Regulates Licensed Child Care Facilities	Regulates Licensed Small Family Child Care Homes	Regulates Licensed Large/Group Family Child Care Homes
Total		52	50	39
AK	Alaska	•	•	•
AL	Alabama	•	•	•
AR	Arkansas	•	•	
AS	American Samoa	•	•	
AZ	Arizona	•		•
CA	California	•	•	•
CO	Colorado	•	•	•
CT	Connecticut	•	•	•
DC	District of Columbia	•	•	•
DE	Delaware	•	•	•
FL	Florida	•	•	•
GA	Georgia	•	•	
HI	Hawaii	•	•	•
IA	Iowa	•	•	•
ID	Idaho	•	•	•

State Abbreviation	State	Regulates Licensed Child Care Facilities	Regulates Licensed Small Family Child Care Homes	Regulates Licensed Large/Group Family Child Care Homes
IL	Illinois	•	•	•
IN	Indiana	•	•	
KS	Kansas	•	•	•
KY	Kentucky	•	•	
LA	Louisiana	•	•	
MA	Massachusetts	•	•	•
MD	Maryland	•	•	•
ME	Maine	•	•	
MI	Michigan	•	•	•
MN	Minnesota	•	•	•
MO	Missouri	•	•	•
MS	Mississippi	•	•	•
MT	Montana	•	•	•
NC	North Carolina	•	•	
ND	North Dakota	•	•	•
NE	Nebraska	•	•	•
NH	New Hampshire	•	•	•
NJ	New Jersey	•		
NM	New Mexico	•	•	•
NV	Nevada	•	•	•
NY	New York	•	•	•
OH	Ohio	•	•	•
OK	Oklahoma	•	•	•
OR	Oregon	•	•	•
PA	Pennsylvania	•	•	•
RI	Rhode Island	•	•	•
SC	South Carolina	•	•	•
SD	South Dakota	•	•	•
TN	Tennessee	•	•	•
TX	Texas	•	•	•
UT	Utah	•	•	•
VA	Virginia	•	•	
VT	Vermont	•	•	
WA	Washington	•	•	
WI	Wisconsin	•	•	
WV	West Virginia	•	•	•
WY	Wyoming	•	•	•

Licensed Facilities

Question: Total number of licensed child care facilities on December 31, 2017

Analysis: The total number of licensed child care programs as of December 31, 2017 was just over 248,000. Nationally that represents 4.7 licensed programs per 1000 children ages 0 to 12. In just under 58% of the states, Child Care Centers were the most prevalent licensed program type, followed by Small FCC Homes in 33% of the states, and Large/Group FCC Homes in slightly less than 10% of the states. Three states reported a total number of facilities in excess of 50 per 1000 children ages 0 to 12, while five states reported less than one facility per 1000 children ages 0 to 12. The total counts in this report encompass all facility types reported in the survey responses including centers, small FCC homes, large/group FCC homes, and “Other licensed facilities”.

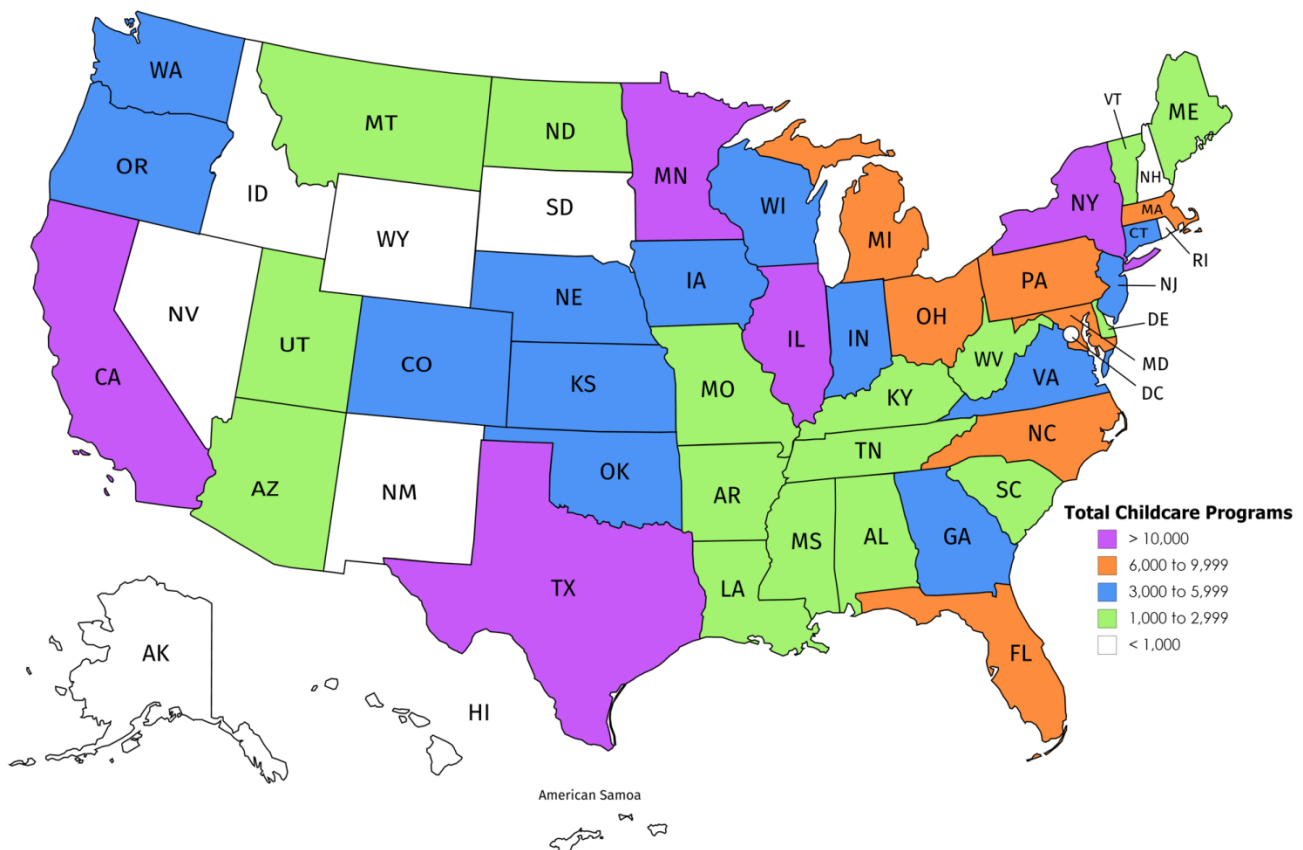
Examples of “Other licensed facilities”:

- Out of school time-school age only
- Children’s Resident Camps, temporary shelter programs, programs serving teen parents, foster care placement and adoption agencies
- Child Placing Agencies and Residential Child Care Facilities and Day Treatment Programs
- In-Home Child Care Provider, who provides child care services in the child’s own home
- Drop-in Centers
- Informal and relative homes

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	Other Licensed Child Care Facilities	Total number of all Licensed Child Care Programs
Total	109,436	83,942	37,278	5,741	248,217
AK	231	267	64	N/A	562
AL	962	492	254	N/A	1,708
AR	1,620	346	N/A	194	2,160
AS	22	1	N/A	N/A	23
AZ	2,215	N/A	284	N/A	2,499
CA	15,300	15,900	11,200	N/A	42,400
CO	3,000	1,668	292	140	5,100
CT	1,389	2,017	26	N/A	3,432
DC	352	78	31	N/A	461
DE	460	614	76	29	1,179
FL	4,768	1,010	294	N/A	6,072
GA	3,062	1,594	N/A	N/A	4,656
HI	585	349	6	N/A	940
IA	1,515	711	2,048	N/A	4,274
ID	374	52	287	N/A	713
IL	3,012	6,736	754	N/A	10,502
IN	712	2,645	N/A	N/A	3,357
KS	1,025	2,800	1,306	413	5,544
KY	1,921	262	N/A	86	2,269
LA	1,484	236	N/A	7	1,727
MA	2,856	5,690	Not Reported	471	9,017
MD	2,493	5,602	132	215	8,442
ME	724	930	N/A	48	1,702
MI	4,424	3,026	1,713	N/A	9,163
MN	1,738	6,761	1,695	N/A	10,194
MO	1,879	968	142	N/A	2,989
MS	1,460	11	18	3	1,492
MT	262	255	423	242	1,182
NC	4,527	1,735	N/A	N/A	6,262
ND	290	286	854	60	1,490

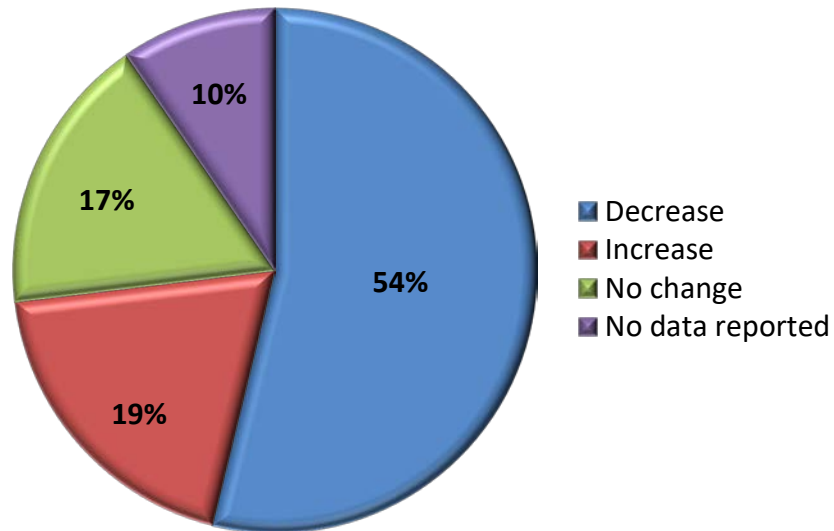
State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	Other Licensed Child Care Facilities	Total number of all Licensed Child Care Programs
NE	998	1,456	646	156	3,256
NH	689	65	84	N/A	838
NJ	3,965	N/A	N/A	1,680	5,645
NM	746	110	125	N/A	981
NV	336	88	37	N/A	461
NY	4,306	4,020	8,079	2,791	19,196
OH	4,138	2,288	228	N/A	7,247
OK	1,504	1,058	686	N/A	3,248
OR	1,350	1,917	806	N/A	4,073
PA	4,882	1,789	746	N/A	7,417
RI	421	479	9	N/A	909
SC	1,644	815	93	N/A	2,552
SD	218	518	55	148	939
TN	1,609	253	359	11	2,232
TX	9,589	7,551	1,721	22	18,883
UT	353	94	778	N/A	1,225
VA	2,629	1,411	N/A	1	4,041
VT	673	594	N/A	21	1,288
WA	1,647	3,497	N/A	475	5,619
WI	2,280	1,642	N/A	96	4,018
WV	519	1,200	132	112	1,963
WY	278	251	146	N/A	675

Map 1 Total Number of Child Care Programs



Question: Have the numbers of facilities increased or decreased in recent years?

Analysis: The majority of states reported an overall decrease in the number of facilities in recent years. Many states that reported an increase in the number of child care facilities, also reported decreases in family child care homes.



Reasons for decrease in the number of facilities include:

- Increased education/qualification requirements
- Increase in standards due to CCDF requirements
- Substantial increase in fees
- Recession and employment slowdowns
- Career changes
- Retirement
- Business not profitable
- Increased regulations
- Increased academic standards
- Seeking more flexible employment
- Increase in Public preschool programs
- Overall state population decreasing

Licensed Capacity

Question: What was the total licensed capacity (number of slots) for each type of child care facility on December 31, 2017 (or most current count)?

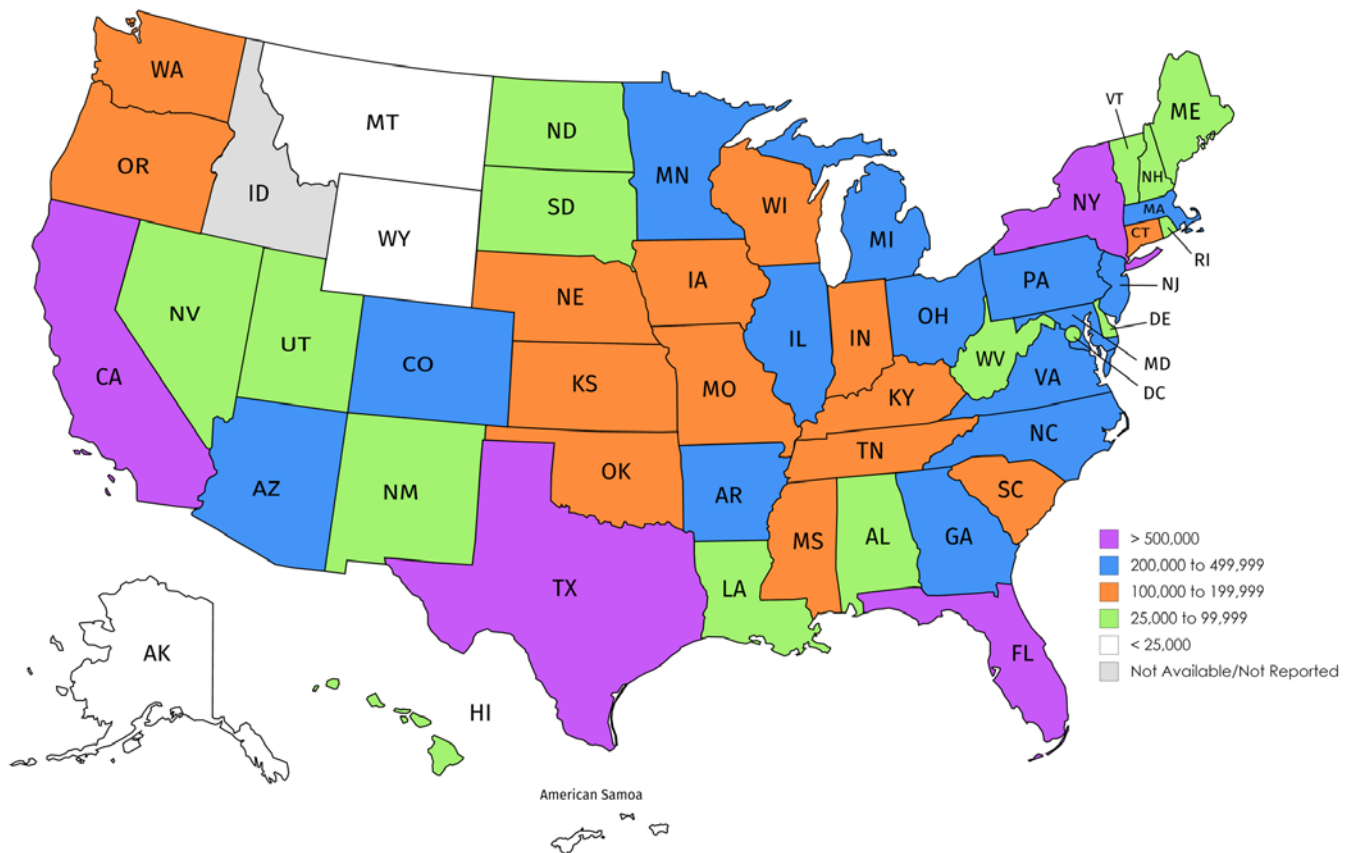
Analysis: For the states and territories reporting (n=51), there were almost 10.5 million slots in licensed child care programs of all types. Nationally this equates to just over 201 licensed slots per 1000 children ages 0 to 12 (US Census Bureau, 2017). The smallest number of licensed slots per 1000 children ages 0 to 12 was in American Samoa, which reported just over 17 slots per 1000 followed by Utah with just over 64 slots per 1000 children. Two states, Arkansas and Vermont reported more than 422 slots per 1000 children ages 0 to 12. The program types with the most slots were child care centers in every state.

The number of programs taken in conjunction with capacity gives an overall idea of the relative size of child care programs in a given state. For example, Illinois and Minnesota were among the states with the largest number of child care programs. Florida, while still having a large number of programs ranked below those two states in overall program count. When looking at capacity however, Florida ranked above both those states in total capacity numbers. This suggests that Illinois and Minnesota, while having more child care programs overall, tend to have smaller capacity per program, while Florida tends to have, on average, programs that provide a larger capacity (larger programs).

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	Other Licensed Child Care Facilities	Total number of all Licensed Child Care Programs
Total	8,714,155	767,760	527,637	477,671	10,487,223
AK	15,194	1,774	753	N/A	17,721
AL	74,990	3,099	3,070	N/A	81,159
AR	174,000	3,962	N/A	29,540	207,502
AS	1,080	12	N/A	N/A	1,092
AZ	253,451	N/A	2755	N/A	256,206
CA	780,000	127,000	156,000	N/A	1,063,000
CO	216,099	21,764	3326	23,364	264,553
CT	99,462	17,916	297	N/A	117,675
DC	24,799	455	287	N/A	25,541
DE	43,883	5,182	901	202	50,168
FL	529,000	10,100	3528	N/A	542,628
GA	349,724	9,543	N/A	N/A	359,267
HI	31,564	2,035	71	N/A	33,670
IA	118,599	5,688	24,764	N/A	149,051
ID	N/A	N/A	N/A	N/A	N/A
IL	239,793	48,378	8,592	N/A	296,763
IN	74,473	N/A	34,028	N/A	108,501
KS	54,667	27,977	15,660	29,252	127,556
KY	167,615	1,552	N/A	N/A	169,167
LA	85,280	N/A	1,416	N/A	86,696
MA	183,175	46,115	N/A	N/A	229,290
MD	157,717	41,164	1,468	14,034	214,383
ME	34,300	10,104	N/A	853	45,257
MI	320,304	16,952	20,329	N/A	357,585
MN	130,464	75,626	23,480	N/A	229,570
MO	131,536	9,590	2,750	N/A	143,876
MS	124,064	124	397	58	124,643
MT	13,066	1,423	4,902	N/A	19,391
NC	426,732	27,851	N/A	N/A	454,583
ND	23,218	2,521	13,090	1,290	40,119
NE	95,478	14,356	7,572	4,241	121,647
NH	44,108	542	1,189	N/A	45,839
NJ	361,680	N/A	N/A	N/A	361,680

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	Other Licensed Child Care Facilities	Total number of all Licensed Child Care Programs
NM	55,950	668	1,480	N/A	58,098
NV	35,159	534	432	N/A	36,125
NY	309,407	31,262	123,512	316,977	781,158
OH	328,906	15,380	2,404	15,380	362,070
OK	105,906	7,551	8,195	N/A	121,652
OR	76,258	19,164	11,608	N/A	107,030
PA	353,042	10,734	8,653	N/A	372,429
RI	30,073	3,114	106	N/A	33,293
SC	181,532	4,805	1,114	N/A	187,451
SD	22,104	6,114	1,083	16,631	45,932
TN	146,742	1,743	4,262	745	153,492
TX	1,049,804	55,164	20,471	652	1,126,091
UT	31,246	747	9,994	N/A	41,987
VA	273,962	14,322	N/A	175	288,459
VT	27,733	5,940	N/A	238	33,911
WA	112,530	33,651	N/A	23,703	169,884
WI	142,190	14,454	N/A	N/A	156,644
WV	36,389	7,200	1,584	336	45,509
WY	15,707	2,408	2,114	N/A	20,229

Map 2 Total Licensed Child Care Capacity



Enrollment

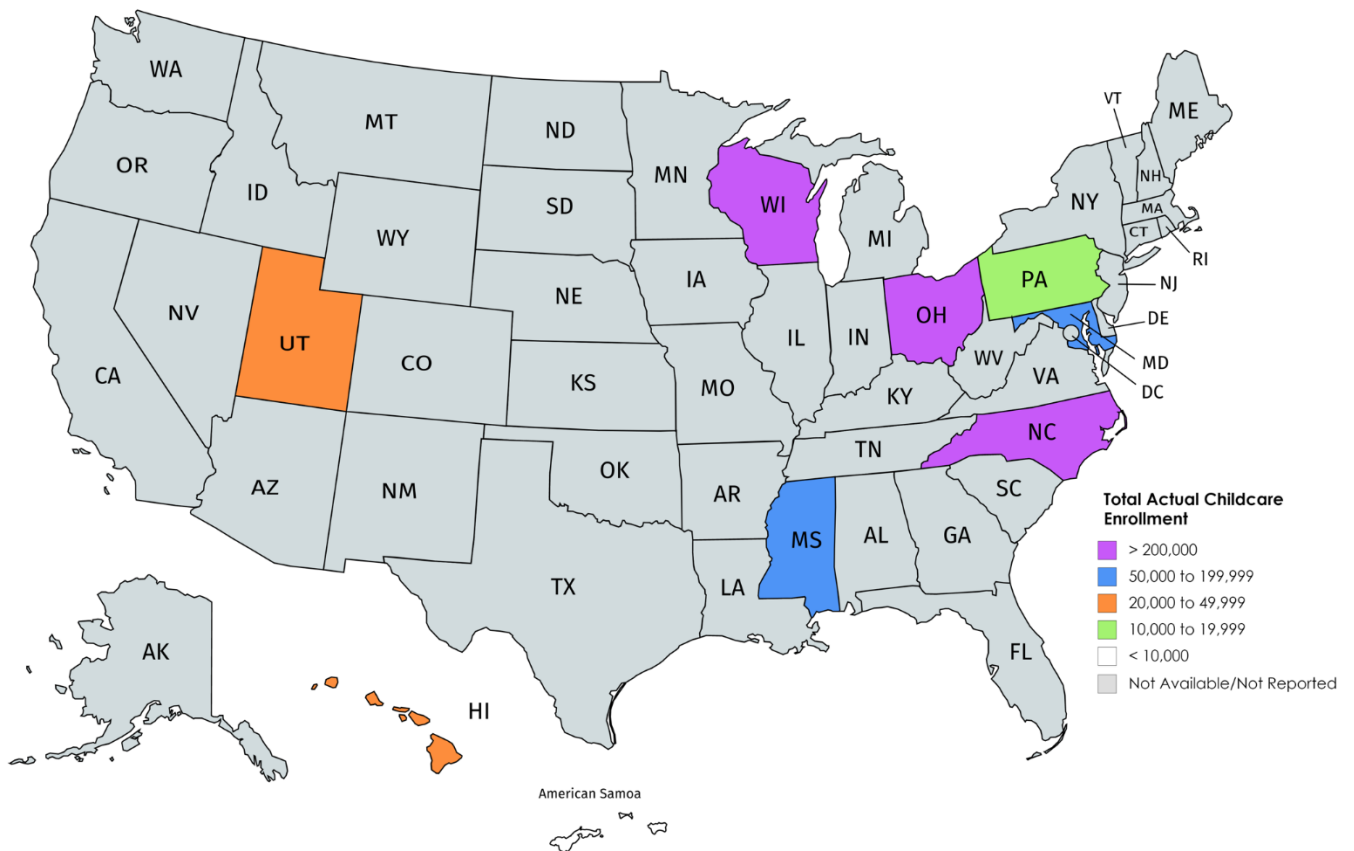
Question: If your state collects and aggregates “actual enrollment” data for facilities (e.g. from resource and referral agencies or other sources) – please include the most current data available on December 31, 2017 (or most current count).

Analysis: Only 9 states reported actual enrollment data for licensed child care programs in their state. 8 of the 9 states reported total licensed enrollment below capacity. Using a weighted average (weighted by total capacity slots) programs were, on average, at approximately 71% of capacity. Only Wisconsin reported licensed enrollment in excess of licensed capacity with enrollment almost 141% above reported capacity. The lack of responses may indicate that most states do not currently track this or have a way of reporting this information

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	Other Licensed Child Care Facilities	Total number for all Licensed Child Care Programs
Total	1,004,368	32,791	12,661	43,970	1,093,790
AK	N/A	N/A	N/A	N/A	N/A
AL	N/A	N/A	N/A	N/A	N/A
AR	N/A	N/A	N/A	N/A	N/A
AS	885	N/A	N/A	N/A	885
AZ	N/A	N/A	N/A	N/A	N/A
CA	N/A	N/A	N/A	N/A	N/A
CO	N/A	N/A	N/A	N/A	N/A
CT	N/A	N/A	N/A	N/A	N/A
DC	N/A	N/A	N/A	N/A	N/A
DE	N/A	N/A	N/A	N/A	N/A
FL	N/A	N/A	N/A	N/A	N/A
GA	N/A	N/A	N/A	N/A	N/A
HI	26,893	1,632	51	N/A	28,576
IA	N/A	N/A	N/A	N/A	N/A
ID	N/A	N/A	N/A	N/A	N/A
IL	N/A	N/A	N/A	N/A	N/A
IN	N/A	N/A	N/A	N/A	N/A
KS	N/A	N/A	N/A	N/A	N/A
KY	N/A	N/A	N/A	N/A	N/A
LA	N/A	N/A	N/A	N/A	N/A
MA	N/A	N/A	N/A	N/A	N/A
MD	166,057	N/A	N/A	14,034	180,091
ME	N/A	N/A	N/A	N/A	N/A
MI	N/A	N/A	N/A	N/A	N/A
MN	N/A	N/A	N/A	N/A	N/A
MO	N/A	N/A	N/A	N/A	N/A
MS	90,091	76	264	15	90,446
MT	N/A	N/A	N/A	N/A	N/A
NC	233,795	11,140	N/A	N/A	244,935
ND	N/A	N/A	N/A	N/A	N/A
NE	N/A	N/A	N/A	N/A	N/A
NH	N/A	N/A	N/A	N/A	N/A
NJ	N/A	N/A	N/A	N/A	N/A
NM	N/A	N/A	N/A	N/A	N/A
NV	N/A	N/A	N/A	N/A	N/A
NY	N/A	N/A	N/A	N/A	N/A
OH	260,237	17,998	3,689	N/A	281,924
OK	N/A	N/A	N/A	N/A	N/A
OR	N/A	N/A	N/A	N/A	N/A
PA	12,302	N/A	N/A	N/A	12,302
RI	N/A	N/A	N/A	N/A	N/A
SC	N/A	N/A	N/A	N/A	N/A
SD	N/A	N/A	N/A	N/A	N/A

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	Other Licensed Child Care Facilities	Total number for all Licensed Child Care Programs
TN	N/A	N/A	N/A	N/A	N/A
TX	N/A	N/A	N/A	N/A	N/A
UT	24,995	720	8,657	N/A	34,372
VA	N/A	N/A	N/A	N/A	N/A
VT	N/A	N/A	N/A	N/A	N/A
WA	N/A	N/A	N/A	N/A	N/A
WI	189,113	19,223	N/A	11,923	220,259
WV	N/A	N/A	N/A	N/A	N/A
WY	N/A	N/A	N/A	N/A	N/A

Map 3 Total Child Care Enrollment



LICENSING AND HEAD START

Summary:

The survey section on Head Start was new for 2017 so there is no comparative data for 2014. More than 90 percent of states reported that at least some Head Start Centers were required to be licensed, though less than half (35%) reported that all Head Start Centers were required to be licensed. Only five states reported that no Head Start Centers were required to get a license. The most common reasons for Head Start Centers not having to be licensed were because the programs were based in a public or private school or had some exemptions unique to Head Start Centers. A couple states reported that licensing was not required because the Centers were only open a limited time.

Thirty one states responded to a question on total Head Start enrollment in their state. The states responding represent 1.9 million children between the ages of 0 and 5 who live in households at or below the Federal Poverty Level.

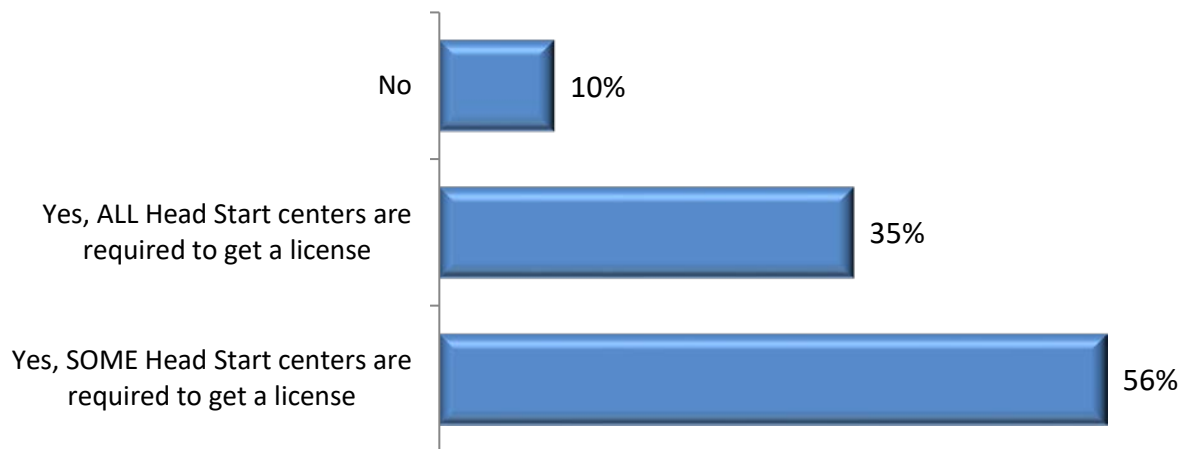
Nationally, among those states reporting, there are approximately 2.4 licensed Head Start programs per 1,000 young children in poverty. The number of centers varied between approximately 1 per 1,000 to more than 7 per 1,000. The average for those states reporting was about 3 licensed Head Start programs per 1,000 young children in poverty.

Sixty percent of states responding (N=50) said that half or more of their Head Start programs were licensed. Thirty percent of states responding did not know the number of licensed Head Start Programs. States reported having trouble getting data on Head Start programs and difficulty identifying them since they aren't always identified as a Head Start program in the licensing database or because a different agency collected information on Head Start Centers.

Head Start – Licensing

Question: Are Head Start Centers required to get a license?

Analysis: Almost every state, more than 90%, requires at least SOME Head Start centers to get a license. Slightly less than 35% require ALL Head Start centers to get a license and less than 10% reported that no Head Start centers were required to get a license.



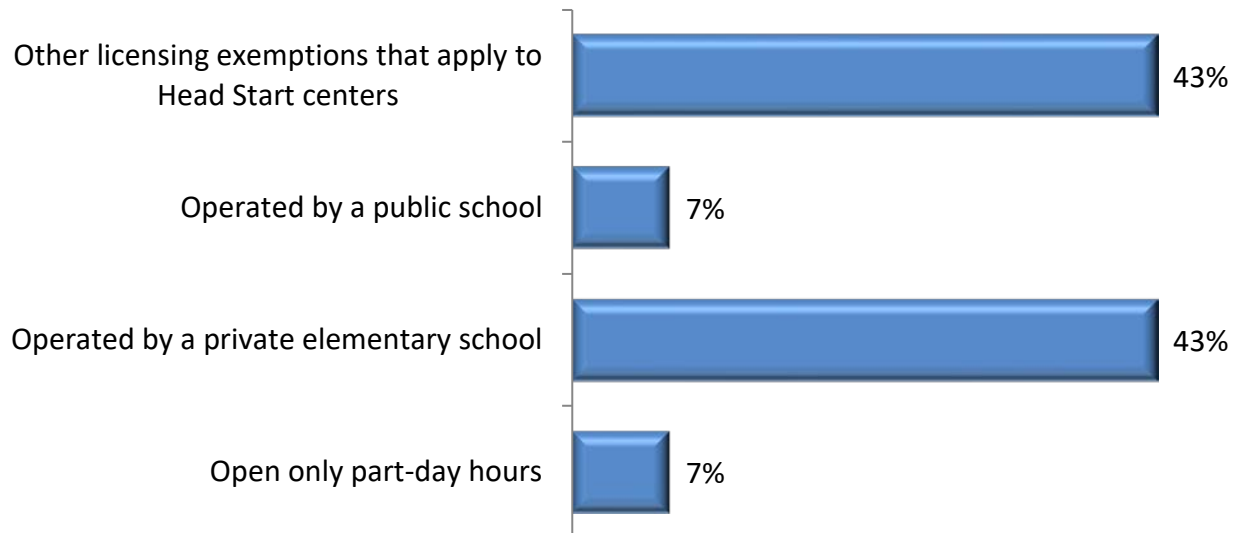
State	No	Yes, ALL Head Start centers are required to get a license	Yes, SOME Head Start centers are required to get a license
Total	5	18	29
AK			•
AL			•
AR		•	
AS	•		
AZ		•	

State	No	Yes, ALL Head Start centers are required to get a license	Yes, SOME Head Start centers are required to get a license
CA		•	
CO			•
CT			•
DC			•
DE		•	
FL			•
GA			•
HI		•	
IA	•		
ID			•
IL			•
IN			•
KS			•
KY			•
LA		•	
MA			•
MD		•	
ME		•	
MI		•	
MN			•
MO		•	
MS			•
MT			•
NC		•	
ND	•		
NE	•		
NH		•	
NJ		•	
NM			•
NV		•	
NY			•
OH		•	
OK			•
OR			•
PA			•
RI		•	
SC		•	
SD	•		
TN			•
TX			•
UT			•
VA			•
VT		•	
WA			•
WI			•
WV			•
WY			•

Head Start – Exemption Characteristics

Question: If some Head Start centers are required to get a license, which characteristics allow a Head Start center to be exempt from licensing?

Analysis: 27 of 29 states which responded that only SOME Head Start centers were required to be licensed provided explanations for the exemptions. More than half (52%) reported that Head Start centers operated by a public or private school were not required to be licensed; 2 states reported that Head Start centers aren't licensed because they are only open for part-day hours. More than 44% reported there were some other licensing exemptions that applied to Head Start centers.

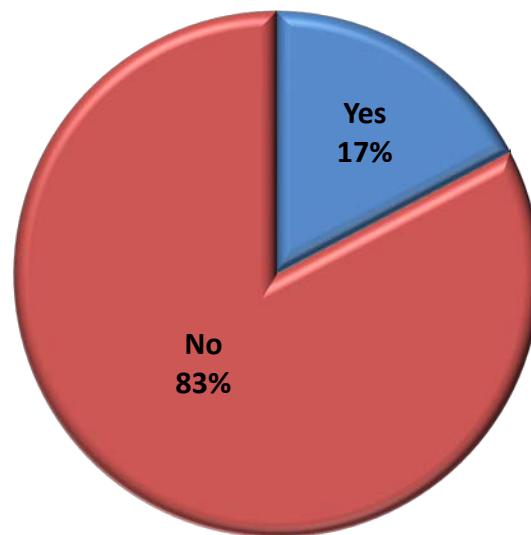


State	Open only part-day hours	Operated by a public school	Operated by a private elementary school	Other licensing exemptions that apply to Head Start centers
Total	2	12	2	12
AK			•	•
AL		•		
AR				
AS				
AZ				
CA				
CO				
CT				•
DC		•		
DE				
FL			•	
GA				•
HI				
IA				
ID				•
IL		•		
IN				
KS		•		
KY				•
LA				
MA		•		

State	Open only part-day hours	Operated by a public school	Operated by a private elementary school	Other licensing exemptions that apply to Head Start centers
MD				
ME				
MI				
MN				•
MO				
MS				•
MT	•			
NC				
ND				
NE				
NH				
NJ				
NM		•		
NV				
NY				•
OH				
OK		•		
OR				•
PA				•
RI				
SC				
SD				
TN		•		
TX		•		
UT				•
VA		•		
VT				
WA				•
WI		•		
WV	•			
WY		•		

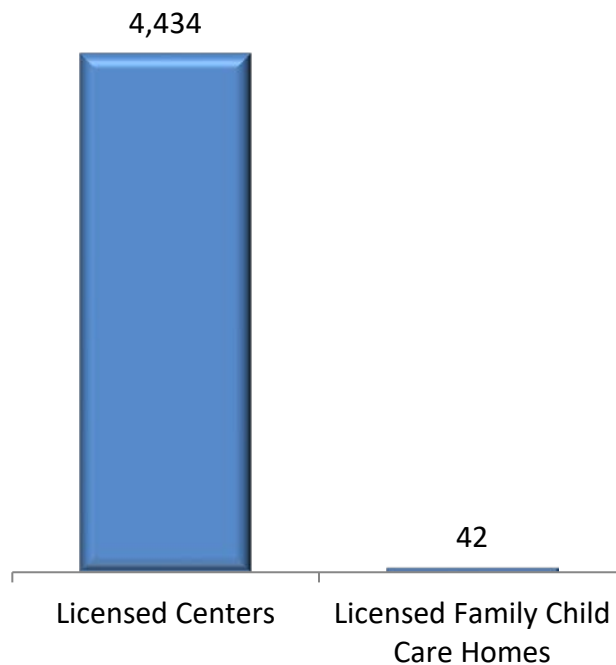
Head Start – Challenges

Question: Have there been any challenges for Head Start centers in meeting the licensing requirements?



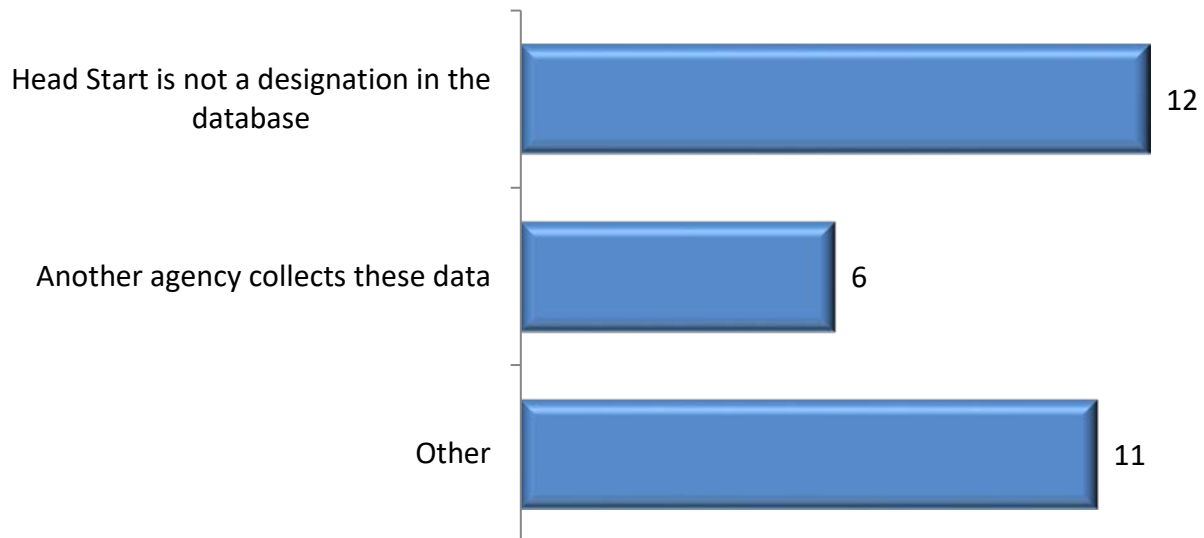
Question: Please provide information about the number of licensed Head Start centers and family child care homes in your state/territory as of December 31, 2017.

Analysis: Only 31 states reported the number of Licensed Head Start centers and Licensed Head Start FCC homes, 21 states did not provide data. The responding states reported a total of 4,434 licensed Head Start Centers and 42 Licensed Head Start FCC homes.



Question: If you cannot provide the number of licensed Head Start centers and family child care homes, please describe why the data is not available.

Analysis: While 21 states did not report the number of licensed Head Start center and FCC homes, 28 states reported issues collecting data on the number of Head Start centers. More than half reported that Head Start was not a designation in the database used to count licensed facilities. About 21% reported that a different agency collected the data while approximately 39% reported having other reasons.

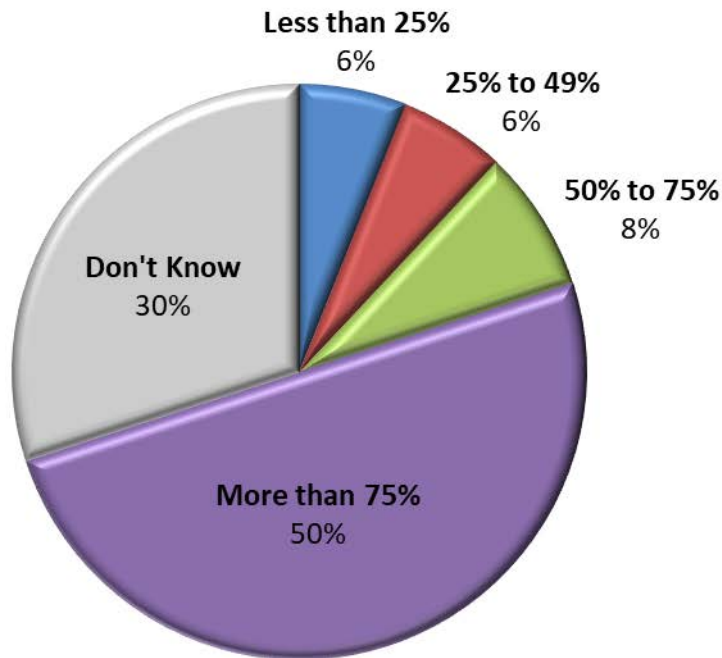


State	Head Start is not a designation in the database	Another agency collects these data	Other
Total	12	6	11
AK		.	.
AL			
AR			
AS			.
AZ			.
CA		.	
CO	.		
CT			
DC			
DE	.		
FL		.	
GA			.
HI			
IA	.		
ID	.		
IL			.
IN			.
KS		.	
KY			.
LA			.
MA			
MD			
ME			
MI			
MN	.		

State	Head Start is not a designation in the database	Another agency collects these data	Other
MO	•		
MS			
MT	•		
NC			
ND	•		
NE			•
NH			
NJ		•	
NM			
NV			
NY			•
OH		•	
OK			
OR			
PA			
RI	•		
SC			
SD			
TN	•		
TX	•		
UT			
VA	•		
VT			
WA			•
WI			
WV			
WY			

Question: Approximately what percentage of Head Start centers are licensed (whether voluntarily or because of a requirement) in your state/territory as of December 31, 2017?

Analysis: Almost 60% of the states reporting (n=50) said that more than 50% of Head Start centers are licensed, and half said more than 75% of Head Start centers are licensed. Only 12% of states reported less than half of their Head Start centers are licensed. A total of 30% of the states reporting did not know what percentage of Head Start centers are licensed.



State	Less than 25%	25 – 49%	50 – 75%	Greater than 75%	Do not know
Total	3	3	4	25	15
AK	•				
AL				•	
AR				•	
AS					•
AZ				•	
CA					•
CO				•	
CT			•		
DC				•	
DE				•	
FL					
GA			•		
HI				•	
IA		•			
ID					•
IL					•
IN					•
KS		•			
KY					•
LA				•	
MA			•		

State	Less than 25%	25 – 49%	50 – 75%	Greater than 75%	Do not know
MD				•	
ME				•	
MI				•	
MN					•
MO				•	
MS			•		
MT				•	
NC				•	
ND					•
NE	•				
NH				•	
NJ				•	
NM				•	
NV					•
NY					•
OH					•
OK				•	
OR				•	
PA					
RI				•	
SC				•	
SD	•				
TN				•	
TX					•
UT					•
VA					•
VT				•	
WA					•
WI				•	
WV		•			
WY				•	

LICENSING STAFF

Summary:

Child care licensing line staff often have multiple roles and are rarely limited to inspecting just one type of facility or just child care programs. The number of staff dedicated to inspecting only centers or just FCC homes declined between 2014 and 2017 (from 10 to 9 and 10 to 7 respectively) but the number of states reporting staff doing both increased (from 33 to 39). The number of staff assigned to other social services (such as foster care, therapeutic group homes, etc.) also declined including other child services (from 7 to 4) and adult services (from 3 to 2). The number of states reporting variation by county or area of the state also declined (from 20 to 16). So states are trending toward more focus on just child care licensing inspections from their line staff, with less variability in regulations, but with staff being less focused on specific program types.

The number of line staff FTEs increased by approximately 400 between 2014 and 2017 with 29 states reporting increases and 5 states reporting no changes. Overall caseloads also dropped with the average caseload of 100 per line staff in 2014 dropping to 88 in 2017. The median caseload dropped from 85 in 2014 to approximately 70 in 2017. Larger numbers of staff does not always equate to lower caseloads. For example, California has the third highest number of line staff of all states yet has the highest caseload. Most states have not conducted a workload analysis.

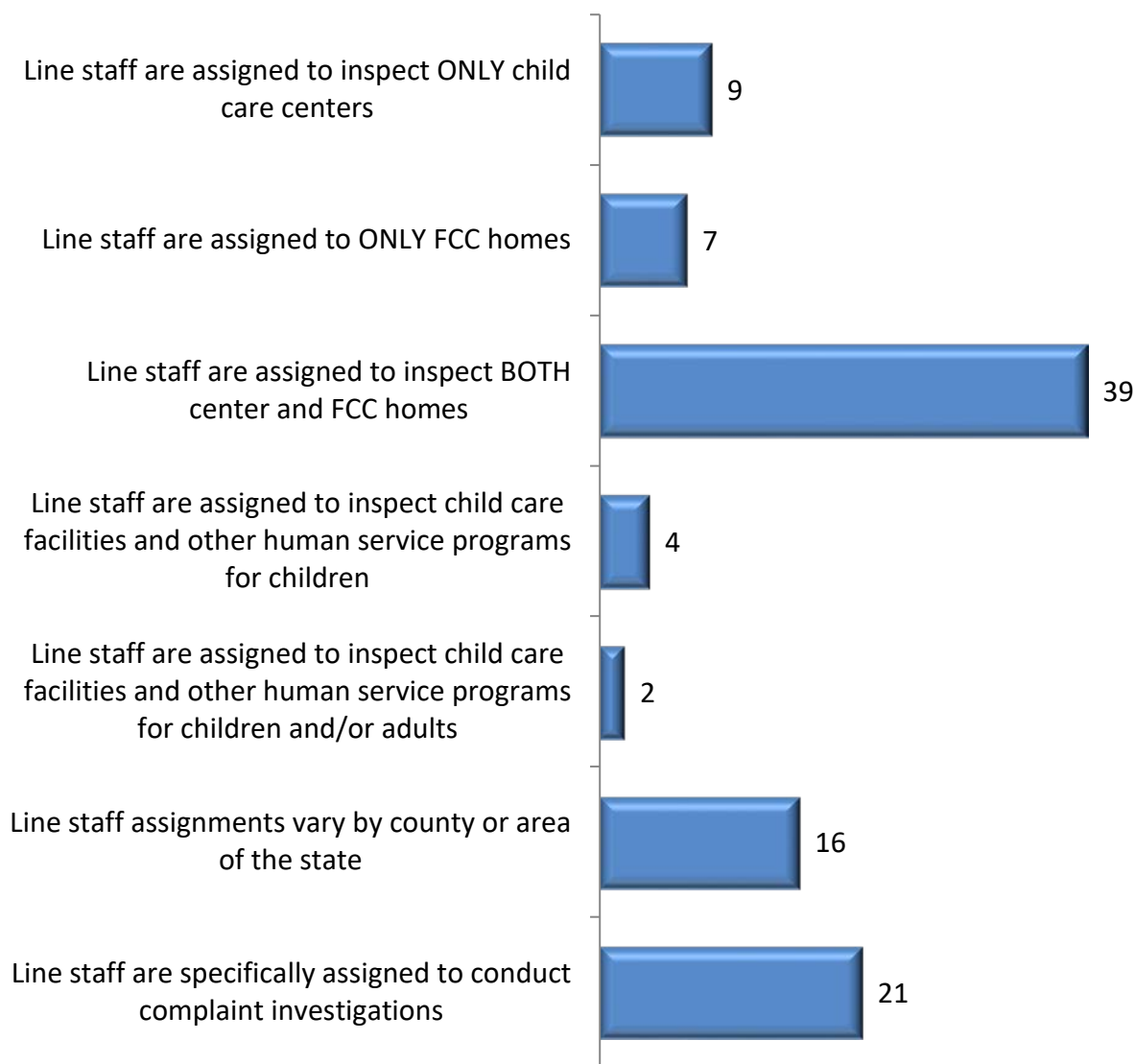
In 2017 there were an average 8.4 line staff per supervisor across all states, an increase of more than 2.5 FTEs per supervisor over the 2014 average of 5.8. The median actually decreased from 6 FTEs per supervisor in 2014 to just under 5 FTEs per supervisor in 2017.

Line Staff Assignments and Caseload

Question: How are the child care licensing line staff assigned to inspect licensing child care programs in your state?

Analysis: In two states, line staff inspected only child care centers but were also responsible for complaint investigations. In six states, staff are responsible for either centers or homes, but not both, and four of those states also handled complaints. In one state, line staff are responsible for inspecting child care facilities and other human service programs for children and/or adults, and in two states Line staff are assigned to inspect child care facilities and other human service programs for children.

In the majority of states, line staff are assigned to inspect both centers and homes. In 39 states, or just over 76% (n=51), line staff are responsible for inspecting both centers and FCC homes and in 15 of those states (59%) line staff also investigated complaints. In three states where line staff inspected both, they were also responsible for inspecting other human services programs. Slightly less than one-third of states reported that line staff assignments varied by county or area of the state.

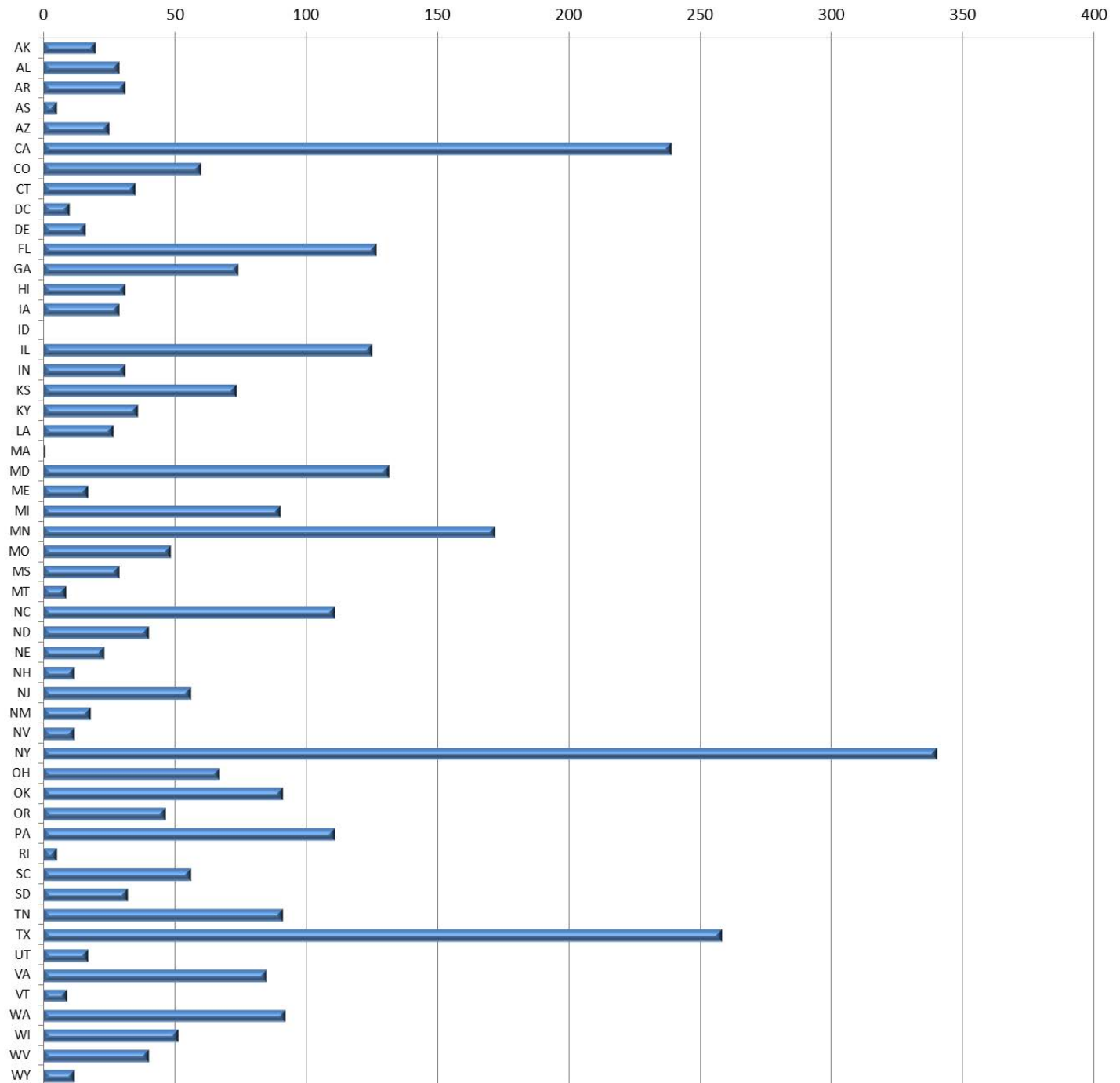


State	Line staff are assigned to inspect ONLY child care centers	Line staff are assigned to ONLY FCC homes	Line staff are assigned to inspect BOTH center and FCC homes	Line staff are assigned to inspect child care facilities and other human service programs for children	Line staff are assigned to inspect child care facilities and other human service programs for children and/or adults	Line staff assignments vary by county or area of the state	Line staff are specifically assigned to conduct complaint investigations
Total	9	7	39	4	2	16	21
AK			.				
AL	.	.					
AR			.				
AS			.				
AZ			.				
CA			.				.
CO			.	.			
CT	.	.					.
DC			.				
DE				.		.	
FL			.			.	
GA			.				.
HI			.				
IA	.	.		.		.	
ID							
IL	.	.	.			.	.
IN			.				
KS						.	
KY			.				
LA			.			.	.
MA	.	.					.
MD			.		.		.
ME			.				.
MI			.				
MN	.					.	.
MO			.				
MS			.				.
MT			.			.	
NC			.				.
ND			.			.	.
NE			.			.	.
NH			.	.			
NJ	.					.	.
NM			.				.
NV			.			.	.
NY						.	
OH			.			.	
OK			.				
OR			.				.
PA			.				
RI			.				
SC			.			.	
SD			.				
TN					.		

State	Line staff are assigned to inspect ONLY child care centers	Line staff are assigned to ONLY FCC homes	Line staff are assigned to inspect BOTH center and FCC homes	Line staff are assigned to inspect child care facilities and other human service programs for children	Line staff are assigned to inspect child care facilities and other human service programs for children and/or adults	Line staff assignments vary by county or area of the state	Line staff are specifically assigned to conduct complaint investigations
TX			•				
UT	•	•					•
VA			•			•	
VT			•				
WA			•				
WI			•				•
WV	•	•					•
WY			•				•

Question: What is the total number of child care licensing LINE STAFF conducting inspections in your state?

Analysis: Total number of line staff conducting inspections generally varied according to overall state population and through program structure (such as other state agencies or departments conducting some or all of the inspections). New York, Texas, and California reported the most staff, whereas American Samoa and Rhode Island reported the lowest levels of staffing. Massachusetts did not report and Idaho reported that local Health and Fire Departments conduct inspections.



Question: Have you increased or reduced the numbers of licensing staff in the last year? What is the cause for this increase or decrease?

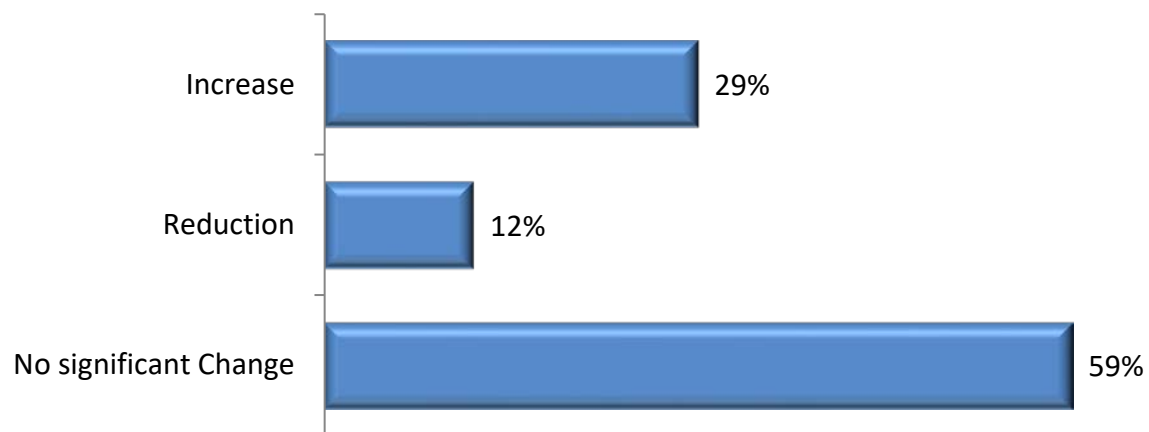
Analysis: 59% of states reported no significant change in licensing staff during the previous year while 29% reported an increase and 12% reported a decrease.

Reasons for increase included:

- CCDF funding requirement changes
- Changes in frequency of inspections from biannually to annually

Reasons for reduction include:

- Reduction in the number of licensed child care programs requiring inspections
- Budget reductions
- Hiring freeze



State	Increase	Reduction	No significant change
Total	15	6	30
AK			•
AL	•		
AR		•	
AS	•		
AZ		•	
CA			•
CO			•
CT		•	
DC	•		
DE			•
FL	•		
GA	•		
HI			•
IA			•
ID			•
IL	•		
IN	•		
KS			•
KY			•
LA			•
MA			

State	Increase	Reduction	No significant change
MD			•
ME		•	
MI			•
MN	•		
MO			•
MS	•		
MT		•	
NC			•
ND			•
NE			•
NH	•		
NJ			•
NM			•
NV			•
NY			•
OH	•		
OK		•	
OR	•		
PA			•
RI			•
SC			•
SD			•
TN			•
TX	•		
UT			•
VA	•		
VT			•
WA	•		
WI			•
WV			•
WY			•

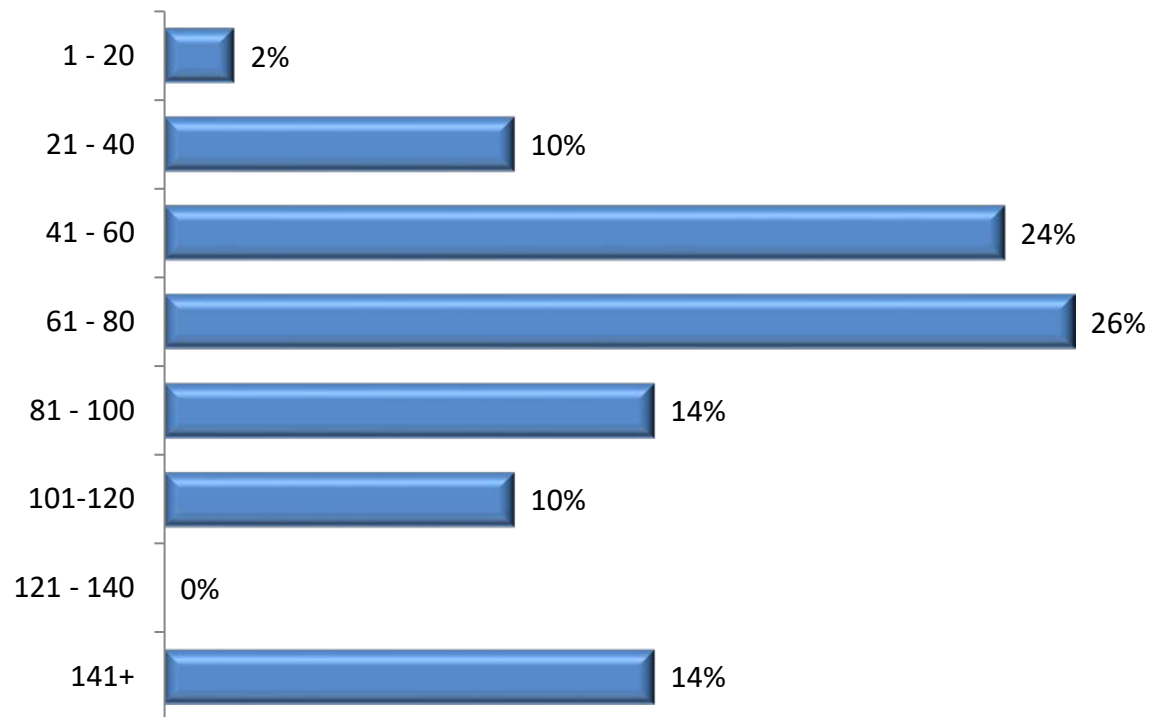
Question: What is the average statewide caseload for all facility types combined for line staff assigned to inspect early and school-age care programs, e.g., child care centers and family child care homes?

Analysis: Average line staff caseload ranged from a low of 6 for American Samoa to 182 in Rhode Island. Average caseload was about 80 per line staff, while the Median was about 70 per line staff.

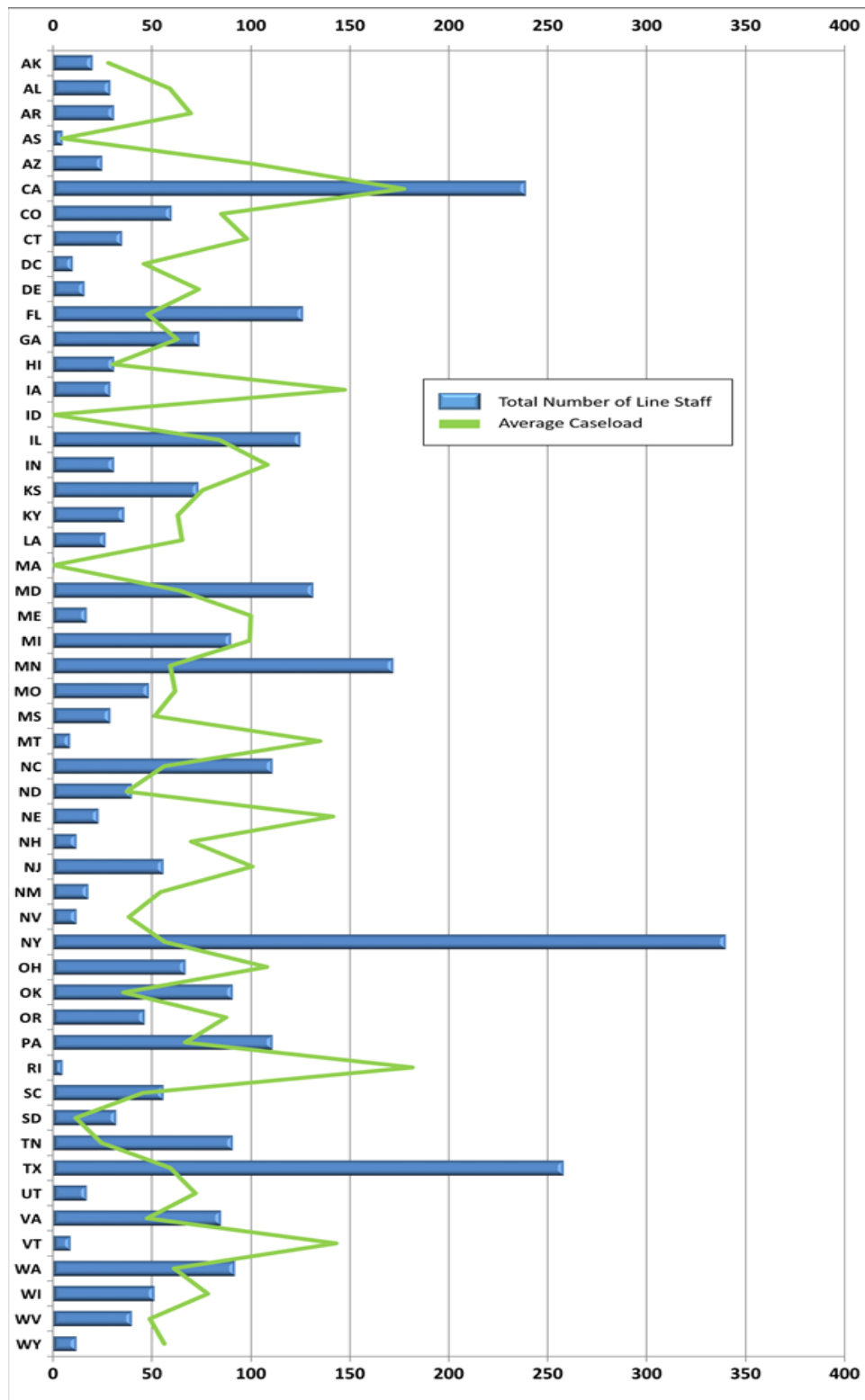
Not included in data

ID: Inspections completed by Local Health and Fire Departments

MA: Not Reported

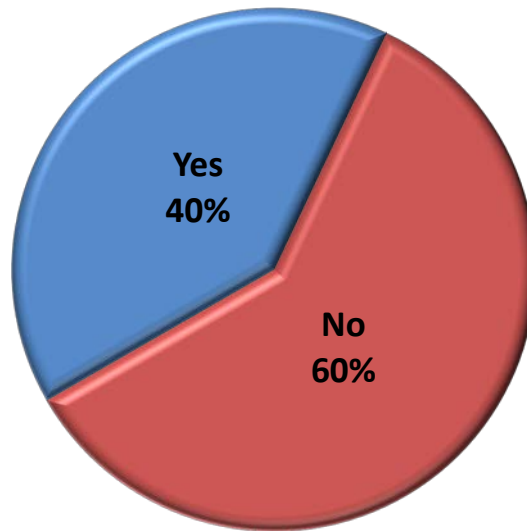


Note that higher levels of staffing did not necessarily mean lower caseloads. By superimposing Average Caseload over total staffing in the graph below it is possible to see the relationship between staffing and caseload for each state. New York, which has the highest overall staffing, has an average caseload below the average for all states. California, however, which has the third highest overall staffing, also has one of the highest average caseloads per line staff.



Question: Has your state conducted a workload analysis?

Analysis: Less than half of all states reported completing a workload analysis. One fourth of the states that had completed an analysis had not conducted it within the last two years.



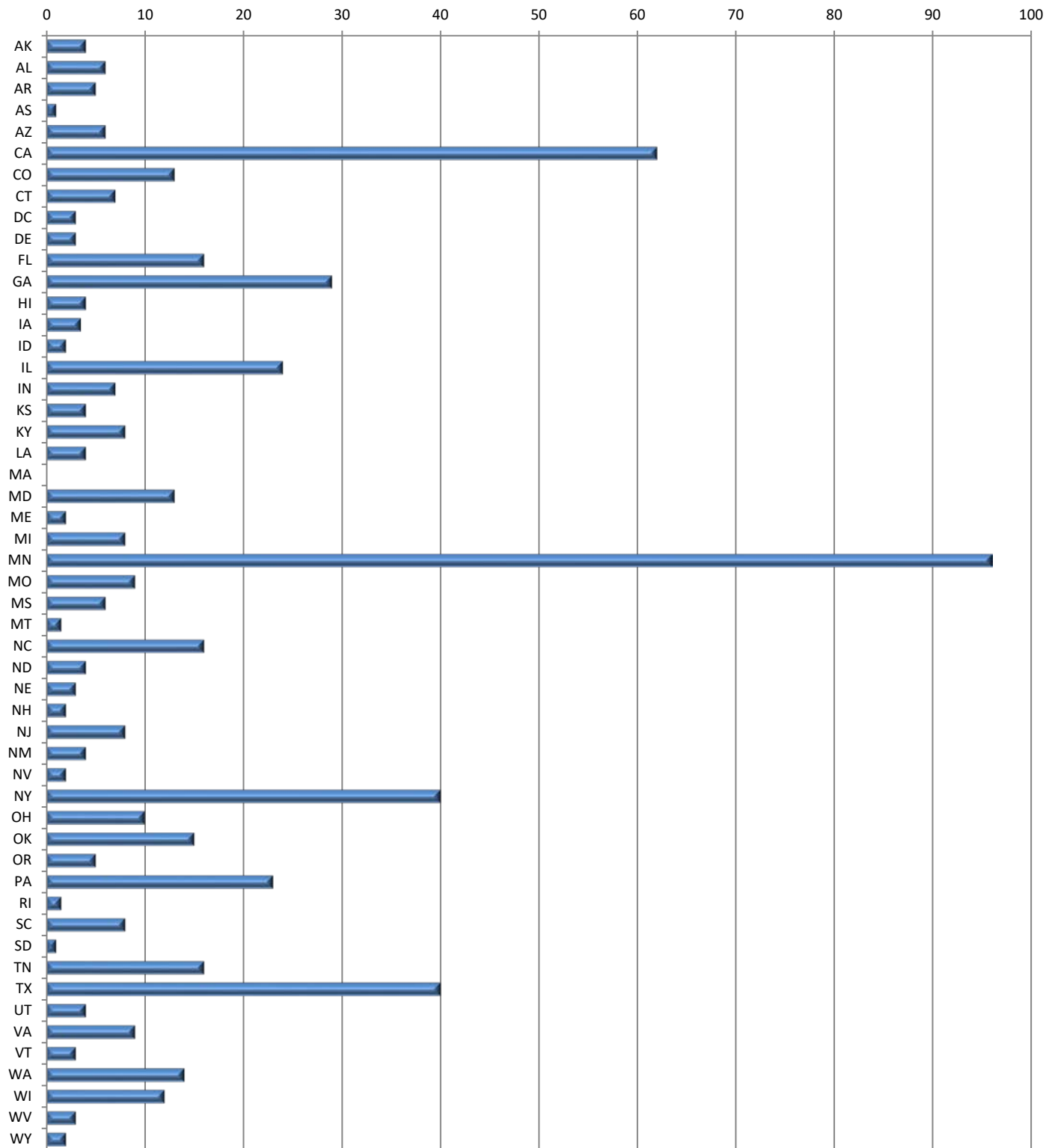
State	Yes	Date Conducted	No
Total	21		31
AK			•
AL			•
AR	•	2017	
AS			•
AZ			•
CA	•	2015	
CO	•	2014	
CT			•
DC	•	2018	
DE			•
FL	•	2018	
GA	•	2018	
HI			•
IA			•
ID	•	2017	
IL			•
IN	•	2017	
KS			•
KY	•	2018	
LA	•	2018	
MA			•
MD			•
ME			•
MI			•
MN			•
MO			•
MS	•	2012	
MT	•	2018	
NC			•
ND			•
NE			•
NH			•

State	Yes	Date Conducted	No
NJ			•
NM			•
NV	•	2018	
NY	•	2017	
OH			•
OK	•	2009	
OR	•	2018	
PA			•
RI	•	2017	
SC			•
SD			•
TN	•	2014	
TX			•
UT	•	2017	
VA			•
VT	•	2017	
WA			•
WI	•	2018	
WV			•
WY			•

Supervisory Staff

Question: What is the total number of child care licensing SUPERVISORS in your state?

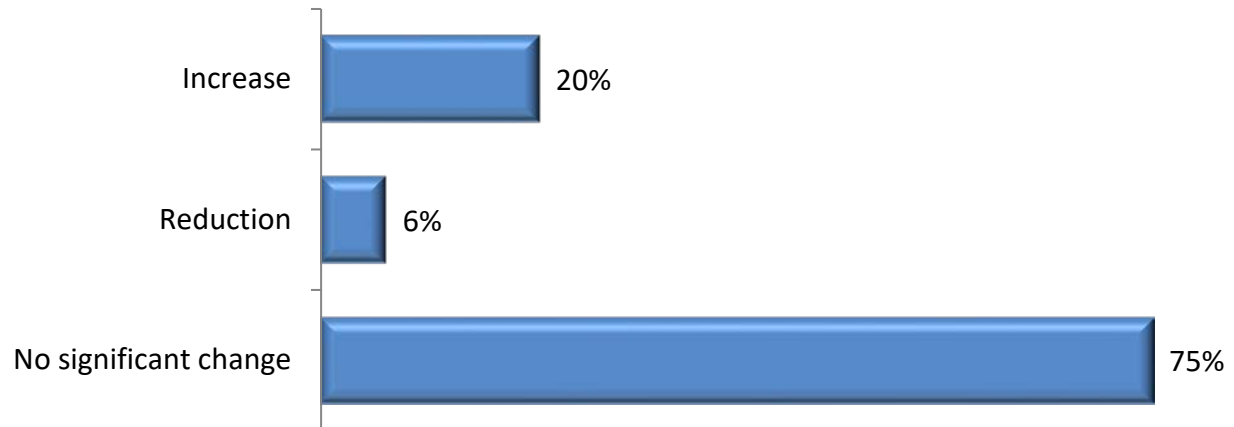
Analysis: The total number of supervisors ranged from a high of 96 in Minnesota to less than 5 supervisors in 22 states. The mean number of supervisors was almost 12 per state while the median was 6.



Question: Have you increased or reduced the numbers of supervising staff in the last year?

Analysis: Of the 51 states reporting, 75% reported no significant change is supervising staff while 20% reported an increase and 6% reported a decrease in supervising staff.

The most common reason for an increase was to handle a recent or planned increase in number of line staff conducting inspections. The reasons for supervising staff reductions included staff attrition and budget reductions.



State	Increase	Reduction	No significant change
Total	10	3	38
AK			•
AL	•		
AR			•
AS			•
AZ		•	
CA			•
CO			•
CT			•
DC	•		
DE			•
FL	•		
GA	•		
HI			•
IA			•
ID			•
IL			•
IN	•		
KS			•
KY			•
LA			•
MA			
MD		•	
ME			•
MI			•
MN	•		
MO			•
MS	•		
MT			•
NC			•
ND			•
NE			•
NH			•

State	Increase	Reduction	No significant change
NJ			•
NM			•
NV			•
NY			•
OH	•		
OK		•	
OR			•
PA			•
RI			•
SC			•
SD			•
TN			•
TX			•
UT			•
VA			•
VT			•
WA			•
WI	•		
WV	•		
WY			•

LICENSE EXEMPT PROGRAMS

Summary:

Information gathering on license exempt programs was a new area for the 2017 licensing survey. Questions were asked on subsidy payments, voluntary licensure, inspections, and licensing requirements.

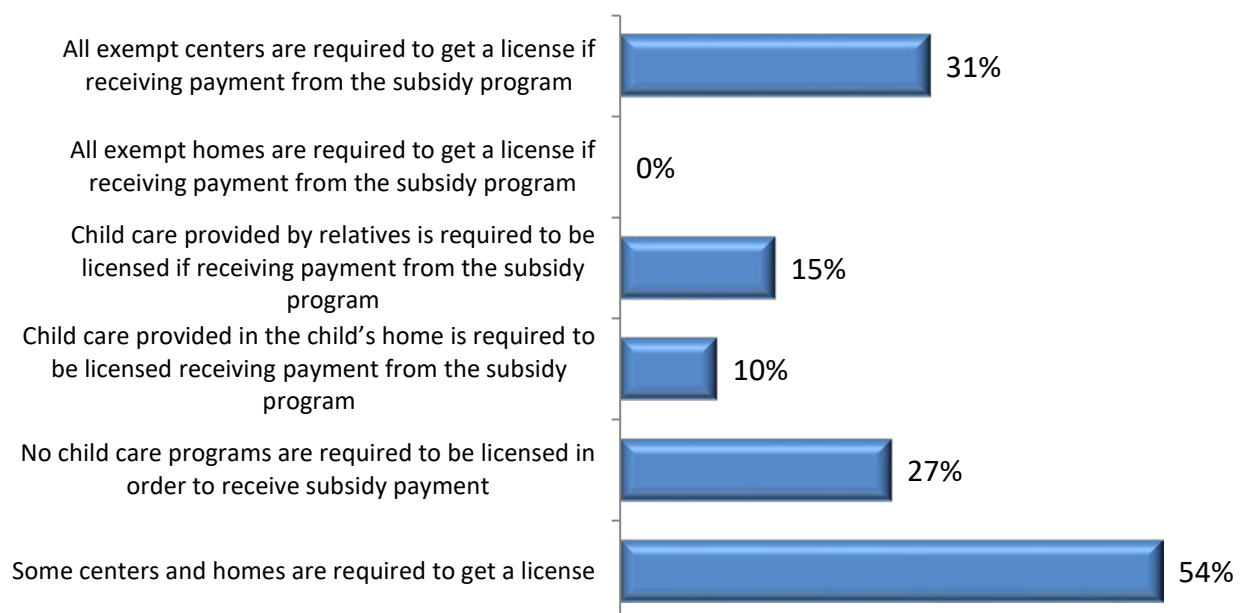
Nearly every state has exemptions for certain types of programs though in nearly three-fourths of states, licensure is a requirement for receiving subsidy payments for some programs and only 14 states said licensure was not a prerequisite for receiving subsidy payments. Many states reported that the licensing requirements were different for exempt programs and that exempt centers and homes each had separate requirements. More than 94 percent of states reported a voluntary pathway to licensure for most, if not all exempt programs. Only three out of 52 states reported no voluntary licensure for exempt programs.

Just over half of the states reporting said that licensing agency staff was responsible for inspections of license exempt homes. It should be noted the 2014 Child Care Block Grant Reauthorization required inspections for license-exempt programs accepting subsidy. For those states reporting (N=36), more than half said existing staff were responsible for both licensed and license exempt centers and homes. Six states reported hiring a total of 72 additional staff to handle inspections of license exempt programs. Of 27 states reporting on caseloads related to exempt programs, just over half reported that caseloads had increased for the inspection of license-exempt centers and homes. In about 41% of the states, caseloads remained the same.

License Exempt and Subsidy Payments

Question: Are license-exempt centers and homes required to get a license if they receive payment from the child care subsidy program?

Analysis: Almost three-fourths (72.5%) of states reported that at least some exempt centers and homes are required to get a license in order to receive payment from the subsidy program. Virtually all centers are required to be licensed unless they have specific exemptions (government facilities) or do not meet the definition of a child care program (such as day camps). In other instances, they may remain exempt but must meet some other regulatory requirements. Family child care homes that are exempt usually must meet some other formal requirements including meeting local ordinances, receiving an alternate designation (such as registered or informal) that still requires oversight.



State	All exempt centers are required to get a license if receiving payment from the subsidy program	All exempt homes are required to get a license if receiving payment from the subsidy program	Child care provided by relatives is required to be licensed if receiving payment from the subsidy program	Child care provided in the child's home is required to be licensed receiving payment from the subsidy program	No child care programs are required to be licensed in order to receive subsidy payment	Some centers and homes are required to get a license
Total	16	10	8	5	14	28
AK					•	•
AL						•
AR	•	•				
AS	•	•	•			
AZ						•
CA						•
CO	•					•
CT						•
DC	•	•				
DE						
FL					•	•
GA	•					•
HI					•	
IA	•					•
ID						•
IL						•
IN					•	•
KS	•					
KY						•
LA		•	•	•		•
MA					•	
MD						•
ME						•
MI						•
MN		•				•
MO					•	
MS	•	•	•	•		
MT					•	
NC	•	•				
ND	•	•				
NE						•
NH					•	
NJ	•					
NM	•	•	•			
NV						•
NY						•
OH						•
OK	•	•	•			
OR					•	
PA	•					•
RI						•
SC					•	
SD	•					•
TN						•
TX			•	•		
UT					•	
VA					•	

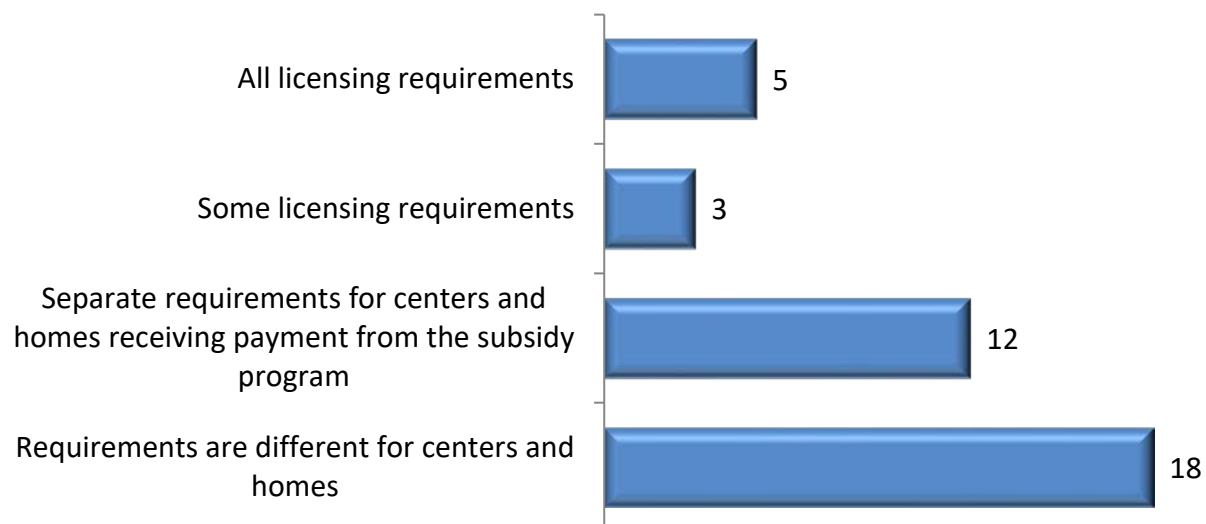
State	All exempt centers are required to get a license if receiving payment from the subsidy program	All exempt homes are required to get a license if receiving payment from the subsidy program	Child care provided by relatives is required to be licensed if receiving payment from the subsidy program	Child care provided in the child's home is required to be licensed receiving payment from the subsidy program	No child care programs are required to be licensed in order to receive subsidy payment	Some centers and homes are required to get a license
VT	•		•	•		
WA						•
WI					•	
WV			•	•		•
WY					•	

Licensing Requirements for Exempt Programs

Question: Which program requirements apply to license-exempt centers and homes receiving payment from the subsidy program?

Analysis: Only 5 (25%) of the states reporting (n=20) indicated that all licensing requirements were required for license exempt centers and homes receiving subsidy payments while 3 states reported that at least some of the requirements applied. In 60% of reporting states, there are separate requirements for license-exempt centers and homes receiving subsidy payments.

There were reported differences between exempt and non-exempt centers and homes in 18 states. The most frequent difference is that license exempt homes are regulated differently, usually with less stringent requirements including ratios, professional development, and frequency and intensity of inspections.



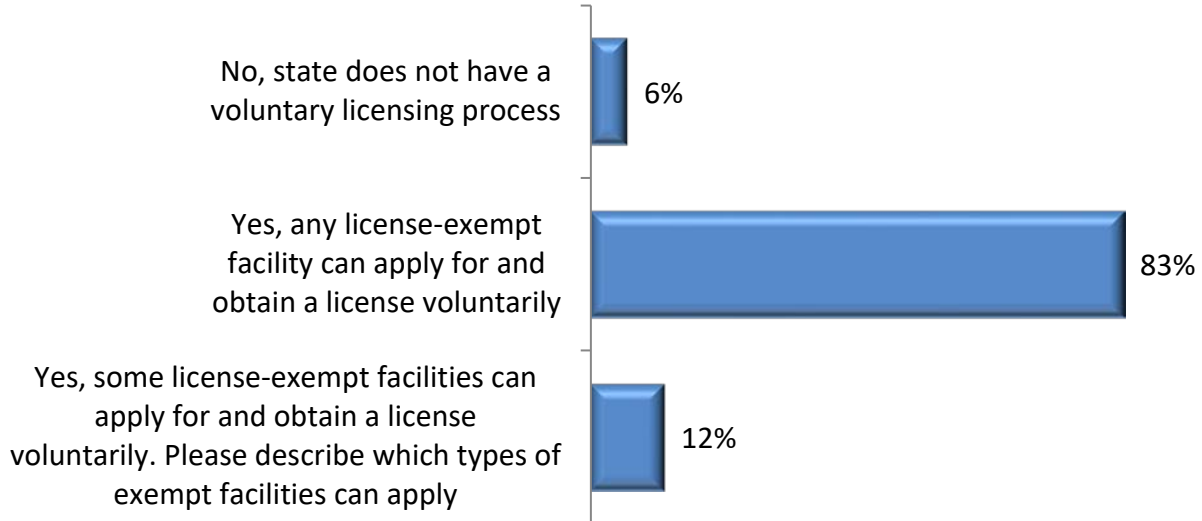
State	All licensing requirements	Some licensing requirements	Separate requirements specifically for license-exempt centers and homes receiving payment from the subsidy program	Requirements are different for license-exempt centers and homes
Total	5	3	12	18
AK			•	
AL				•
AR	•			•
AS	•			
AZ				

State	All licensing requirements	Some licensing requirements	Separate requirements specifically for license-exempt centers and homes receiving payment from the subsidy program	Requirements are different for license-exempt centers and homes
CA				
CO			•	
CT				•
DC				•
DE				
FL			•	
GA				•
HI				
IA				•
ID				
IL				
IN				
KS				
KY				
LA				•
MA				
MD				
ME				
MI				
MN				
MO				
MS				
MT			•	•
NC		•		•
ND	•			
NE				
NH			•	•
NJ	•			
NM			•	•
NV				
NY				
OH	•			•
OK				
OR		•		•
PA				
RI		•		•
SC			•	•
SD			•	•
TN			•	
TX				
UT			•	
VA			•	•
VT				
WA			•	•
WI				
WV				
WY				

Voluntary Licensure of Exempt Facilities

Question: If a license-exempt facility wants to obtain a license, does the state have a process for voluntary licensure?

Analysis: Almost 83% of states reported that any license exempt facility that wanted to could apply for and obtain a license voluntarily. Another 11% of states reported that some exempt facilities could get a license. Those that could not were usually informal, religious, military, tribal, school-based, or those not meeting the definition of child care.

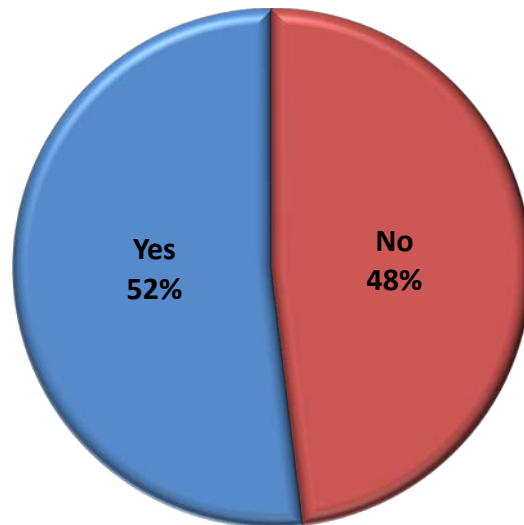


State	No, state does not have a voluntary licensing process	Yes, any license-exempt facility can apply for and obtain a license voluntarily	Yes, some license-exempt facilities can apply for and obtain a license voluntarily.
Total	3	43	6
AK			•
AL			•
AR		•	
AS	•		
AZ		•	
CA		•	
CO		•	
CT		•	
DC		•	
DE		•	
FL		•	
GA		•	
HI		•	
IA		•	
ID		•	
IL		•	
IN		•	
KS		•	
KY		•	
LA		•	
MA		•	
MD	•		
ME		•	
MI		•	
MN		•	
MO		•	
MS		•	
MT		•	
NC		•	

State	No, state does not have a voluntary licensing process	Yes, any license-exempt facility can apply for and obtain a license voluntarily	Yes, some license-exempt facilities can apply for and obtain a license voluntarily.
ND		•	
NE		•	
NH		•	
NJ		•	
NM		•	
NV		•	
NY		•	
OH		•	
OK		•	
OR		•	
PA		•	
RI		•	
SC		•	
SD		•	
TN		•	
TX			•
UT			•
VA			•
VT		•	
WA			•
WI		•	
WV	•		
WY		•	

Inspections of License Exempt Centers

Question: The Child Care and Development Fund now requires states to conduct an annual inspection of center-based facilities and home-based providers that are legally exempt from licensing and receive payment from CCDF. Are inspections of license-exempt centers and homes administered by the licensing agency?



State	Yes	No
Total	26	24
AK	•	
AL	•	
AR	•	
AS	•	
AZ		•
CA		•
CO	•	
CT	•	
DC	•	
DE		•
FL	•	
GA	•	
HI		•
IA	•	
ID		•
IL		•
IN	•	
KS		•
KY		•
LA	•	
MA		Did Not Respond
MD		•
ME		•
MI		•
MN		•
MO		•
MS		•
MT	•	
NC	•	
ND	•	
NE		•

State	Yes	No
NH	•	
NJ	•	
NM	•	
NV		•
NY		•
OH		•
OK		•
OR	•	
PA		•
RI	•	
SC	•	
SD	•	
TN	•	
TX		•
UT	•	
VA	•	
VT		•
WA	•	
WI		•
WV		Did Not Respond
WY		•

Question: Which staff are conducting the inspections of license-exempt centers and homes?

Analysis: Of the 26 states that reported the licensing agency was responsible for inspecting license-exempt centers and homes, 19 (73 percent) reported that existing staff were responsible for inspecting both licensed and license-exempt programs. Four states reassigned existing staff to inspect license-exempt centers and homes, three states hired new staff to inspect both and three states hired new staff to inspect only license-exempt centers and homes.

In all, 12 states reported hiring new staff to conduct inspections of license-exempt programs. On average, these states hired an additional 6 staff members for these inspections.

State	Existing licensing agency staff assigned to inspect BOTH licensed and license-exempt centers and homes	Existing licensing agency staff reassigned to inspect ONLY license-exempt centers and homes	New licensing agency staff assigned to inspect BOTH licensed and license-exempt centers and homes	New licensing agency staff hired to inspect ONLY license-exempt centers and homes	Other staff, contractors, or entities (please describe specifically who is conducting the inspections)	New staff were hired to conduct these inspections	Number of new staff hired
Total	20	4	3	3	6	12	72
AK	•						
AL	•					•	6
AR	•						
AS	•				•		
AZ							
CA							
CO		•					
CT	•						
DC					•		
DE							
FL	•					•	
GA	•	•		•		•	4
HI							
IA	•						
ID							
IL							

State	Existing licensing agency staff assigned to inspect BOTH licensed and license-exempt centers and homes	Existing licensing agency staff reassigned to inspect ONLY license-exempt centers and homes	New licensing agency staff assigned to inspect BOTH licensed and license-exempt centers and homes	New licensing agency staff hired to inspect ONLY license-exempt centers and homes	Other staff, contractors, or entities (please describe specifically who is conducting the inspections)	New staff were hired to conduct these inspections	Number of new staff hired
IN					•	•	
KS							
KY							
LA	•					•	4
MA							
MD							
ME							
MI							
MN							
MO							
MS							
MT	•						
NC	•						
ND	•						
NE							
NH	•					•	2
NJ	•					•	8
NM				•		•	16
NV							
NY							
OH	*						
OK							
OR	•		•			•	8
PA							
RI	•						
SC	•				•		
SD	•						
TN			•			•	
TX							
UT		•					
VA	•	•	•	•		•	19
VT							
WA					•	•	5
WI							
WV					*		
WY							

* These states responded to this question but were omitted from the counts any analysis since previous responses indicate they do not actually have or inspect license exempt centers or homes

Question: Which statement(s) best describe your states' staffing assignments of license-exempt centers and homes receiving payment from the subsidy program?

Analysis: Half the states reporting indicated that staff are assigned to inspect both licensed and license-exempt centers and homes that receive subsidy payments. Other responses indicated that there were no exempt centers or homes participating in the subsidy program, or that the state only had exempt homes, not centers. One state reported that they only inspected exempt homes for health and safety or had Memoranda of Understanding for inspections of exempt centers (typically tribal or military).

State	Staff are assigned to inspect ONLY license-exempt centers and homes	Staff are assigned to inspect ONLY license-exempt HOMES	Staff are assigned to inspect ONLY license-exempt CENTERS	Staff are assigned to inspect BOTH licensed and license-exempt centers and homes	Staff are assigned to inspect BOTH licensed and license-exempt HOMES	Staff are assigned to inspect BOTH licensed and license-exempt CENTERS	Other
Total	2	2	0	14	1	2	7
AK				•			
AL							•
AR							•
AS				•			
AZ							
CA							
CO	•						
CT						•	
DC		•					
DE							
FL				•			
GA				•			
HI							
IA				•			
ID							
IL							
IN				•			
KS							
KY							
LA							•
MA							
MD							
ME							
MI							
MN							
MO							
MS							
MT				•			
NC				•			
ND					•		
NE							
NH				•			
NJ						•	
NM		•					
NV							
NY							
OH				*			
OK							
OR				•			
PA							
RI							•

State	Staff are assigned to inspect ONLY license-exempt centers and homes	Staff are assigned to inspect ONLY license-exempt HOMES	Staff are assigned to inspect ONLY license-exempt CENTERS	Staff are assigned to inspect BOTH licensed and license-exempt centers and homes	Staff are assigned to inspect BOTH licensed and license-exempt HOMES	Staff are assigned to inspect BOTH licensed and license-exempt CENTERS	Other
SC				•			
SD				•			
TN				•			
TX							
UT	•						
VA							•
VT							
WA							•
WI							
WV							*
WY							

* These states responded to this question but were omitted from the counts any analysis since previous responses indicate they do not actually have or inspect license exempt centers or homes.

Question: How has the addition of inspecting license-exempt centers and homes receiving payment from the subsidy program impacted staff caseloads?

Analysis: Of the 26 states reporting, nearly 54% reported that caseloads had increased for the inspection of license-exempt centers and homes. In just under 40% of the states, caseloads remained the same. One state reported a decrease in caseloads due at least in part to increased staffing hired to conduct license-exempt inspections.

State	Caseloads have increased	Caseloads have decreased	Caseloads have remained the same
Total	14	2	11
AK	•		
AL			•
AR			•
AS			•
AZ			
CA			
CO			•
CT	•		
DC			•
DE			
FL	•		
GA	•		
HI			
IA	•		
ID			
IL			
IN			•
KS			
KY			
LA			•
MA			
MD			
ME			
MI			
MN			
MO			
MS			
MT	•		

State	Caseloads have increased	Caseloads have decreased	Caseloads have remained the same
NC			•
ND	•		
NE			
NH	•		
NJ	•		
NM			•
NV			
NY			
OH		*	
OK			
OR	•		
PA			
RI			•
SC	•		
SD	•		
TN	•		
TX			
UT	•		
VA		•	
VT			
WA			
WI			
WV			*
WY			

* These states responded to this question but were omitted from the counts any analysis since previous responses indicate they do not actually have or inspect license exempt centers or homes.

Question: How many license-exempt facilities are being inspected as of December 31, 2017?

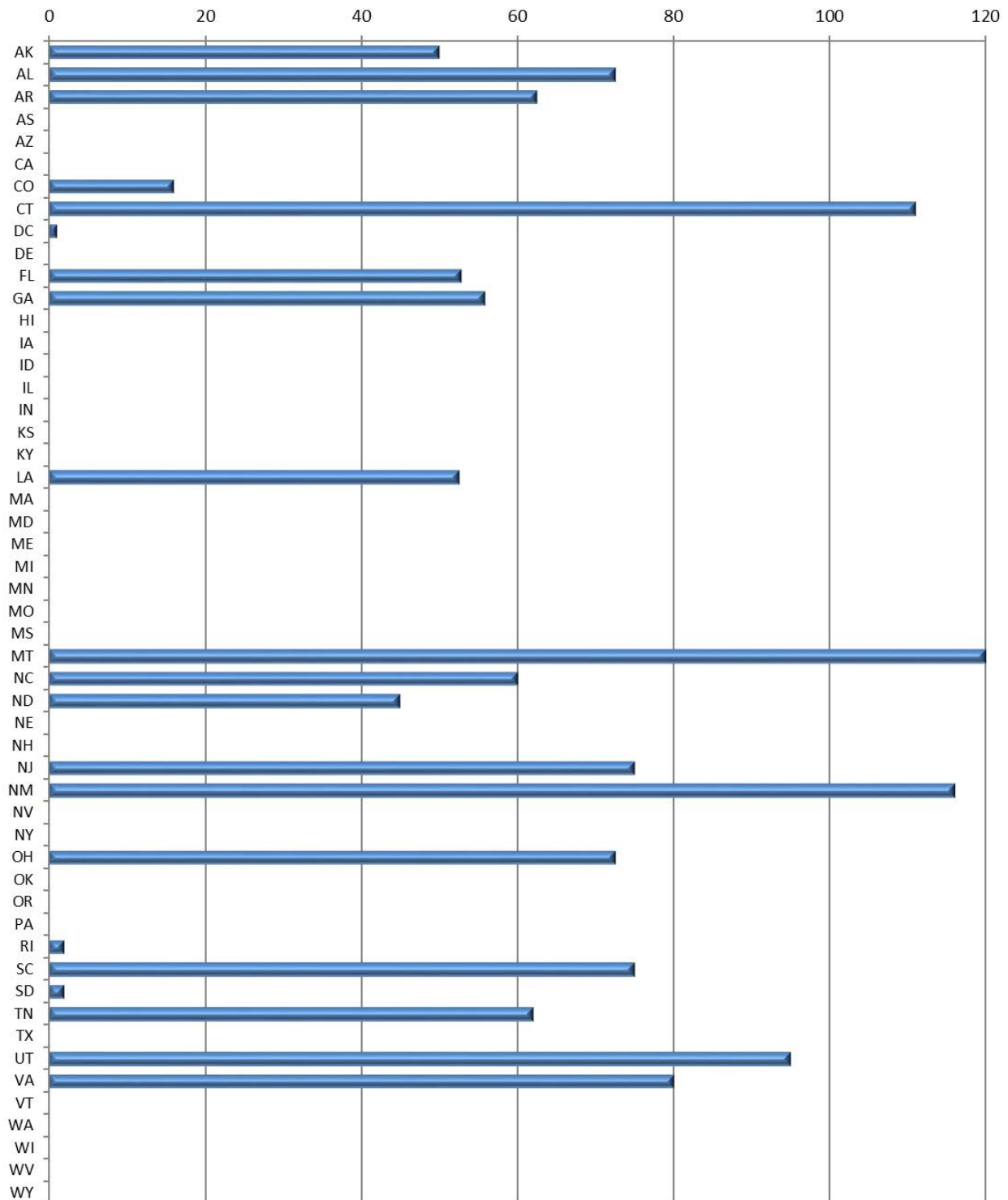
Analysis: A total of 19 states provided data on the number of license-exempt facilities being inspected. A total of 14 states (74%) reported inspections of license-exempt homes with a mean of 500 per state and a median of 181 per state. Eleven states (58%) reported inspections of license-exempt centers with a mean of 414 per state and a median of 300 per state. A total of 5 states (26%) reported inspections of license-exempt in-home providers with a mean of 153 per state and a median of 7 per state.

State	License-exempt homes	License-exempt centers	In-home providers (in a child's home)
Total	6996	4557	763
AK	19	0	62
AL		678	
AR	0	0	0
AS	0	0	0
AZ			
CA			
CO	16	0	0
CT	0	251	0
DC	0	0	2
DE			
FL	119	881	0
GA	68	299	0
HI			
IA	400	0	0
ID			
IL			
IN	126	395	2
KS			
KY			
LA	236	0	7

State	License-exempt homes	License-exempt centers	In-home providers (in a child's home)
MA			
MD			
ME			
MI			
MN			
MO			
MS			
MT	0	0	0
NC	0	344	
ND			
NE			
NH	0	0	0
NJ		982	
NM	1857	0	0
NV			
NY			
OH			
OK			
OR	2764	40	690
PA			
RI	0		
SC	277	254	0
SD	10	0	0
TN	81	300	
TX			
UT	248	133	0
VA	775		
VT			
WA			
WI			
WV			
WY			

Question: What is the average caseload for staff assigned to inspect license-exempt centers and homes receiving payment from the subsidy program?

Analysis: The average caseload for staff assigned to inspect license-exempt centers and homes receiving payment from the subsidy program for those states reporting (n=21) was 61 per staff. The median is 62 per staff. It is important to note that the reported caseloads may include mixed caseloads of licensed and license-exempt programs.



LICENSING INSPECTIONS

Summary:

Overall Trend

The broad trend between 2014 and 2017 saw a slight increase in the number of FCC homes that were required to be inspected prior to licensure. License renewals are now required in two additional states for each program type, and states are moving toward unannounced rather than announced inspections for routine compliance inspections. While a majority of states conduct full compliance inspections, there has been a downward trend in the frequency.

Inspections Prior to Licensure

In both 2014 and 2017, every state reported that they conduct inspections of child care centers prior to issuing a license. An additional 5 states in 2017 reported inspecting small FCC homes and one additional state reported doing so for large/group FCC homes. Inspections conducted prior to issuing a license are predominantly announced inspections with very little change seen between 2014 and 2017. The number of states reporting unannounced inspections, however, has dropped by almost half.

Routine and Renewal Inspections

There was a slight increase of states reporting that they renewed child care licenses but there was a slight decrease in inspections conducted prior to renewal in centers and a slight uptick in small FCC homes. There was a minor decrease in the number of unannounced renewal inspections and a very small decrease in the number of announced inspections. Every state reported in 2014 that routine compliance inspections were conducted for centers. That number decreased by one in 2017, and the number of large/group FCC homes with routine compliance inspections dropped by three. Only one state said routine compliance inspections were announced for any facility type in 2017, a drop from 11 for centers and 12 for FCC homes in 2014.

Frequency of Inspections

The number of states conducting license inspections at least twice a year increased by two for centers and three for small FCC homes. There was no change for large/group FCC homes. No states in 2017 reported that all programs were not inspected on a regular basis. The number of states reporting centers were inspected once a year increased by two, while an additional seven states reported inspecting small FCC homes once a year (an increase of almost 14 percent). This corresponded to a drop in the number of states reporting that inspections take place only once every two or three years.

License Renewal

There was a drop in the number of states reporting non-expiring licenses for all program types. This corresponded to an increase in the number of one, two, and three-year renewals for centers. Two fewer states reported large/group FCC homes had their licenses renewed once a year, which corresponded to an increase in the number of states with large/group FCC homes that had to renew licenses every three years. The frequency of license renewals for small FCC homes remained largely unchanged other than two fewer states reporting non-expiring licenses.

Abbreviated vs Full Compliance Inspections

While there was a small decrease in the number of states reporting that they did full compliance inspections more than once a year in 2017, the number of states that performed them at least once a year did not change significantly. The number of states reporting full compliance inspections once every two years dropped by more than half (from 13 to 6) for centers, and by 40 percent (from 10 to 6) for large/group FCC homes. The number of states conducting full compliance inspections once every two years dropped by one between 2014 and 2017 for small FCC homes. There was an increase of one state for each program type reporting full compliance inspections once every three years.

Types of Licensing Inspections

Analysis: In most cases, child care centers are rigorously inspected both prior to issuing a license and upon license renewal. Routine inspections are almost always unannounced. In almost 90% of states, compliance inspections are conducted for license renewal for all facility types. Roughly two-thirds of compliance inspections conducted for license renewal are unannounced.

Question: Are inspections to assess compliance conducted of licensed child care programs PRIOR TO ISSUING A LICENSE? Are the inspections conducted announced or unannounced?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Inspections conducted prior to issuing a license	52	45	39
Inspections are announced	44	38	34
Inspections are unannounced	11	9	7

Question: Are inspections to assess compliance conducted of licensed child care programs for LICENSE RENEWAL? Are inspections conducted announced or unannounced?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Licenses are renewed	43	37	34
Inspections for license renewal are conducted	39	33	30
Inspections are announced	14	14	13
Inspections are unannounced	29	23	20

Question: Are ROUTINE INSPECTIONS conducted on licensed child care programs to review compliance with the regulations? Are inspections conducted announced or unannounced?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Routine inspections for compliance are conducted	50	44	36
Inspections are announced	1	1	1
Inspections are unannounced	50	44	36

Frequency of Licensing Inspections

Question: Once a license is issued, how often are licensing inspections conducted for each facility type?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
More than three times a year	4	4	3
Three times a year	3	2	1
Twice a year	16	12	12
Once a year	27	24	20
Once every two years	2	2	1
Once every three years	1	1	1
Not inspected on a regular basis	0	0	0
Other	10	7	5

Frequency of Licensing Renewal

Question: After initial licensure, how often are licenses renewed for each facility type? Applies to certification or registration, if appropriate.

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Once a year	21	16	16
Once every 2 years	15	14	12
Once every 3 years	7	6	5
Non-expiring license	8	7	5
Other	2	4	2

Inspections and Monitoring

Question: How often does the state conduct a FULL COMPLIANCE REVIEW for each type of licensed child care facility?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
More than three times a year	1	1	0
Three times a year	1	1	1
Twice a year	4	4	4
Once a year	29	23	21
Once every two years	6	7	6
Once every three years	4	3	2
Less than once every 3 years	1	1	1
Not conducted	1	1	0
Other	7	7	4

Note: TX reported both once a year and once every two years. The once per year inspections are for registered FCC homes receiving CCDF subsidy payments.

ABBREVIATED INSPECTIONS

Summary:

The number of states conducting abbreviated inspections did not change between 2014 and 2017 though the number of states using them for initial licensing inspections and routine compliance dropped. One additional state reported using abbreviated inspections for license renewal. A total of 16 states reported using abbreviated inspections for other reasons in 2014 but that number had dropped to just one by 2017.

	2014	2017
Yes	35	35
No	16	16
Initial licensing inspections	3	1
Routine compliance inspections	24	23
License Renewal inspections	3	4
Other	16	1

Two more states reported using “Key Indicators” in 2017 versus 2014 to determine what requirements should be included in abbreviated inspections. States in 2014 were much more likely to use a mix of methods to determine requirements than in 2017. There was a drop of eight states using consensus between 2014 and 2017, a drop of 2 states using risk assessment, and a drop of four states reporting “Other” methods. More states reported more than one method in 2014 than in 2017.

	2014	2017
Key Indicator System	8	10
Consensus	31	21
Risk Assessment	19	17
Other	6	2

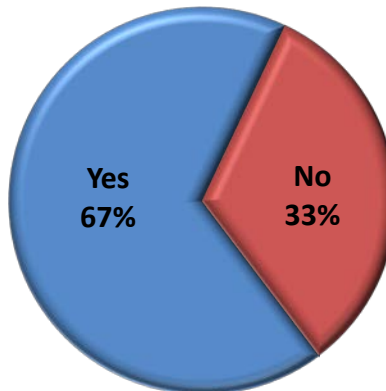
In 2017, three fewer states reported having general policies in place to determine when to switch between abbreviated and full compliance inspections. The number of states reporting policies for specific program types did not significantly change.

	2014	2017
No, the state does not have policies	13	15
State has policies for Child Care Centers	24	23
State has policies for Small FCC Homes	17	17
State has policies for Large/Group FCC Homes	19	17

Using Abbreviated Inspections

Question: Does the state ever use an abbreviated compliance inspection during monitoring inspections of licensed child care facilities?

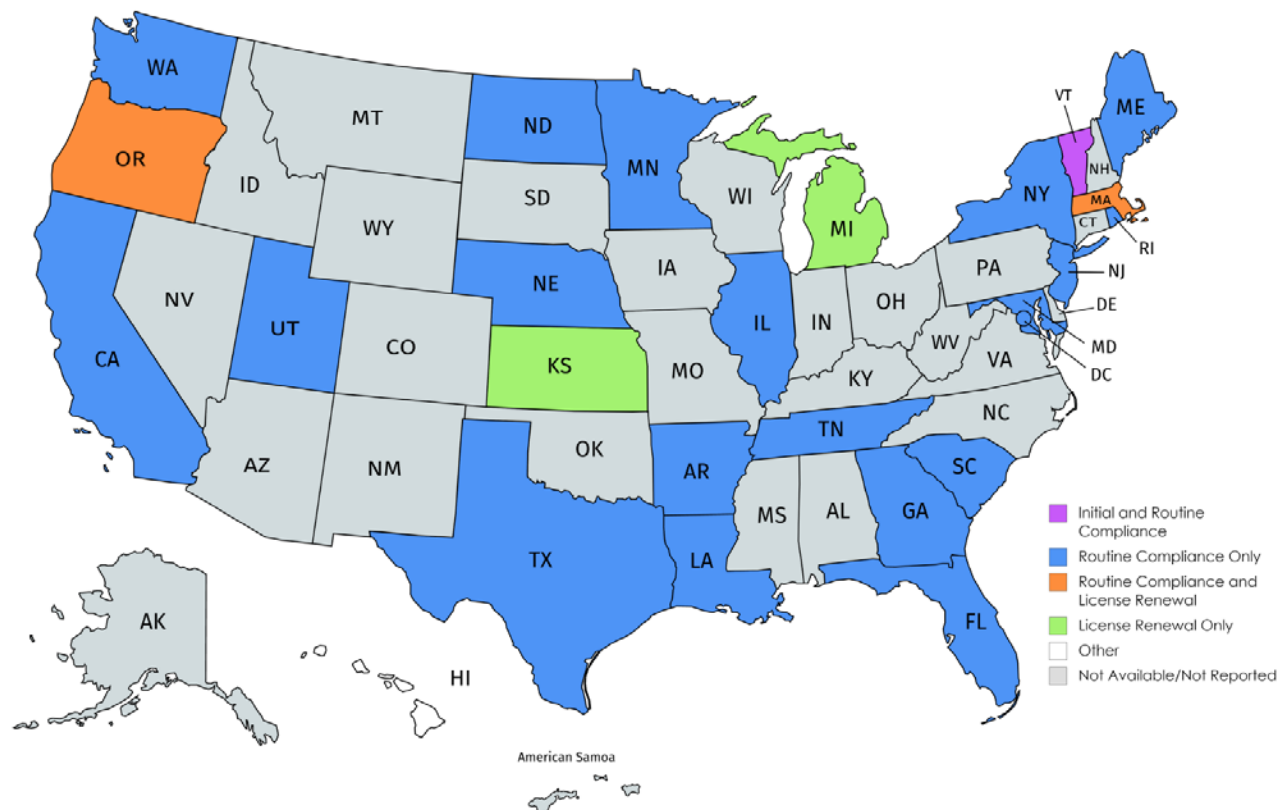
Analysis: 67% of states (n=52) reported using an abbreviated compliance inspection at some point during monitoring inspections of licensed facilities. A total of 23 states reported using an abbreviated inspection for routine compliance, 4 states indicated they used an abbreviated inspection for license renewal inspections. Only one state used an abbreviated inspection for initial licensing inspections. That state also reported using abbreviated inspections for routine renewal inspections. One state reported that an abbreviated checklist could be used in the off-year of a 2-year licensing cycle or during any additional drop-in visit in addition to the required annual unannounced visit.



State	Yes	No	Initial licensing inspections	Routine compliance inspections	License Renewal inspections	Other
Total	35	17	1	23	4	1
AK	•					
AL		•				
AR	•			•		
AS		•				
AZ	•					
CA	•			•		
CO	•					
CT		•				
DC	•			•		
DE		•				
FL	•			•		
GA	•			•		
HI	•					•
IA		•				
ID		•				
IL	•			•		
IN		•				
KS	•				•	
KY		•				
LA	•			•		
MA	•			•	•	
MD	•			•		
ME	•			•		
MI	•				•	
MN	•			•		
MO		•				
MS		•				
MT	•					

State	Yes	No	Initial licensing inspections	Routine compliance inspections	License Renewal inspections	Other
NC		•				
ND	•			•		
NE	•			•		
NH		•				
NJ	•			•		
NM	•					
NV	•					
NY	•			•		
OH		•				
OK	•					
OR	•			•	•	
PA		•				
RI	•			•		
SC	•			•		
SD		•				
TN	•			•		
TX	•			•		
UT	•			•		
VA		•				
VT	•		•	•		
WA	•			•		
WI		•				
WV	•					
WY	•					

Map 4 Use of Abbreviated Inspections



Abbreviated Inspection Requirements

Question: How did the state choose which requirements to include in the abbreviated review?

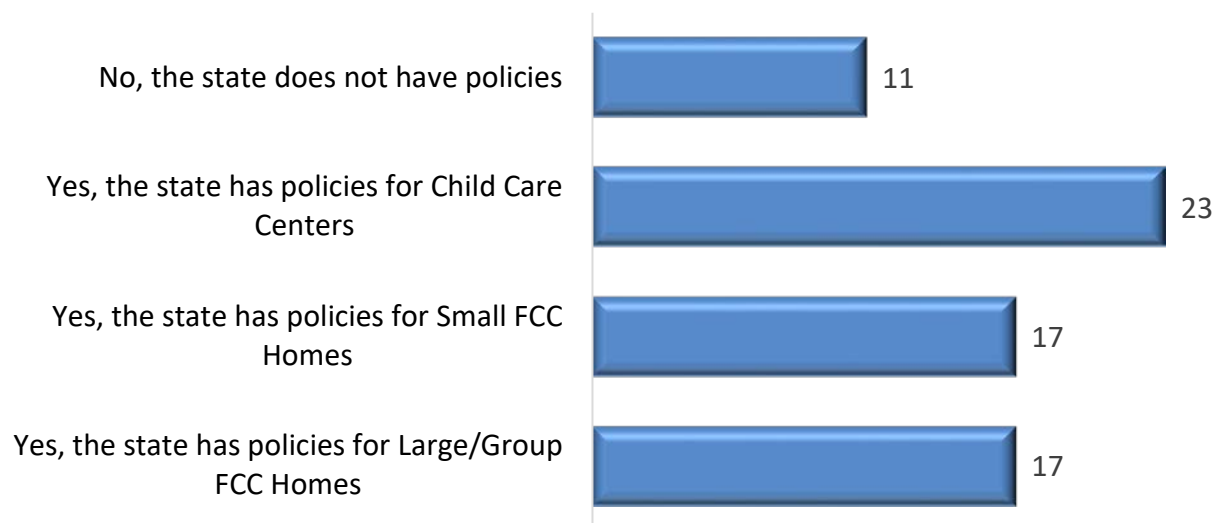
Analysis: For those states conducting abbreviated inspections (n=35), 29% reported that requirements included in an abbreviated review were developed through statistical methodology that would predict overall compliance with the full set of rules. 60% of states reported that abbreviated reviews included those items most critical to all inspections while 49% reported that requirements were based on an assessment of risk to children if the program were not in compliance. One state reported developing their process in coordination with NARA and state regulatory staff.

State	"Key indicator system" developed through a statistical methodology of requirements that would predict compliance with the full set of rules	Selection of requirements based on a consensus of those considered most critical to include in all inspections	Selection of requirements based on an assessment of risk of harm to children if not in compliance	Other
Total	10	21	17	2
AK		•	•	
AL				
AR		•	•	
AS				
AZ		•	•	
CA		•	•	
CO		•		
CT				
DC		•	•	
DE				
FL			•	
GA	•	•	•	
HI			•	•
IA				
ID				
IL	•			
IN				
KS	•			
KY				
LA		•	•	
MA	•	•	•	
MD	•			
ME	•			
MI	•	•	•	•
MN		•		
MO				
MS				
MT	•			
NC				
ND		•		
NE		•		
NH				
NJ		•		
NM		•		
NV		•		
NY			•	
OH				
OK			•	
OR	•			
PA				
RI		•	•	
SC		•		

State	"Key indicator system" developed through a statistical methodology of requirements that would predict compliance with the full set of rules	Selection of requirements based on a consensus of those considered most critical to include in all inspections	Selection of requirements based on an assessment of risk of harm to children if not in compliance	Other
SD				
TN			•	
TX		•		
UT		•	•	
VA				
VT		•	•	
WA	•			
WI				
WV				
WY				

Question: Does the state have policies on determining when to switch from an abbreviated compliance review to a full compliance review?

Analysis: Of the 35 states that reported conducting abbreviated inspections, 32 responded to the question on policies. Of those 32, 11 (34%) reported having no policies on determining when to switch from an abbreviated to full compliance review while 72% of states reported having policies for child care centers, and 53% for either small FCC homes or large/group FCC homes (or both).



State	No, the state does not have policies	Yes, the state has policies for Child Care Centers	Yes, the state has policies for Small FCC Homes	Yes, the state has policies for Large/Group FCC Homes
	Total Number of States Responding	Total Number of States that Regulate		
	32	52	50	39
Total	11	23	17	17
AK		•	•	•
AL				
AR		•		
AS				
AZ		•		•
CA		•	•	•
CO		•	•	•
CT				
DC	•			
DE				

State	No, the state does not have policies	Yes, the state has policies for Child Care Centers	Yes, the state has policies for Small FCC Homes	Yes, the state has policies for Large/Group FCC Homes
FL		•	•	•
GA		•	•	
HI	•			
IA	*			
ID	*			
IL		•	•	•
IN				
KS		•	•	•
KY	*			
LA		•		
MA		•	•	•
MD	•			
ME		•	•	
MI		•	•	•
MN		•		
MO				
MS	*			
MT		•	•	•
NC				
ND	•			
NE	•			
NH				
NJ	•			
NM	•			
NV		•	•	•
NY		•	•	•
OH				
OK		•	•	•
OR		•		•
PA				
RI		•	•	•
SC	•			
SD				
TN	•			
TX		•		•
UT	•			
VA				
VT				
WA		•	•	
WI				
WV				
WY				

* These states responded to this question despite not conducting abbreviated inspections. They have been omitted from the count and any analysis.

RISK ASSESSMENT

Summary:

An additional seven states reported having conducted risk assessments in 2017 versus 2014. Seven additional states also reported using weighting for all risk factors, three fewer states used only high-risk factors, and two additional states developed categories of requirements identified as high-risk. Despite an additional three states responding on how risk assessments were used in 2017 (2017 N=28; 2014 N=25), the number of states reporting that risk assessments were used for determining enforcement actions, monitoring the high-risk rules during abbreviated inspections, and for using violations of high-risk requirements to determine the frequency of licensing inspections all declined. Only the number of states reporting that risk assessment was used to categorize violations remained the same. When determining how to select and categorize risk levels, one additional state reported using an internal process and four fewer states reported using research. The question on using feedback from stakeholders was not asked in 2014.

Conducting Risk Assessments

Question: Has the state identified licensing program requirements that pose the greatest risk of harm to children if violated (i.e., conducted a risk assessment of program requirements)?

Analysis: A total of 33 states reported that they have identified licensing program requirements that pose the greatest risk of harm to children if violated while 19 states either had not identified those requirements or did not respond to the survey question. Of the states that reported those requirements had been identified, 13 (39%) states indicated that all requirements were given a risk level/weight. Two of those states also said they had identified categories of requirements that were high risk. A total of 6 (18%) states indicated that only the highest risk requirements were identified. 39% of the states indicated that they had identified categories identified as high risk (2 of whom also reported risk requirements were all given a risk level/weight). Three states reported having risk assessment processes in development, 1 state reported that key rules related to risk were identified by consensus and one state reported they focused on identifying serious rules violations.

State	Yes	No	All requirements were given a risk level/weight	Only the highest risk requirements were identified	Categories of requirements were identified as high-risk	Other
Total	33	19	13	6	13	4
AK	•		•	•	•	
AL		•				
AR	•				•	
AS		•				
AZ	•			•		
CA	•		•			
CO		•				
CT	•				•	
DC	•				•	
DE	•			•		
FL		•				
GA	•				•	
HI	•			•		
IA		•				
ID	•					•
IL	•		•			
IN		•				
KS	•		•			
KY	•		•			
LA	•				•	
MA	•				•	
MD		•				

State	Yes	No	All requirements were given a risk level/weight	Only the highest risk requirements were identified	Categories of requirements were identified as high-risk	Other
ME	•		•			
MI	•			•		
MN		•				
MO		•				
MS	•		•			
MT	•			•		
NC		•				
ND	•				•	
NE		•				
NH	•				•	
NJ	•		•			
NM		•				
NV		•				
NY		•				
OH	•		•			
OK		•				
OR	•		•			
PA		•				
RI		•				
SC	•				•	
SD		•				
TN	•				•	
TX	•		•			
UT	•		•		•	
VA	•		•			
VT	•					•
WA	•					•
WI	•					•
WV		•				
WY	•				•	

Using Risk Assessments

Question: How is the risk assessment used?

Analysis: A total of 28 states reported on the uses for risk assessment. The uses were pretty evenly distributed among the reporting states with multiples states reporting more than a single use.

State	Categorizing violations	Determining enforcement actions	Monitoring the high-risk rules during abbreviated inspections	Violations of high-risk requirements determine the frequency of licensing inspections or additional follow-up visits	Other
Total	15	15	14	17	4
AK	•	•	•	•	
AL					
AR				•	
AS					
AZ		•	•	•	
CA	•	•	•	•	
CO					
CT					
DC		•			

State	Categorizing violations	Determining enforcement actions	Monitoring the high-risk rules during abbreviated inspections	Violations of high-risk requirements determine the frequency of licensing inspections or additional follow-up visits	Other
DE		•			
FL					
GA	•	•	•	•	
HI			•		•
IA					
ID					•
IL					
IN					
KS			•		
KY	•				
LA	•	•	•	•	
MA				•	
MD					
ME			•		
MI			•	•	•
MN					
MO					
MS	•	•		•	
MT			•		
NC					
ND	•	•		•	
NE					
NH	•				
NJ					
NM					
NV					
NY					
OH	•	•		•	
OK					
OR	•	•		•	
PA					
RI					
SC	•				
SD					
TN			•		
TX	•	•		•	
UT	•		•		
VA	•	•		•	
VT	•		•	•	
WA		•	•	•	•
WI		•		•	
WV					

Question: How was the selection of risk levels and categorization of rules into those levels done?

Analysis: Of the 33 states conducting risk assessment, 29 responded to this follow-up question. A majority of states (86%) reported that selection of risk levels and categorization was done through an internal process with consensus of licensing agency staff and other experts. More than half (52%) reported using research and resources to assist in setting risk levels. Almost 38% sought feedback from stakeholders.

State	An internal process of seeking the opinion and consensus of licensing agency staff and other experts on rules that would cause the most risk of harm	Development of a statistical methodology	Review of research and resources such as Caring for our Children	Work with an external consultant	Feedback from stakeholders, such as child care providers or representatives from child care industry	Other
Total	25	4	15	6	11	1
AK	•		•			
AL						
AR	•		•			
AS						
AZ	•		•		•	
CA						
CO						
CT	•					
DC			•			
DE	•		•			
FL						
GA	•		•	•	•	
HI						•
IA						
ID						
IL	•			•	•	
IN						
KS	•				•	
KY		•				
LA	•		•	•	•	
MA	•			•		
MD						
ME	•	•	•			
MI	•			•		
MN						
MO						
MS	•		•		•	
MT		•				
NC						
ND	•		•			
NE						
NH	•		•		•	
NJ						
NM						
NV						
NY						
OH	•		•		•	
OK						
OR	•			•	•	
PA						
RI						
SC	•					
SD						

State	An internal process of seeking the opinion and consensus of licensing agency staff and other experts on rules that would cause the most risk of harm	Development of a statistical methodology	Review of research and resources such as Caring for our Children	Work with an external consultant	Feedback from stakeholders, such as child care providers or representatives from child care industry	Other
TN	•					
TX	•		•		•	
UT	•		•		•	
VA	•	•				
VT	•					
WA						
WI	•					
WY	•		•			

COMPLIANCE, DIFFERENTIAL MONITORING, AND TECHNICAL ASSISTANCE

Summary:

There was no change between 2014 and 2017 in the number of states reporting having defined compliance within their licensing requirements. In each year, 20 states reported that compliance was defined. There was an increase of four states using compliance to inform parents of a provider's status, an increase of two states using it for enforcement actions, and two states using compliance for determining eligibility for subsidy payments. There was little other change and the question on participation in the food program was not asked in 2014.

In 2017 there was a net gain of four states reported using differential monitoring, though seven states that reported using it in 2014 reported not using it in 2017, while 11 reported using it in 2017 that did not do so in 2014. A net total of three additional states reported using differential monitoring for centers and five additional states reported using it for both large and small FCC homes.

Overall between 2014 and 2017 there was generally little change in the number of states reporting that they provided technical assistance (TA) to providers. There was an increase of two states reporting that TA was given to any provider type to help them improve quality and exceed minimum licensing regulations, and one less state providing TA to any provider type to help them achieve compliance with the regulations.

Defining Compliance

Question: Has the state defined "compliance" with licensing requirements in your policies, e.g., substantial compliance, a pattern of compliance, in good standing?

Analysis: Only 6% of states reported defining compliance within their licensing requirements.

A total of 23 states reported on the use of compliance monitoring. Most (91%) reported that compliance was used to determine enforcement actions and slightly more than half said compliance was used to determine the frequency of inspections. A total of 13 states (57%) reporting using compliance for determining receipt of a subsidy or as a criteria for eligibility in special programs.

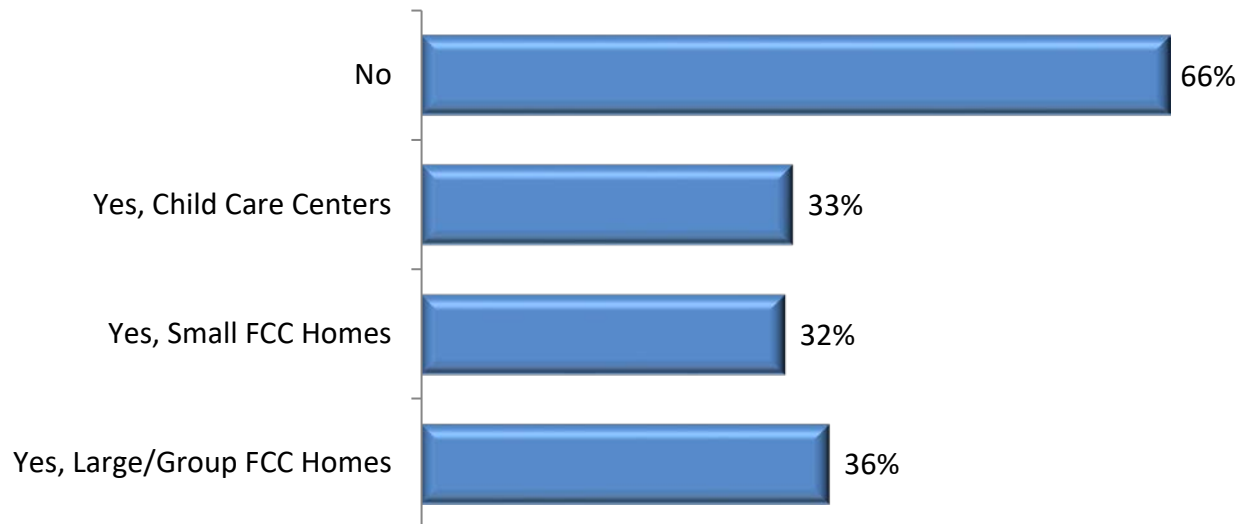
State	Yes	No	Informing parents of the provider's status	Determining enforcement actions including non-renewal of license	Determining the frequency or depth of licensing inspections	Determining eligibility for receipt of child care subsidy funding	Determining eligibility for participation in the Child and Adult Care Food Program (CACFP)	Determining eligibility for participation in quality initiatives, e.g., grants, incentives	Determining eligibility for participation in QRIS or meeting a QRIS standard	Other
Total	20	32	15	21	12	9	5	7	11	1
AK	•		•	•	•	•	•	•	•	
AL		•								
AR	•			•	•				•	
AS		•								
AZ	•		•	•	•					
CA		•								
CO		•								
CT		•								
DC		•	•	•						
DE		•								
FL	•		•	•						
GA	•		•	•						
HI		•								

State	Yes	No	Informing parents of the provider's status	Determining enforcement actions including non-renewal of license	Determining the frequency or depth of licensing inspections	Determining eligibility for receipt of child care subsidy funding	Determining eligibility for participation in the Child and Adult Care Food Program (CACFP)	Determining eligibility for participation in quality initiatives, e.g., grants, incentives	Determining eligibility for participation in QRIS or meeting a QRIS standard	Other
IA		•								
ID	•		•	•		•				
IL		•								
IN	•		•	•	•	•		•	•	
KS		•								
KY	•		•	•	•					
LA	•		•	•	•	•	•	•	•	
MA	•				•					
MD		•								
ME		•								
MI	•			•						•
MN		•								
MO		•								
MS		•		•	•					
MT		•								
NC		•	•	•		•			•	
ND		•								
NE	•			•		•			•	
NH		•								
NJ		•								
NM		•								
NV	•		•							
NY		•								
OH		•								
OK	•			•	•			•	•	
OR		•								
PA	•			•						
RI		•								
SC	•		•	•		•	•	•	•	
SD		•								
TN	•			•					•	
TX		•								
UT	•		•	•	•	•	•	•	•	
VA	•		•	•	•	•				
VT	•		•	•	•		•	•	•	
WA		•								
WI		•								
WV		•								
WY		•								

Differential Monitoring

Question: Does the state have a system of differential frequency of monitoring based on compliance records or quality rating level for each type of child care facility?

Analysis: Two-thirds of the states responding (n=50) reported they did not have a system of differential frequency of monitoring. Almost all states that reported using differential monitoring use it for all program types. A total of 18 states use differential monitoring for at least one type of facility.



State	No	Yes Child Care Centers	Yes Small FCC Homes	Yes Large/Group FCC Homes
	Number of States Responding	Total Number of States that Regulate		
	50	52	50	39
Total	33	17	16	14
AK	•	•	•	•
AL	•			
AR	•	•	•	•
AS	•			
AZ	•			
CA	•	•	•	•
CO	•	•	•	•
CT	•			
DC	•			
DE	•	•	•	•
FL	•			
GA	•	•	•	
HI	•			
IA	•			
ID	•			
IL	•			
IN	•			
KS	•	•	•	•
KY	•			
LA	•	•		
MA	•	•	•	•
MD	•	•	•	•
ME	•	•	•	

State	No	Yes Child Care Centers	Yes Small FCC Homes	Yes Large/Group FCC Homes
MI	•			
MN	•			
MO	•			
MS			•	•
MT		•	•	•
NC	•			
ND				
NE	•			
NH	•			
NJ	•			
NM	•			
NV	•			
NY	•			
OH		•		
OK		•	•	•
OR	•			
PA	•			
RI	•			
SC	•			
SD	•			
TN		•	•	•
TX		•	•	•
UT	•			
VA	•			
VT		•	•	•
WA	•			
WI	•			
WV	•			
WY	•			

Provision of Technical Assistance to Licensees

Question: Do child care licensors provide technical assistance (TA), e.g., guidance, resources, training, and/or consultation to licensees?

Analysis: Virtually all child care centers receive TA throughout the licensing and regulatory process as do most small FCC and large/group FCC homes. While TA is heavily geared toward regulations and compliance issues, a majority of states report TA on research-related and non-compliance issues. States also refer all provider types to other agencies and organizations when needed.

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Licensors provide TA/consultation to licensees to help them achieve compliance with the regulations	50	44	37
Licensors provide TA/consultation to licensees to help them improve quality and exceed minimum licensing regulations	35	30	26
Licensors provide individual program TA/consultation related to specific non-compliance issues	46	40	33
Licensors provide resources to individual programs related to specific non-compliance issues	47	41	34
Licensors provide training to multiple programs at the same time related to topics based on current early childhood research	25	20	17
Licensors provide resources to multiple programs at the same time related to topics based on current early childhood research	26	21	17
Licensors provide training to multiple programs at the same time related to topics based on specific non-compliance issues	29	24	21
Licensors provide resources to multiple programs at the same time related to topics based on specific non-compliance issues	29	24	20

Question: When do licensors provide technical assistance (TA) and/or consultation?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
During application inspection visits	50	44	37
During routine inspection visits	49	43	36
During renewal inspection visits	38	34	29
On the telephone	50	43	38
As needed by licensee	49	43	36
As needed determined by licensor	43	38	31
Other	11	10	7

Question: Do licensors ever refer licensees to other agencies, organizations, or people for TA and/or consultation?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Referrals made to other agencies, organizations, or people	50	43	37

TECHNOLOGY AND DATA

Summary:

States are increasingly using their licensing databases for multiple purposes including evaluating their own staffing and tracking inspection and enforcement actions against providers. Licensing databases are more interconnected with other state agencies more than ever before. The number of states using portable devices for inspections, and considering other tools for licensing doubled, or nearly doubled in almost every area.

In 2014, 50 states reported having a licensing database and one state reported not having one. In 2017, 47 states reported having one or more databases to store information, three states reported databases were in development, and one state which previously reported having a database in 2014 reported they did not have a database for licensing information. The state which previously did not have one reports one is in development.

In 2014, 49 states responded to how their licensing databases were used while only 33 states responded to the same question in 2017. Comparing the same 33 states across the three-year time span shows that every state is using their database for more purposes. Eight additional states reported using the database to evaluate staff performance, seven additional states reported using databases for enforcement purposes and six additional states reporting using the databases for analyzing workloads and evaluating licensing programs and strategies. One additional state said the database was used for email addresses and one additional state used the database for training. One less state reported using the database to determine differential monitoring levels. Of the new categories added to the 2017 survey, more than half the reporting states reported using the databases for those purposes.

Category for Database Usage Added in 2017	Percentage Reporting Database Used for Given Purpose
Comply with federal reporting requirements	85%
Analyze longitudinal trends	55%
Coordinate with other agencies	70%
Analyze regional differences	70%

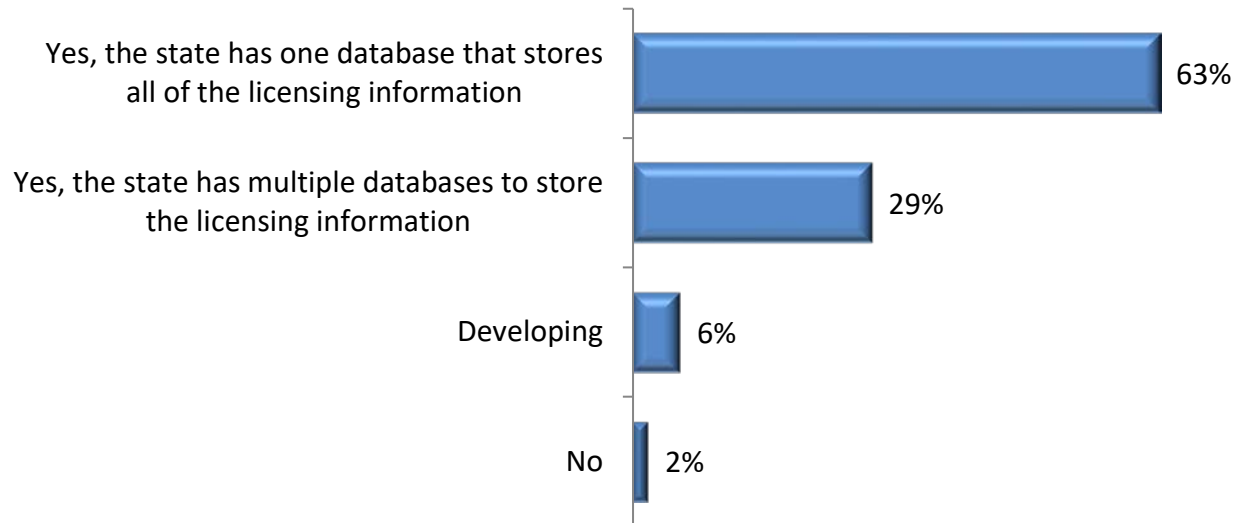
Licensing databases are becoming increasingly interconnected with other state agencies. Seven additional states report connecting with the subsidy payment system and eight additional states report a link with child protective services. An additional four states link with the child care resource and referral agency while eight additional states report linking with QRIS and/or other quality systems. The number of states reporting that they tracked the cause of injuries more than doubled, growing from seven in 2014 to 16 in 2017.

The number of states using portable devices for inspections of any program type grew slightly, from 33 states in 2014 to 35 states in 2017. The number of states reporting that they were considering using other tools grew from 24 in 2014, to 26 in 2017. In 2014, there were three states that did not use portable devices and were not considering their use, while in 2017, only two of those states still reported not using or considering the use of devices.

Licensing Database

Question: Does the state have a computerized database to store licensing information about child care facilities?

Analysis: A total of 33 states have a single licensing database while 15 states have multiple databases to store licensing information. Three states reported developing a database in 2017 and one state said they did not have a licensing database.



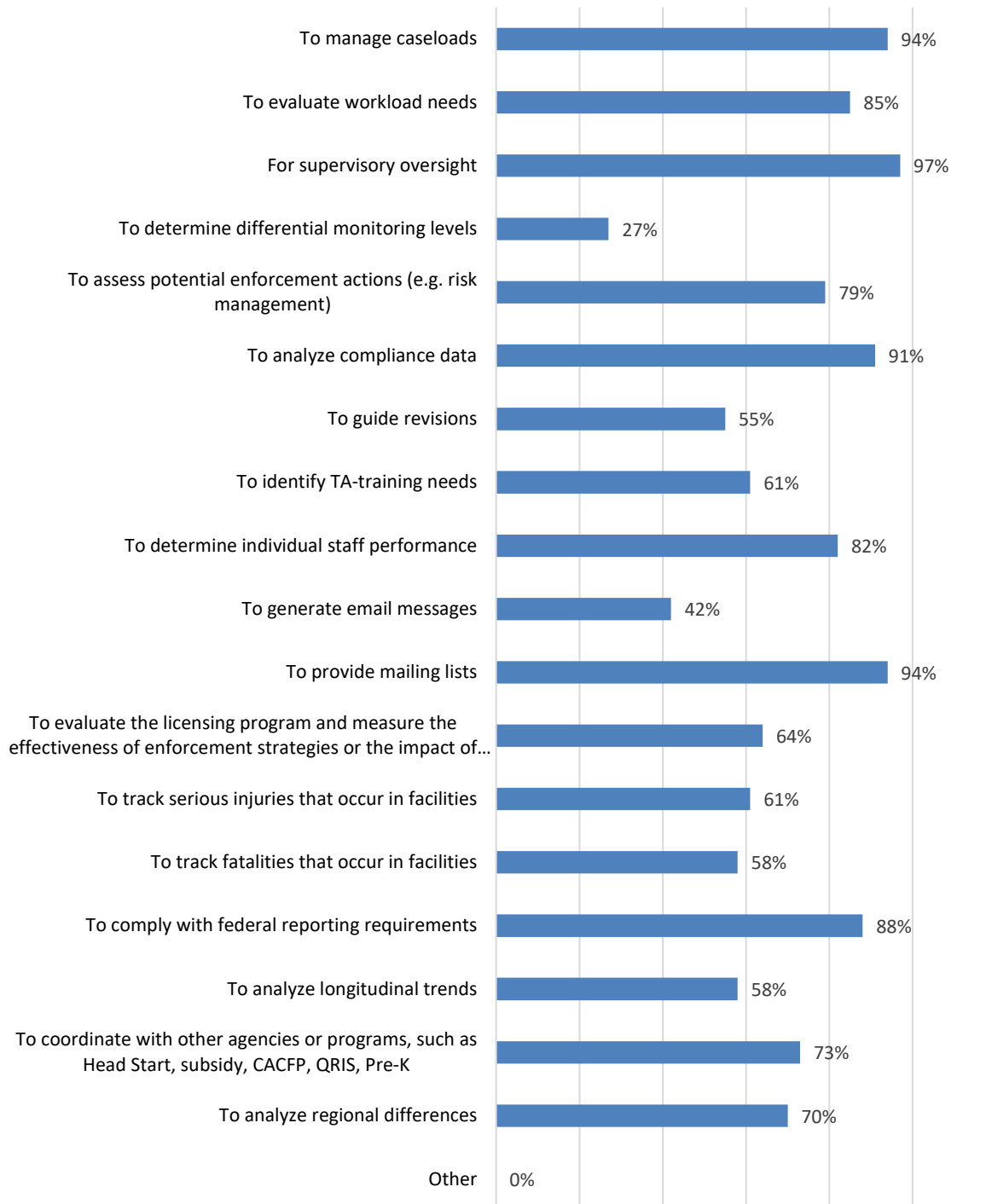
State	Yes, the state has one database that stores all of the licensing information	Yes, the state has multiple databases to store the licensing information	Developing	No
Total	33	15	3	1
AK	•			
AL	•			
AR	•			
AS	•			
AZ		•		
CA		•		
CO		•		
CT	•			
DC	•			
DE	•			
FL	•			
GA	•			
HI	•			
IA		•		
ID		•		
IL		•		
IN		•		
KS	•			
KY	•			
LA		•		
MA			•	
MD		•		
ME	•			
MI		•		
MN		•		
MO	•			

State	Yes, the state has one database that stores all of the licensing information	Yes, the state has multiple databases to store the licensing information	Developing	No
MS	•			
MT	•			
NC	•			
ND			•	
NE				•
NH		•		
NJ			•	
NM	•			
NV	•			
NY	•			
OH	•			
OK	•			
OR	•			
PA	•			
RI	•			
SC	•			
SD	•			
TN		•		
TX	•			
UT	•			
VA	•			
VT		•		
WA		•		
WI	•			
WV	•			
WY	•			

Using the Licensing Database

Question: How is the licensing database used?

Analysis: Two-thirds of states responded (n=33) regarding database use and the majority use it for multiple reasons including supervisory oversight (97%), managing caseloads (94%), analyzing compliance data (91%), and in support of many other activities. Only a handful of states, just over 27% of states reporting, indicated the database is used to determine differential monitoring levels.



State	To manage caseloads	To evaluate workload needs	For supervisory oversight	To determine differential monitoring levels	To assess potential enforcement actions (e.g. risk management)
Total	31	28	32	9	26
AK	•	•	•	•	•
AL	•	•	•		•
AR	•	•	•	•	•
AS	•	•	•		•
AZ					
CA					
CO					
CT	•		•		
DC	•	•	•		•
DE			•		•
FL	•		•	•	•
GA	•	•	•	•	•
HI	•	•	•		
IA					
ID					
IL					
IN					
KS	•	•	•	•	•
KY	•	•	•		•
LA					
MA					
MD					
ME	•	•	•	•	•
MI					
MN					
MO	•	•	•		•
MS	•	•	•		•
MT	•	•	•		•
NC	•	•	•		•
ND					
NE					
NH					
NJ					
NM	•	•	•		
NV	•	•	•		•
NY	•	•	•		•
OH	•	•	•	•	•
OK	•	•	•	•	•
OR	•	•	•		
PA	•	•	•		
RI					
SC	•	•	•		•
SD	•	•	•		•
TN					
TX	•	•	•	•	•
UT	•	•	•		•
VA	•	•	•		•
VT					
WA					
WI	•		•		•
WV	•	•	•		
WY	•	•	•		•

Use of Licensing Data – Continuation A

State	To analyze compliance data	To guide revisions	To identify TA-training needs	To determine individual staff performance	To generate email messages
Total	30	18	20	27	14
AK	•	•	•	•	•
AL				•	
AR	•	•	•	•	
AS	•		•	•	•
AZ					
CA					
CO					
CT	•		•	•	
DC	•	•	•	•	
DE	•				
FL	•			•	
GA	•	•	•	•	•
HI	•	•			•
IA					
ID					
IL					
IN					
KS	•	•	•	•	•
KY	•			•	•
LA					
MA					
MD					
ME	•			•	•
MI					
MN					
MO	•	•	•		•
MS	•	•	•	•	•
MT	•				
NC	•	•	•	•	
ND					
NE					
NH					
NJ					
NM	•		•	•	
NV	•			•	•
NY	•	•	•	•	
OH	•	•	•	•	•
OK	•	•	•	•	
OR	•	•		•	•
PA	•				
RI					
SC	•		•	•	
SD	•	•	•	•	
TN					
TX	•	•		•	•
UT	•	•	•	•	•
VA	•	•	•	•	
VT					
WA					
WI	•			•	
WV					
WY					

State	To provide mailing lists	To evaluate the licensing program and measure the effectiveness of enforcement strategies or the impact of policy changes over time on outcomes such as improved compliance, fewer revocations or fewer child injuries	To track serious injuries that occur in facilities	To track fatalities that occur in facilities
Total	31	21	20	19
AK	•	•		
AL	•		•	•
AR	•	•	•	•
AS	•	•	•	•
AZ				
CA				
CO				
CT	•	•	•	•
DC	•	•	•	•
DE	•	•	•	•
FL	•		•	•
GA	•	•	•	•
HI	•	•		
IA				
ID				
IL				
IN				
KS	•	•	•	•
KY	•	•	•	•
LA				
MA				
MD				
ME	•	•		
MI				
MN				
MO	•			
MS	•	•	•	•
MT	•	•		
NC		•		
ND				
NE				
NH				
NJ				
NM	•		•	•
NV	•			
NY	•	•		
OH	•	•	•	•
OK	•	•	•	•
OR	•		•	•
PA		•		
RI	•			
SC	•			
SD	•	•	•	
TN				
TX	•	•	•	•
UT	•	•	•	•
VA	•			
VT				
WA				
WI	•		•	•
WV	•			
WY	•		•	•

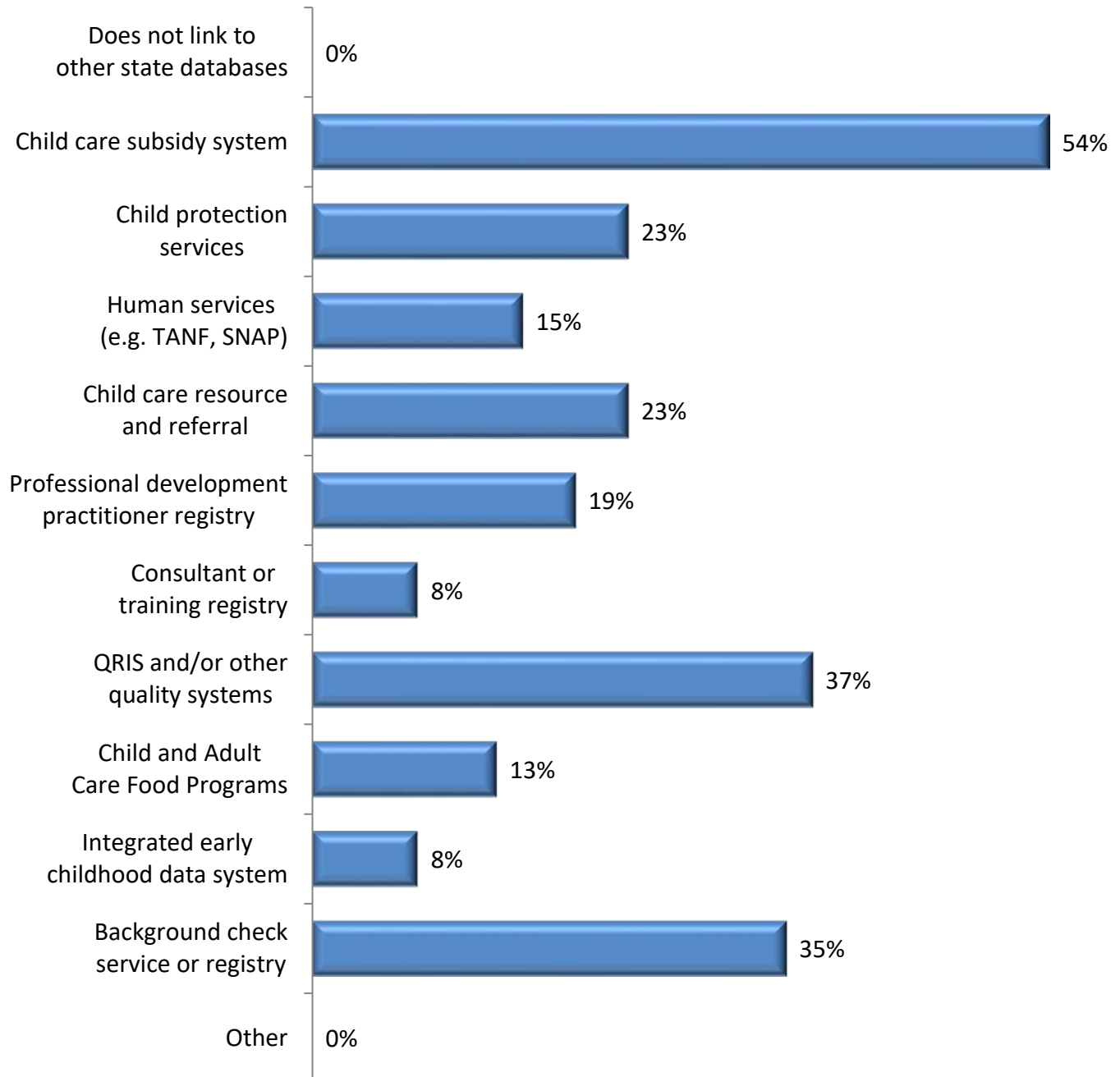
Use of Licensing Data – Continuation C

State	To comply with federal reporting requirements	To analyze longitudinal trends	To coordinate with other agencies or programs, such as Head Start, subsidy, CACFP, QRIS, Pre-K	To analyze regional differences	Other
Total	29	19	24	23	0
AK	•			•	
AL	•	•	•		
AR	•	•	•	•	
AS	•	•	•		
AZ					
CA					
CO					
CT	•				
DC	•	•	•	•	
DE	•				
FL	•	•	•	•	
GA	•	•	•	•	
HI				•	
IA					
ID					
IL					
IN					
KS	•	•	•	•	
KY		•	•	•	
LA					
MA					
MD					
ME		•	•	•	
MI					
MN					
MO	•		•	•	
MS	•	•	•	•	
MT	•		•	•	
NC	•		•	•	
ND					
NE					
NH					
NJ					
NM	•	•	•	•	
NV	•		•	•	
NY	•	•	•	•	
OH	•	•	•	•	
OK	•	•	•	•	
OR	•	•	•		
PA	•				
RI					
SC	•	•	•	•	
SD	•			•	
TN					
TX	•	•	•	•	
UT	•	•	•		
VA	•		•	•	
VT					
WA					
WI	•	•	•	•	
WV	•				
WY	•				

Database Linkages

Question: Is the licensing database linked to other state databases?

Analysis: 67% of states reported (n=35) that the licensing database linked to other states databases. Just over half (54%) reported a link to the child care subsidy system.



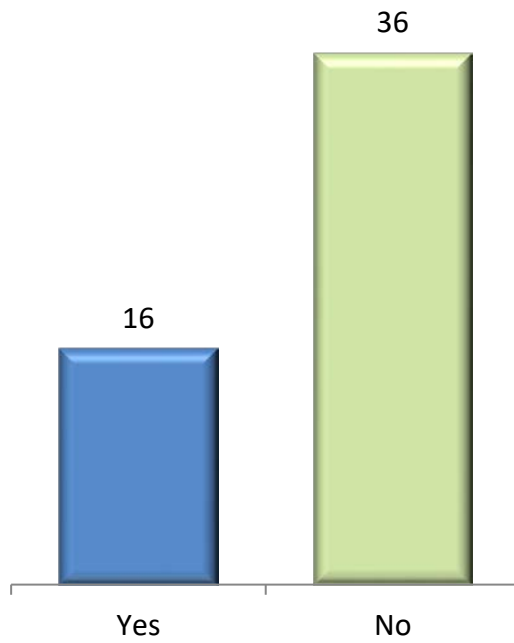
Licensing Database Linkages

State	Does not link to other state databases	Child care subsidy system	Child protection services	Human services, (e.g. TANF, SNAP)	Child care resource and referral	Professional development practitioner registry
Total	0	28	12	8	12	10
AK		•				
AL		•			•	
AR		•				
AS						
AZ						
CA						
CO		•	•		•	•
CT						
DC						
DE						
FL						
GA		•			•	
HI		•		•		•
IA		•				•
ID						
IL			•		•	
IN		•			•	
KS						
KY		•		•	•	
LA						
MA						
MD		•	•	•		•
ME		•	•			
MI		•		•	•	
MN		•				
MO		•		•		
MS		•		•		
MT		•	•	•	•	•
NC						
ND						
NE						
NH						
NJ						
NM		•	•			
NV						
NY		•	•			
OH		•				•
OK		•	•			•
OR		•			•	•
PA						
RI			•			
SC		•			•	
SD						
TN		•				
TX			•			
UT		•				
VA		•				
VT		•	•	•	•	•
WA		•	•			
WI		•				
WV						
WY					•	•

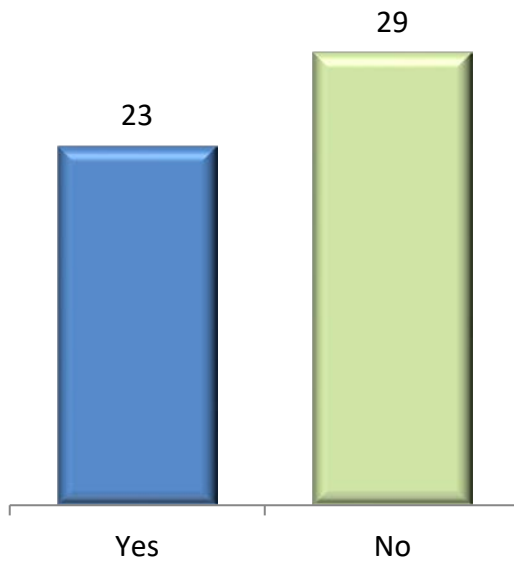
Licensing Database Linkages - Continuation

State	Consultant or training registry	QRIS and/or other quality systems	Child and Adult Care Food Programs	Integrated early childhood data system	Background check service or registry	Other
Total	4	19	7	4	18	0
AK						
AL		•				
AR		•				
AS						
AZ						
CA						
CO		•			•	
CT						
DC						
DE						
FL	•					
GA		•	•	•	•	
HI					•	
IA						
ID						
IL		•	•	•	•	
IN		•				
KS					•	
KY		•	•			
LA						
MA						
MD	•	•				
ME		•			•	
MI		•	•	•	•	
MN		•			•	
MO						
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NC		•			•	
ND						
NE						
NH						
NJ						
NM						
NV						
NY			•		•	
OH		•				
OK		•			•	
OR		•			•	
PA						
RI				•		
SC	•	•			•	
SD						
TN					•	
TX					•	
UT		•	•		•	
VA					•	
VT	•	•			•	
WA						
WI						
WV						
WY						

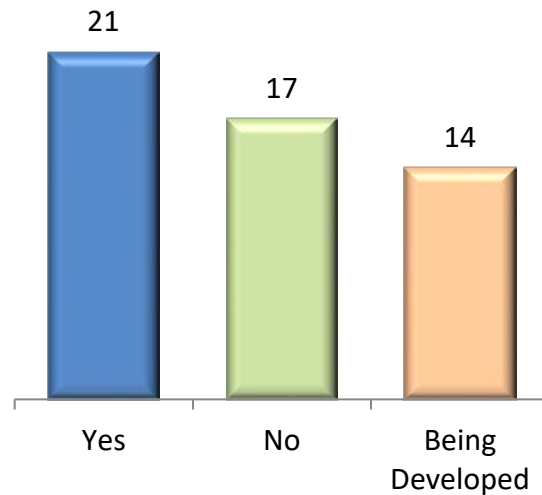
Question: If your licensing database system tracks serious injuries and fatalities that occur in child care facilities, does the system capture and categorize them by type and cause?



Question: Has your agency produced a publicly available report from your licensing data in the last two years?



Question: Does your state have an online license application process or is one being developed?



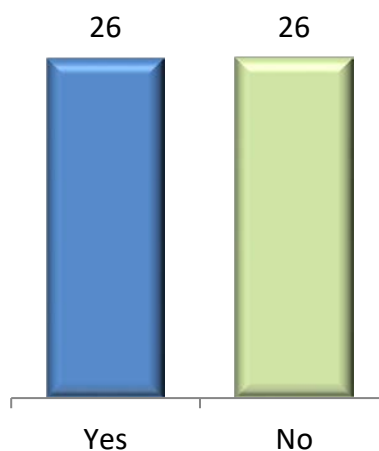
Portable Devices and Other Tools

Question: Is your state using, or considering using, portable, hand-held devices such as smart phones, laptops, and/or computer tablets with specific software for capturing information during licensing inspections?

Analysis: 65% of states that regulate child care centers reported using portable devices for inspections of child care centers and 16 additional states reported considering their use. 58% of states that regulate small FCC homes and 64% of states that regulate large/group FCC homes reported using portable devices. Only two states reported not using, or considering the use of portable devices for inspections in any facility type.

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Portable devices used for inspections	34	29	25
State is considering the use of portable devices for inspections	17	15	12

Question: Is the state using, or considering using, any other tools/devices/technology (such as laser measuring devices)?



COMPLAINTS

Summary:

Since 2014, the number of states relying on hotlines, either shared or dedicated lines, for receiving complaints increased by 25 percent with states less likely to rely on the general licensing agency phone number. Only one additional state added a web-based form for complaints. The number of states investigating complaints for the three program types changed little, though approximately 10 percent fewer states reported having separate staff within the licensing agency for investigating complaints. Three additional states reported that they would conduct an unannounced inspection in relation to a complaint, only when needed for the investigation.

The number of states reporting that they investigate anonymous complaints for centers and small FCC homes decreased by 4 states and 3 states respectively, while there was an increase of 15 states investigating anonymous complaints in large/group FCC homes. Overall there was a decline in the reported number of complaints filed, though the percent substantiated increased from 31 percent to 33 percent between 2014 and 2017. For child abuse and neglect complaints, there was little change in the number of states reporting who conducted the investigations though the number of states reporting law enforcement involvement decreased by eight.

	2014	2017
Licensing Agency	25	26
Protective Services	39	37
Police/Law Enforcement	15	26
Specialized Unit	34	16
Other	16	12

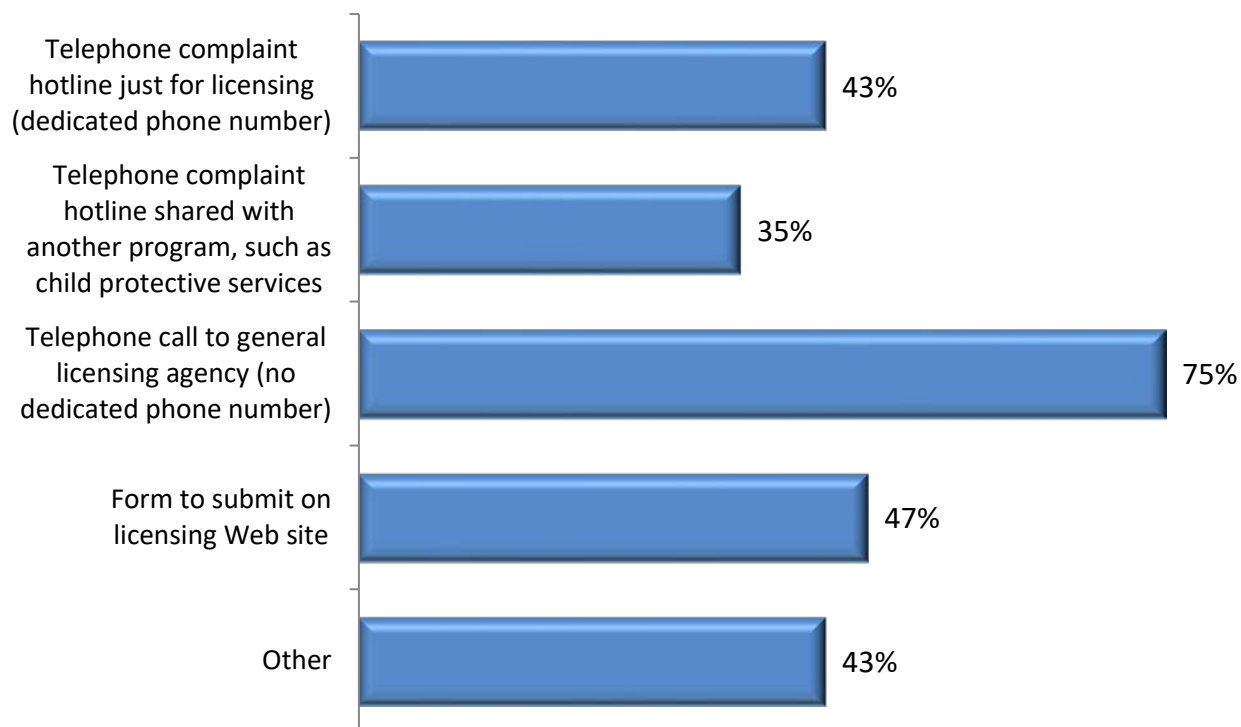
States were much more likely to investigate complaints against license-exempt programs in 2017 than in 2014. There was a 10 percent increase in the total number of states reporting that they investigated all complaints against exempt facilities, and a 19 state increase reported in the number of investigations involving subsidy payments or federal/state funding. The number of states reporting that they did not investigate or had no mechanism for complaints to be filed against license-exempt facilities dropped by a third.

	2014	2017
Yes, all complaints are investigated	8	13
Yes, a referral is made on allegations of abuse or neglect	27	29
Yes, if there are allegations of serious health and safety risks	6	14
Yes, to determine or verify that the facility is legally exempt	22	25
Yes, a referral is made to the subsidy program if the provider is receiving federal or state funding	7	12
Yes, for legally-exempt facilities that receive payment from the subsidy system	--	14
No, the licensing agency does not investigate complaints filed against legally-exempt facilities	15	9
No, there is no mechanism for a complaint to be filed against a license-exempt facility	0	1
Other	17	15

Complaint Submissions

Question: What mechanisms are in place for parents to submit complaints about licensed child care providers?

Analysis: 75% of responding states (n=51) reported parents submitted complaints to a general licensing agency number. Almost half (47%) have a web-based form for submission and 43% have a dedicated complaint hotline.



State	Telephone complaint hotline just for licensing (dedicated phone number)	Telephone complaint hotline shared with another program, such as child protective services	Telephone call to general licensing agency (no dedicated phone number)	Form to submit on licensing Web site	Other
Total	22	18	38	24	22
AK			•		•
AL	•				
AR			•	•	
AS			•		•
AZ			•	•	
CA	•				
CO	•				•
CT	•			•	
DC	•	•			
DE		•	•	•	
FL		•	•		•
GA	•		•		•
HI			•		
IA	•				
ID		•		•	
IL	•	•	•		•
IN	•		•	•	
KS		•	•	•	•
KY			•		

State	Telephone complaint hotline just for licensing (dedicated phone number)	Telephone complaint hotline shared with another program, such as child protective services	Telephone call to general licensing agency (no dedicated phone number)	Form to submit on licensing Web site	Other
LA	•	•	•		•
MA			•		
MD	•		•		•
ME		•	•		
MI					
MN					•
MO		•	•	•	
MS	•		•	•	•
MT			•	•	
NC			•		•
ND			•		
NE	•			•	
NH		•	•	•	
NJ	•				
NM		•	•		•
NV			•	•	
NY	•	•	•	•	•
OH	•		•	•	
OK		•	•	•	
OR			•	•	•
PA	•			•	•
RI		•	•		•
SC		•	•	•	•
SD	•		•	•	
TN	•				•
TX		•	•		•
UT	•		•	•	
VA	•		•	•	•
VT			•	•	
WA		•	•		
WI			•	•	
WV		•	•		
WY	•				•

Complaint Investigations

Question: Does the state licensing agency conduct investigations on licensing complaints?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Licensing agency conducts complaint investigations	51	43	36

Question: If the licensing agency conducts complaint investigations, what agency staff or other professionals are used to conduct the investigations?

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Same staff who conduct inspections for initial licensure and routine compliance	47	39	33
Separate staff who only work on complaint investigations	8	8	5
Staff from another agency	9	7	8

Question: Do investigations of complaints include an unannounced visit to the facility?

Analysis: Every state responding to the survey (n=51) reported the use of unannounced visits to a facility to investigate a complaint. 63% reported using unannounced visits for every complaint, while 37% reporting using an unannounced visit only when an on-site visit is needed for the investigation.

State	Yes, an unannounced visit is conducted for every complaint received	Yes, but only when an on-site visit is needed for the investigation	No, unannounced visits are not routinely conducted	No, visits are conducted, but they are announced	Other
Total	32	19	0	0	6
AK	•				
AL	•				
AR	•				
AS		•			
AZ		•			
CA	•				
CO	•				
CT	•				
DC	•				
DE	•				
FL	•				
GA	•				
HI		•			
IA		•			
ID		•			
IL	•				
IN	•				
KS	•				
KY	•				
LA	•				
MA					•
MD	•				

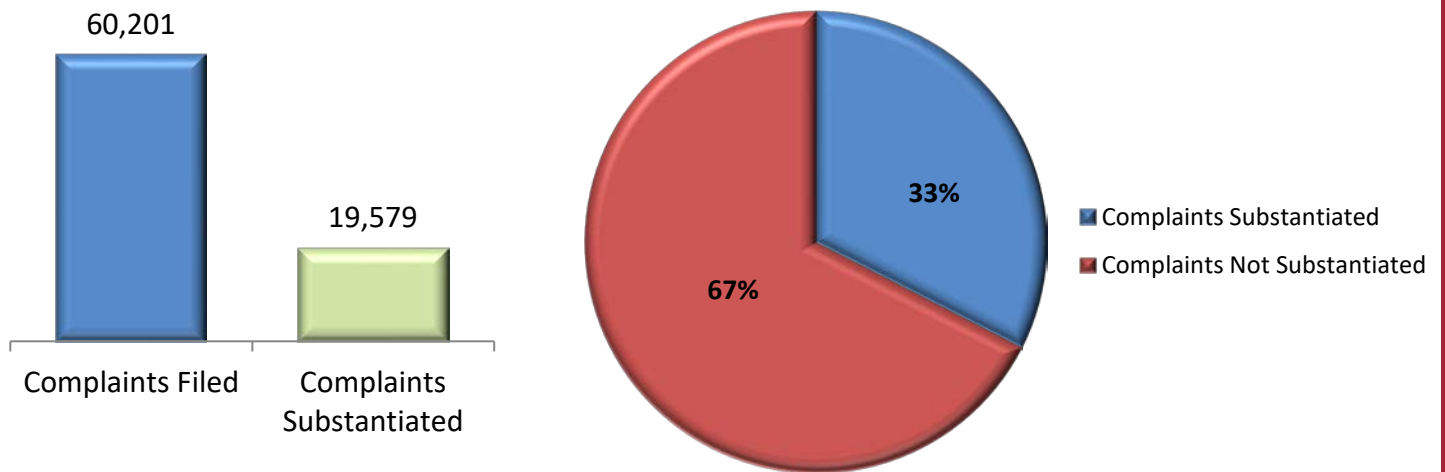
State	Yes, an unannounced visit is conducted for every complaint received	Yes, but only when an on-site visit is needed for the investigation	No, unannounced visits are not routinely conducted	No, visits are conducted, but they are announced	Other
ME	•				
MI					
MN		•			
MO					•
MS	•				
MT		•			
NC	•				
ND	•				
NE	•				
NH	•	•			•
NJ	•				
NM	•				
NV		•			
NY	•				
OH	•	•			
OK		•			
OR	•				
PA	•				
RI		•			
SC	•				•
SD		•			
TN		•			
TX		•			
UT	•	•			
VA		•			•
VT					•
WA	•				
WI		•			
WV	•				
WY		•			

Question: The state investigates complaints filed anonymously for which type of licensed child care facilities?

State	Yes	Not Reported	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			52	50	39
Total	32	18	45	38	29
AK	•		•	•	•
AL	•		•	•	•
AR	•		•	•	
AS	•		•	•	
AZ		•			
CA	•		•	•	•
CO	•				
CT	•		•	•	•
DC	•		•	•	•
DE	•				
FL	•		•	•	•
GA	•		•	•	
HI		•	•	•	•
IA		•	•	•	•
ID		•	•		•
IL		•	•	•	•
IN	•		•		•
KS	•		•	•	•

State	Yes	Not Reported	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
KY	•		•	•	
LA	•		•		
MA		•	•	•	
MD	•		•	•	•
ME	•		•	•	
MI		•			
MN		•	•		
MO		•	•	•	•
MS	•		•	•	•
MT		•	•	•	•
NC	•		•	•	
ND	•		•	•	•
NE	•				
NH	•		•	•	•
NJ		•	•		
NM	•		•	•	•
NV	•		•	•	•
NY	•		•	•	•
OH		•	•		•
OK		•	•	•	•
OR	•		•	•	•
PA		•	•	•	•
RI	•		•	•	•
SC	•		•	•	•
SD		•	•		
TN		•	•	•	•
TX	•		•	•	
UT	•				
VA		•	•	•	
VT	•		•	•	
WA		•	•	•	
WI		•	•	•	
WV	•				
WY		•	•	•	•

Question: How many licensing complaints were filed in CALENDAR YEAR 2017? How many were substantiated?
43 states reporting

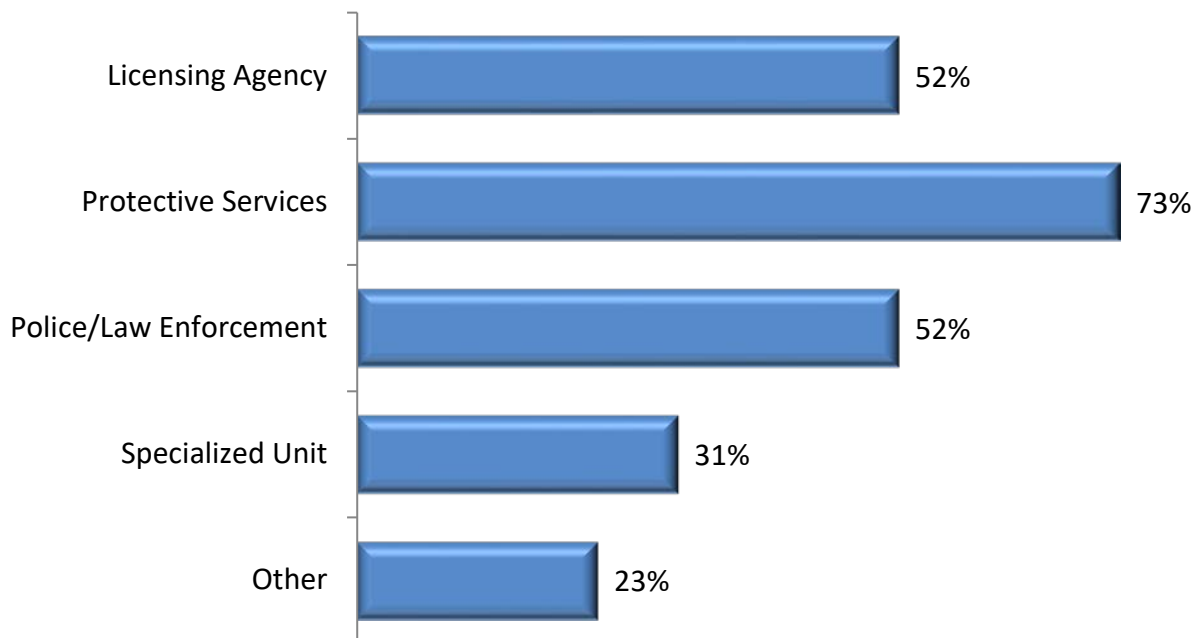


Question: What was the nature of the licensing complaints that were filed in CALENDAR YEAR 2017?

Analysis: Of the 75% of states responding (n=39), the majority (77%) reported Supervision as a complaint, 74% responded that Ratios were an issue, and 33% reported complaints regarding Discipline.

Question: Which state agencies investigate child abuse and neglect complaints against licensed child care facilities?

Analysis: 73% of states responding indicated that child protective services investigate abuse and neglect complaints while just over half (52%) report the licensing agency and/or police/law enforcement investigates complaints.



State	Licensing agency	Protective services	Police/law enforcement agency	Specialized unit for child abuse and neglect	Other
Total	27	38	27	16	12
AK	•				
AL	•	•	•		•
AR	•	•			
AS	•	•	•		
AZ	•	•	•	•	
CA	•	•	•		
CO		•	•		
CT	•	•	•		
DC	•	•	•	•	
DE		•	•	•	
FL		•	•	•	
GA	•	•	•	•	
HI	•	•			
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IN	•	•	•		
KS		•			
KY		•			
LA		•			
MA	•			•	•
MD		•	•	•	•
ME				•	
MI					
MN	•	•			
MO	•	•	•	•	
MS	•	•	•	•	•
MT		•			
NC	•				•
ND		•		•	
NE	•	•	•		
NH	•		•		
NJ				•	
NM	•		•		
NV	•	•	•		
NY	•	•	•		•
OH		•			
OK		•			
OR	•	•	•	•	
PA		•			
RI		•			•
SC	•	•	•		•
SD		•			
TN		•	•		•
TX		•			
UT	•	•	•		
VA		•	•		
VT	•	•	•	•	•
WA				•	
WI					•
WV			•	•	
WY		•			•

Question: Does the licensing agency investigate or make referrals when complaints are received on legally-exempt facilities?

Analysis: Approximately 60% of reporting states (n=51) said they make referrals on allegations of abuse or neglect for legally-exempt facilities. Almost half reported investigating to determine if the facility is, in fact, exempt.

State	Yes, all complaints are investigated	Yes, a referral is made on allegations of abuse or neglect	Yes, if there are allegations of serious health and safety risks	Yes, to determine or verify that the facility is legally exempt	Yes, a referral is made to the subsidy program if the legally-exempt provider is receiving federal or state funding	Yes, for legally-exempt facilities that receive payment from the subsidy system	No, the licensing agency does not investigate complaints filed against legally-exempt facilities	No, there is no mechanism for a complaint to be filed against a license-exempt facility	Other
Total	13	30	14	25	12	14	10	1	16
AK	•								
AL		•	•			•			
AR	•								
AS		•					•		
AZ				•					
CA	•	•	•	•	•				
CO							•		
CT	•	•		•		•			
DC		•		•		•			
DE		•		•					
FL		•	•	•	•	•			•
GA				•					•
HI		•		•					
IA		•			•				
ID			•	•	•	•			•
IL		•			•				•
IN	•	•							•
KS							•	•	•
KY		•		•	•		•		
LA		•	•	•	•	•			
MA							•		
MD									•
ME									•
MI									
MN									•
MO		•	•				•		
MS	•	•	•	•	•	•			
MT							•		
NC		•		•					
ND	•	•							
NE	•								
NH			•	•					•
NJ		•							
NM		•	•	•					
NV		•							
NY		•	•	•	•	•			•
OH		•	•	•					
OK		•		•					
OR		•		•		•			

State	Yes, all complaints are investigated	Yes, a referral is made on allegations of abuse or neglect	Yes, if there are allegations of serious health and safety risks	Yes, to determine or verify that the facility is legally exempt	Yes, a referral is made to the subsidy program if the legally-exempt provider is receiving federal or state funding	Yes, for legally-exempt facilities that receive payment from the subsidy system	No, the licensing agency does not investigate complaints filed against legally-exempt facilities	No, there is no mechanism for a complaint to be filed against a license-exempt facility	Other
PA							•		•
RI	•								
SC		•	•	•	•	•			•
SD		•		•		•			
TN	•	•			•	•			
TX				•					
UT	•	•	•						
VA		•		•	•	•			•
VT	•	•	•	•		•			
WA							•		
WI				•					•
WV	•								•
WY							•		

ENFORCEMENT ACTIONS

Summary:

States report many more enforcement options against child care centers than for FCC homes. There are more enforcement options for small FCC homes than for large/group FCC homes. The same pattern of availability of enforcement options across program types is seen in 2014 and 2017 but more states reported an expanded set of options in 2017.

Between 2014 and 2017 an additional four states said that non-renewal of license was a possible enforcement action for centers, along with three additional states reporting the option for small FCC homes and two for large/group FCC homes. Consent agreements were up five percent across all program types, and civil fines and/or imprisonment were up about three percent across all program types.

In 2014, 45 states reported that enforcement actions affected subsidy payments. Twenty states reported multiple criteria for when the subsidy payment was affected, 27 states reported a single criterion, and only four states did not respond. In 2017, 42 states reported that enforcement actions affected subsidy payments, 27 states reported a single criteria, 14 reported multiple criteria, and 13 states did not respond regarding when they payments were affected.

Two fewer states reported the number of enforcement actions in 2017 than in 2014. Despite fewer states responding, the number of reported civil fines more than doubled in 2017. The number of consent agreements reported increased by 84 percent, and the number of revocations of license reported increased by 28 percent. When comparing the 44 states that responded to both surveys, the number of civil fines in 2017 is more than triple the number in 2014 (two states were responsible for 80 percent of the increase), the number of consent agreements is more than double and there were almost 50 percent more revocations of license. The largest drops were seen in the use of conditional or non-renewal of licenses.

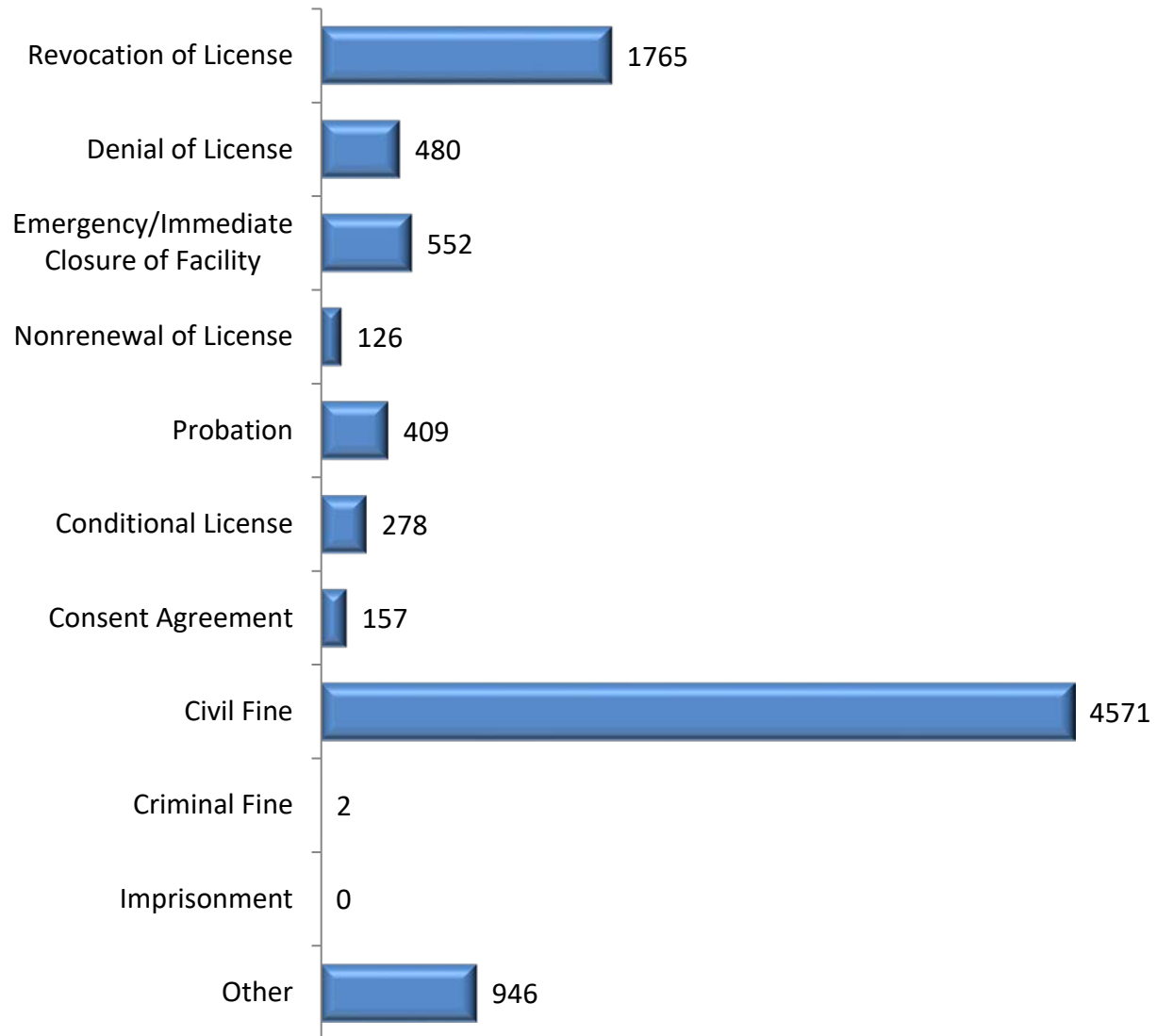
Question: Indicate which of the following corrective and adverse enforcement actions does policy allow you to use with licensed child care facilities?

Analysis: Revocation and denial of license as well as emergency/immediate closure of the facility were the most commonly reported enforcement actions with almost every state having those options for centers and to lesser extent in FCC homes. About 72 percent of states said conditional licenses were options for centers, small FCC homes and in about 75 percent of states for large/group FCC homes. Civil fines were also a commonly reported options across program types.

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Revocation of license	52	45	38
Denial of license	50	43	37
Emergency/immediate closure of facility	51	45	38
Nonrenewal of license	38	33	30
Probation	25	24	18
Conditional license	37	36	29
Consent agreement	21	19	16
Civil fine	31	28	22
Criminal fine	6	6	4
Imprisonment	4	4	3
Other	21	19	13

Questions: Indicate which of the following corrective and adverse enforcement actions were used with licensed child care facilities and the number of enforcement actions that were taken in CALENDAR YEAR 2017?

Analysis: Despite every state reporting that policy allowed revocation of license, non-renewal of license, and emergency facility closure, civil fines are the most frequently used enforcement action by more than two and a half times as often as the next most frequent enforcement action, revocation of license. Civil fines are used more than eight times as often as immediate closure. No enforcement actions were reported that lead to imprisonment. No enforcement actions were reported that lead to imprisonment.



Examples of “Other” enforcement actions include:

- Restriction of license
- Reduced capacity
- Mandated training
- Partial sanctions and exclusions
- Voluntary program improvement plans/corrective action plans (plans of action)

Question: If a licensing enforcement action is taken against a facility, does that affect the provider's receipt of child care assistance/subsidy payment?

Analysis: While approximately one-fourth of states reporting (n=40) indicated that a facility's subsidy payment was affected when an enforcement action was made effective, and approximately 38% said the payment was affected if the action was not appealed or when the action was upheld, the impact on subsidy payments mostly seemed to vary by the type of enforcement action. 90% of reporting states said that the effect on a subsidy payment varied.

State	An enforcement action is made effective	The action is not appealed or is upheld	Varies by type of enforcement action	Other
Total	9	15	36	1
AK			•	
AL			•	
AR			•	
AS			•	
AZ	•	•	•	
CA	•	•	•	
CO			•	
CT				
DC			•	
DE				
FL			•	
GA		•	•	
HI	•	•	•	
IA	•	•		
ID			•	
IL			•	
IN				
KS				
KY		•	•	
LA	•	•	•	
MA			•	
MD	•	•	•	
ME				
MI			•	
MN			•	
MO			•	
MS				
MT				
NC			•	
ND			•	•
NE				
NH		•	•	
NJ			•	
NM			•	
NV				
NY			•	
OH		•		
OK		•	•	
OR			•	
PA				
RI			•	
SC		•		
SD	•	•	•	
TN			•	
TX	•	•		
UT	•	•	•	

State	An enforcement action is made effective	The action is not appealed or is upheld	Varies by type of enforcement action	Other
VA			•	
VT			•	
WA				
WI			•	
WV				
WY			•	

Question: How is the subsidy agency notified of licensing enforcement actions taken against a facility?

Analysis: Out of the 35 states responding, almost half reported that an electronic notice is automatically generated for the subsidy agency when a licensing action is taken. Almost 86% reported personal contact being made between the licensing and subsidy agencies. Just over one-third of reporting states reported a link between the licensing and subsidy agency databases where enforcement actions are monitored.

State	An electronic notice is automatically generated	Personal contact is made between the licensing and subsidy agencies	There is a link between the licensing and subsidy agency databases, and enforcement actions are monitored
Total	17	30	12
AK		•	•
AL	•	•	•
AR		•	
AS	•	•	
AZ		•	
CA		•	
CO	•	•	
CT			
DC	•	•	
DE			
FL	•	•	•
GA	•		
HI		•	•
IA			
ID	•	•	
IL	•	•	•
IN			
KS			
KY	•	•	
LA	•	•	
MA		•	
MD			•
ME			
MI	•		•
MN			•
MO			
MS			
MT			
NC	•		
ND		•	
NE			
NH		•	
NJ	•	•	
NM		•	•
NV			
NY		•	•
OH			
OK		•	
OR	•	•	
PA			
RI		•	
SC			
SD		•	
TN		•	
TX			
UT	•	•	•
VA		•	

State	An electronic notice is automatically generated	Personal contact is made between the licensing and subsidy agencies	There is a link between the licensing and subsidy agency databases, and enforcement actions are monitored
VT	•	•	•
WA			
WI	•	•	
WV			
WY		•	

SHARING LICENSING INFORMATION

Summary:

Between 2014 and 2017 the number of states that made either a full inspection report or summary report available online increased by 9 states (18 percent). In 2014 seven states did not have the reports online and 10 were planning to add them in the future. By 2017, while eight states were still in planning stages, there were no states that either did not or did not plan to make the reports available.

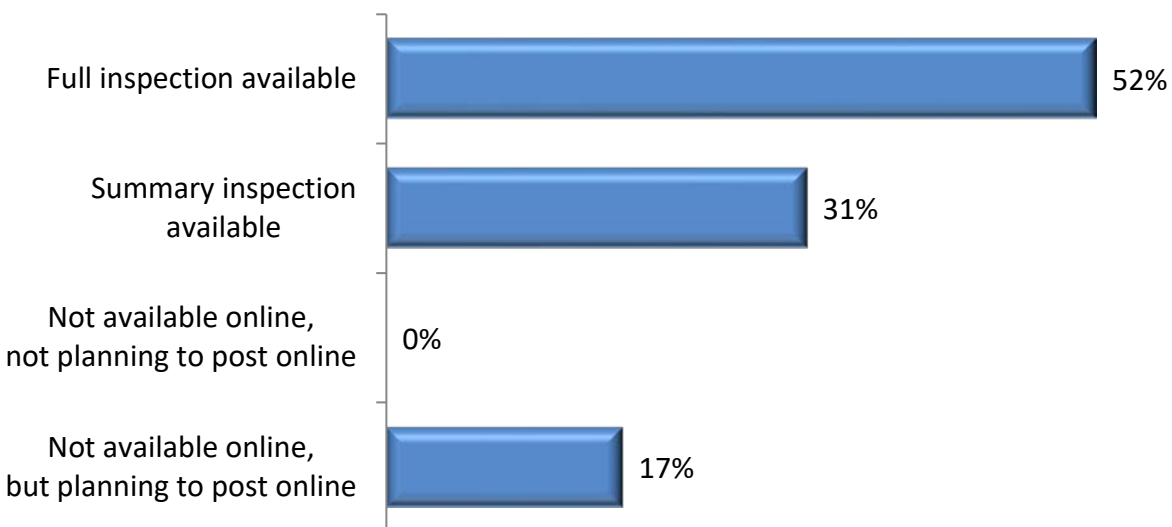
In both 2014 and 2017 nine states included all complaints online. The number of states reporting posting only substantiated complaints online increase from 20 to 32. The number of states not posting any complaint information dropped by one. The number of states that included enforcement actions as part of their online report grew from 21 to 34 states. In 2017, 34 states allowed the facility to review the report before posting while 19 states gave facilities a chance to review the report before posting in 2014.

In 2017, 60 percent of states reported that they provided guidance to the public to help understand the licensing reports they posted online. In 2014, only 53 percent of states said they provided guidance. More than half the states reported having inspection reports available online within a week of inspection. The question on length of time to post an inspection was not asked in 2014.

Shared Online

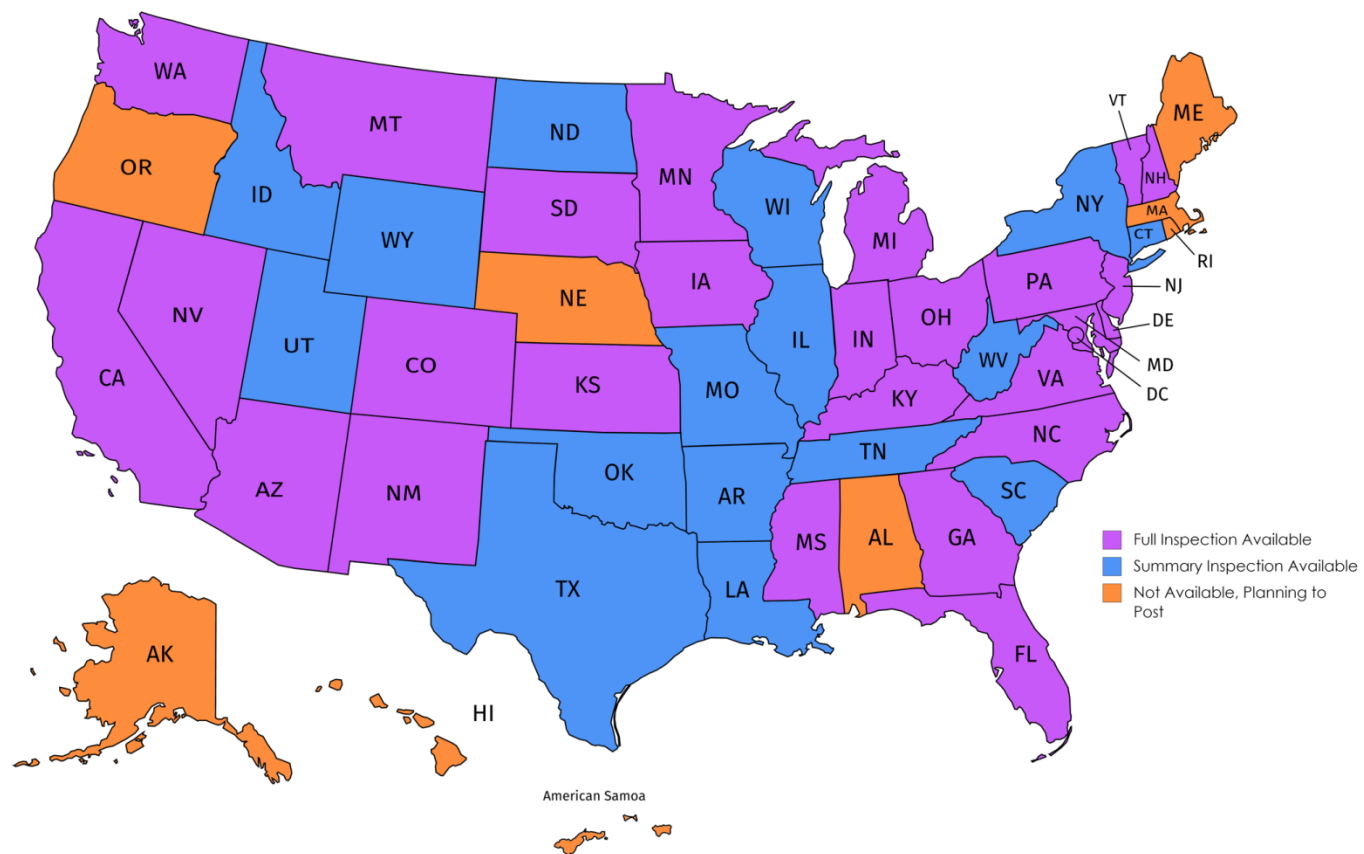
Question: Are licensing inspection reports available on the Internet for parent and public access?

Analysis: More than half of all states reported that full inspection reports are available online while another 31% reported that a summary report is available. All of the states who currently do not post information on the internet reported that they are planning to make reports available online in the future.



State	Yes, the full inspection report is available	Yes, a summary of the report is available	No, inspection reports are not available on the Internet	No, but state is planning to put inspection reports on the Internet
Total	27	16	0	9
AK				x
AL				x
AR		x		
AS				x
AZ	x			
CA	x			
CO	x			
CT		x		
DC	x			
DE	x			
FL	x			
GA	x			
HI				x
IA	x			
ID		x		
IL		x		
IN	x			
KS	x			
KY	x			
LA		x		
MA				x
MD	x			
ME				x
MI	x			
MN	x			
MO		x		
MS	x			
MT	x			
NC	x			
ND		x		
NE				x
NH	x			
NJ	x			
NM	x			
NV	x			
NY		x		
OH	x			
OK		x		
OR				x
PA	x			
RI				x
SC		x		
SD	x			
TN		x		
TX		x		
UT		x		
VA	x			
VT	x			
WA	x			
WI		x		
WV		x		
WY		x		

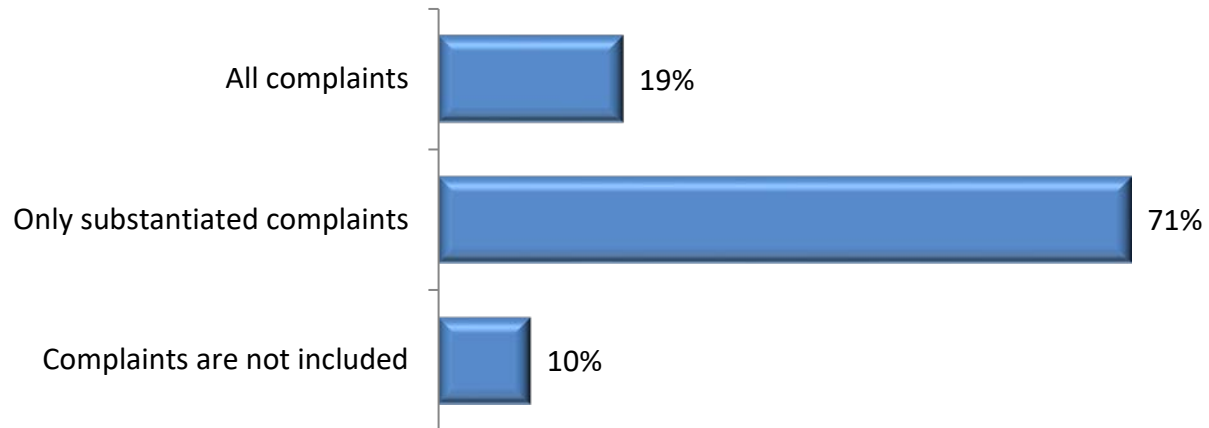
Map 5 Availability of Inspections Online



Complaint Information Shared

Question: If licensing inspection reports are available on the Internet, are complaints filed against facilities included?

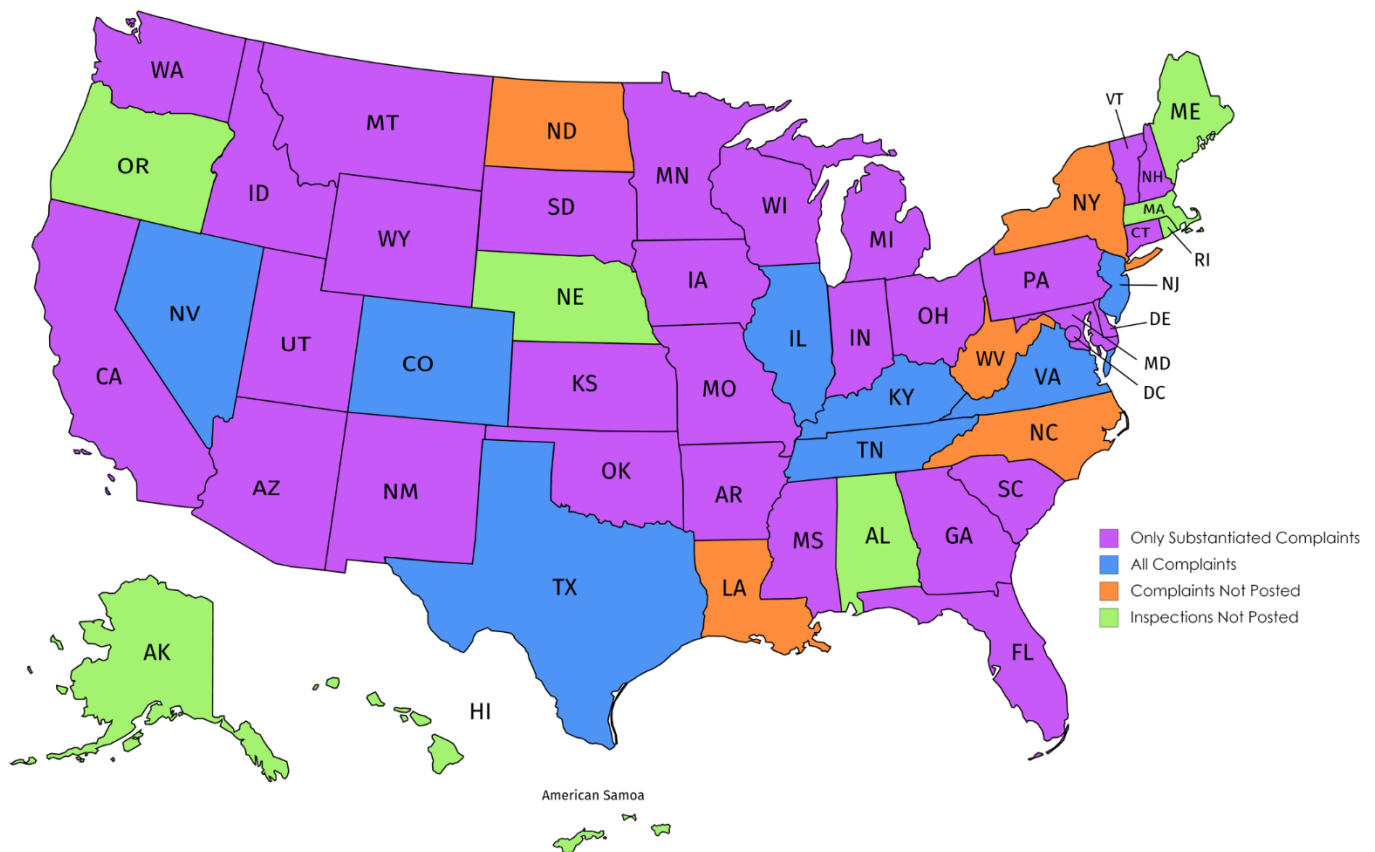
Analysis: Of the 42 states that make inspection reports available online, 38 also include complaints filed against facilities. In 30 of those 38 states, complaints are only included if they are substantiated.



State	Yes, all complaints	Yes, but only substantiated complaints	No, complaints are not included
Total	9	33	5
AK			
AL		•	
AR		•	
AS		•	
AZ		•	
CA		•	
CO	•		
CT		•	
DC		•	
DE		•	
FL		•	
GA		•	
HI			
IA		•	
ID		•	
IL	•		
IN		•	
KS		•	
KY	•		
LA			•
MA			
MD		•	
ME			•
MI		•	
MN		•	
MO		•	
MS		•	
MT		•	
NC			•
ND			•
NE	•		
NH		•	

State	Yes, all complaints	Yes, but only substantiated complaints	No, complaints are not included
NJ	•		
NM		•	
NV	•		
NY			•
OH		•	
OK		•	
OR		•	
PA		•	
RI			
SC		•	
SD		•	
TN	•		
TX	•		
UT		•	
VA	•		
VT		•	
WA		•	
WI		•	
WV			
WY		•	

Map 6 Posting Complaints Online



Question: Do licensing inspection reports published online include enforcement actions and/or corrective action plans? Do child care providers have an opportunity to review reports before they are posted online?

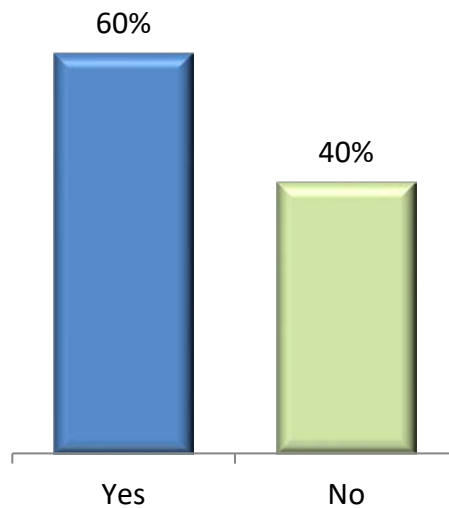
Analysis: A total of 43 states reported posting inspection reports online. Using that number as the basis for analysis, almost 70% of those states include enforcement actions in their online reports, and just over 60% include corrective actions plans. Slightly less than 70% of states allow providers to review reports before the reports are posted online.

State	Reports published online include enforcement actions taken against the program	Reports published online include corrective action plans	Child care providers are given the opportunity to review reports before they are posted to the internet
Total	30	26	30
AK			
AL	*	*	*
AR			•
AS	*	*	*
AZ	•		•
CA		•	•
CO	•	•	•
CT	•	•	
DC	•		
DE	•	•	•
FL		•	•
GA	•	•	•
HI			
IA	•		
ID	•		•
IL	•	•	•
IN	•	•	•
KS	•		•
KY	•		•
LA			•
MA			
MD	•	•	•
ME	*	*	*
MI	•		
MN	•		
MO		•	•
MS	•	•	•
MT			•
NC		•	•
ND			
NE	*	*	
NH	•	•	•
NJ			
NM	•	•	•
NV	•	•	•
NY	•		•
OH	•	•	
OK		•	•
OR	*		*
PA	•	•	•
RI			
SC			
SD	•	•	•
TN	•	•	
TX	•		•
UT	•	•	
VA		•	•
VT	•	•	
WA		•	•

State	Reports published online include enforcement actions taken against the program	Reports published online include corrective action plans	Child care providers are given the opportunity to review reports before they are posted to the internet
WI	•	•	•
WV	•		
WY	•	•	•

**Despite answering affirmatively to this question, these states do not yet publish licensing inspection reports online. They are excluded from any counts and analysis.*

Question: Does the state provide the public any guidance on understanding or interpreting licensing inspection reports?



State	Yes, the State provides guidance to the public	No, the state does not provide guidance to the public
Total	31	21
AK		•
AL		•
AR	•	
AS	•	
AZ	•	
CA	•	
CO	•	
CT		•
DC	•	
DE	•	
FL	•	
GA	•	
HI	•	
IA		•
ID		•
IL	•	
IN	•	
KS	•	
KY	•	
LA		•
MA		•
MD		•
ME		•
MI		•
MN	•	
MO		•

State	Yes, the State provides guidance to the public	No, the state does not provide guidance to the public
MS	•	
MT		•
NC		•
ND		•
NE	•	
NH	•	
NJ		•
NM	•	
NV	•	
NY	•	
OH	•	
OK	•	
OR	•	
PA		•
RI		•
SC	•	
SD	•	
TN		•
TX	•	
UT	•	
VA	•	
VT	•	
WA		•
WI	•	
WV		•
WY		•

Time to Post Online

Question: Describe how long, on average, it takes to post a report to the Internet after an inspection.

Analysis: For the states responding that they post inspection reports online and responding to this follow-up question (n=42), nearly 93% indicated having reports posted within that time frame. More than half (55%) reported having reports posted within a week and almost 17% said reports were posted within a day or less.

State	Immediately after inspection	Within 1 day	Within 1 week	Within 1 month	Longer than 1 month
Total	3	4	16	16	3
AK					
AL			*		
AR					•
AS				*	
AZ				•	
CA			•		
CO			•		
CT			•		
DC				•	
DE		•			
FL			•		
GA				•	
HI					
IA				•	
ID				•	
IL			•		
IN		•			
KS				•	
KY	•				
LA			•		
MA					*
MD				•	
ME				*	
MI				•	
MN				•	
MO				•	
MS			•		
MT				•	
NC			•		
ND					•
NE			*		
NH				•	
NJ			•		
NM					•
NV				•	
NY			•		
OH			•		
OK	•				

ILLEGALLY OPERATING PROVIDERS

Summary:

Almost every state identifies and addresses illegally operating providers through complaints received by the public. Three additional states reported monitoring listings where providers advertise in 2017 and nine additional states reported working with law enforcement in 2017 than in 2014. Nine fewer states reported using education campaigns with the public in 2017 than in 2014, and there were three additional states that used other means.

In 2017, 90 percent of states reported that they encouraged illegally operating providers to become licensed. This represents a decrease from 96 percent of states in 2014. In 2017, six percent fewer states were likely to contact law enforcement, but eight percent more states reported that operating an illegal program was likely to result in a misdemeanor. There was a drop between 2014 and 2017 in the number of states reporting the availability of data or a database to track illegally operating providers. In 2014, 69 percent of states reported the ability to track illegal providers compared to 65 percent in 2017.

Identifying Illegally Operating Providers

Question: How does your agency address the issue of illegally operating providers (providers who are required to be licensed under state statute but are not)?

Analysis: 96% of all states said they respond to complaints received from the public when trying to address illegally operating providers. Almost two-thirds (65%) work with local law enforcement, while 23% monitor local provider listings/advertisements, and 21% use public information/education campaigns to help inform the public.

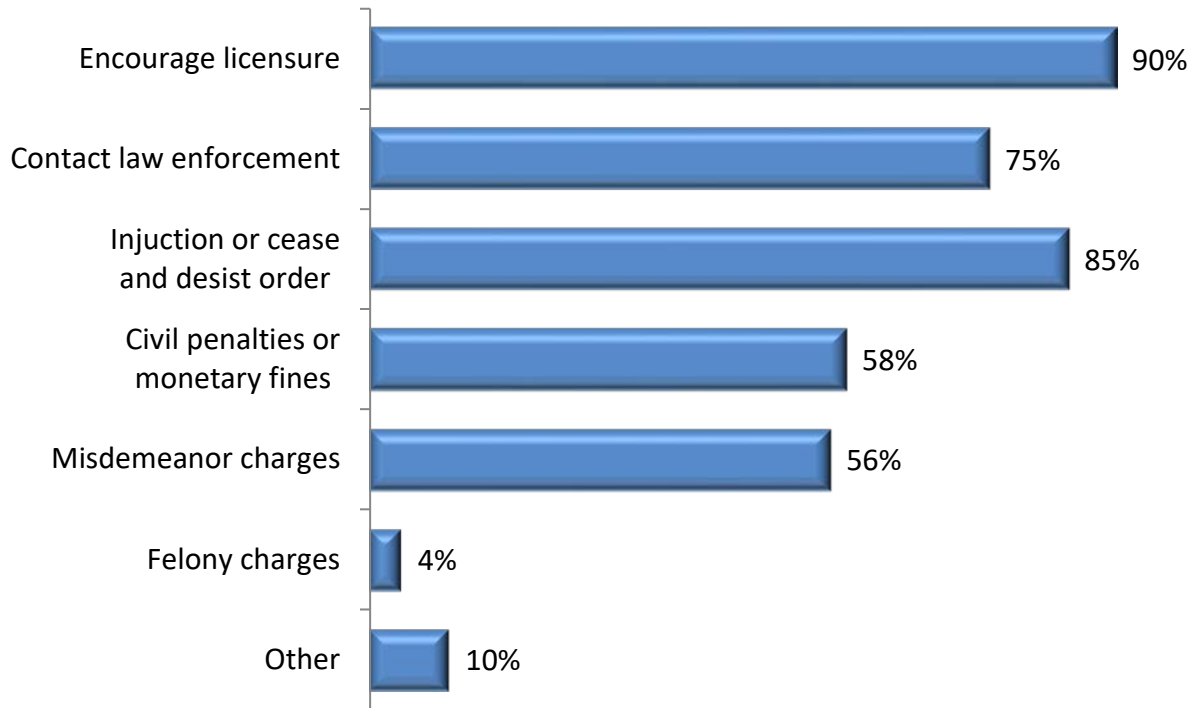
State	Respond to complaints received by the public	Monitor listings where providers advertise	Seek to educate the public with a campaign about licensing	Work with local law enforcement	Other
Total	50	12	11	34	12
AK	•	•		•	•
AL	•	•		•	
AR	•				
AS					•
AZ	•			•	
CA	•		•	•	•
CO	•			•	
CT	•				
DC	•				
DE	•		•		
FL	•		•		
GA	•				•
HI	•				
IA					•
ID	•			•	
IL	•			•	
IN	•	•	•	•	
KS	•	•	•	•	
KY	•	•		•	•
LA	•	•		•	•
MA	•			•	
MD	•	•		•	
ME	•				
MI	•			•	•
MN	•			•	
MO	•			•	
MS	•	•		•	

State	Respond to complaints received by the public	Monitor listings where providers advertise	Seek to educate the public with a campaign about licensing	Work with local law enforcement	Other
MT	•				
NC	•			•	
ND	•	•	•	•	
NE	•				
NH	•				
NJ	•		•	•	•
NM	•			•	
NV	•	•	•	•	
NY	•	•	•	•	•
OH	•			•	
OK	•			•	
OR	•			•	
PA	•				
RI	•				
SC	•			•	
SD	•			•	
TN	•			•	
TX	•		•		•
UT	•			•	
VA	•		•	•	
VT	•				
WA	•			•	•
WI	•				
WV	•	•		•	
WY	•			•	

Addressing Illegally Operating Providers

Question: What actions can be taken when a provider is found to be operating illegally?

Analysis: When a provider is found to be operating illegally, more than 90% of states encourage the provider to become licensed, while in nearly 85% of the cases an injunction or cease and desist order may be issued. In 75% of the instances, law enforcement may be contacted while just under 60% of the time an illegally operating provider may face civil penalties, monetary fines, or misdemeanor charges. In a small percentage of cases (3.8%) felony charges may be filed.



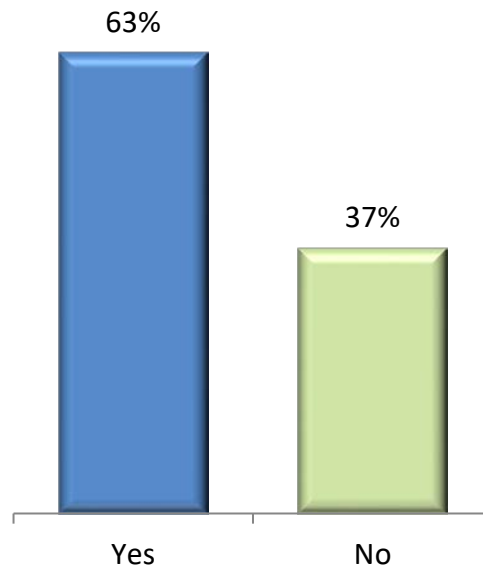
State	The provider may be encouraged to become licensed when possible	Law enforcement may be contacted in certain circumstances	An injunction or cease and desist order may be issued	Civil penalties or monetary fines may be assessed	Misdemeanor charges may be filed	Felony charges may be filed	Other
Total	47	39	44	30	29	2	5
AK	•	•	•	•	•		
AL				•	•		•
AR			•				
AS	•						
AZ	•	•	•	•			
CA	•	•	•	•			
CO	•	•	•		•		
CT	•		•	•			
DC	•	•	•				
DE	•	•	•	•			
FL	•		•	•	•	•	
GA	•	•	•		•		•
HI	•		•	•			
IA					•		
ID	•	•			•		
IL	•	•	•	•	•		•
IN		•	•	•	•		

State	The provider may be encouraged to become licensed when possible	Law enforcement may be contacted in certain circumstances	An injunction or cease and desist order may be issued	Civil penalties or monetary fines may be assessed	Misdemeanor charges may be filed	Felony charges may be filed	Other
KS	•	•	•				
KY	•	•	•				
LA	•	•	•	•			
MA	•	•	•	•			
MD	•	•	•	•	•		
ME	•	•	•	•			
MI	•	•	•				
MN	•	•	•		•		
MO	•	•	•	•	•		
MS	•	•	•		•		
MT	•				•		
NC	•	•	•		•	•	
ND	•	•		•	•		
NE	•	•		•	•		
NH	•		•	•	•		
NJ	•	•					
NM	•	•	•	•	•		
NV	•	•	•		•		
NY	•	•	•	•	•		
OH	•	•	•	•	•		
OK	•	•	•	•	•		
OR	•	•	•	•			
PA	•		•	•			
RI		•	•	•			
SC	•	•	•				•
SD	•	•	•		•		
TN	•	•	•				
TX	•		•				
UT	•	•	•	•	•		
VA	•	•	•		•		•
VT	•		•	•			
WA	•	•	•	•	•		
WI	•	•	•	•	•		
WV	•		•				
WY	•	•	•	•	•		

Tracking Illegally Operating Providers

Question: Does your State keep data on investigations of illegally operating providers?

Analysis: Approximately 60% of states report that they kept data on investigations of illegally operating providers.



Question: How many illegal providers were investigated in 2017 and what actions were taken?

Analysis: 26 states track illegal provider investigations and are able to provide data related to these programs. States reported 8,334 investigations of illegal providers in calendar year 2017. Using a weighted average, approximately 28% of investigations were substantiated. Almost 8% of the illegally operating providers became licensed while just over 11% of the investigations resulted in legal action.

State	How many were investigated in the 2017 calendar year?	What percentage were substantiated as illegally operating care?	What percentage became licensed?	What percentage resulted in legal action?
Total	8,334	28.05%*	7.96%*	11.33%*
AK	Not Available	Not Available	Not Available	Not Available
AL	Not Available	Not Available	Not Available	Not Available
AR	Not Available	Not Available	Not Available	Not Available
AS	Not Available	Not Available	Not Available	Not Available
AZ	137	29%	10%	0%
CA	505	41.9%	Not Available	Not Available
CO	131	Not Available	Not Available	Not Available
CT	132	35%	Not Available	Not Available
DC	20	4%	0%	20%
DE	Not Available	Not Available	Not Available	Not Available
FL	47	100%	55%	Not Available
GA	499	Not Available	Not Available	Not Available
HI	27	40%	1%	0%
IA	Not Available	Not Available	Not Available	Not Available
ID	Not Available	Not Available	Not Available	Not Available
IL	Not Available	Not Available	Not Available	Not Available
IN	Not Available	39%	Not Available	39%
KS	228	44%	Not Available	Not Available

State	How many were investigated in the 2017 calendar year?	What percentage were substantiated as illegally operating care?	What percentage became licensed?	What percentage resulted in legal action?
KY	10	100%	20%	10%
LA	86	1%	Less than 1%	6%
MA	Not Available	Not Available	Not Available	Not Available
MD	324	Not Available	Not Available	1%
ME	Not Available	Not Available	Not Available	Not Available
MI	Not Available	Not Available	Not Available	Not Available
MN	Not Available	Not Available	Not Available	Not Available
MO	226	33%	Not Available	Not Available
MS	63	24%	5%	3%
MT	Not Available	Not Available	Not Available	Not Available
NC	Not Available	45%	Not Available	Not Available
ND	Not Available	Not Available	Not Available	Not Available
NE	Not Available	Not Available	Not Available	Not Available
NH	33	72.7%	Not Available	1%
NJ	Not Available	Not Available	Not Available	Not Available
NM	Not Available	Not Available	Not Available	Not Available
NV	Not Available	Not Available	Not Available	Not Available
NY	1332	23%	32%	69%
OH	118	Not Available	Not Available	3.5%
OK	136	15%	14%	0%
OR	147	40%	Not Available	1.4%
PA	Not Available	Not Available	Not Available	Not Available
RI	Not Available	Not Available	Not Available	Not Available
SC	139	43%	5%	0%
SD	Not Available	Not Available	Not Available	Not Available
TN	296	71%	Not Applicable	Not Applicable
TX	3023	26%	5.3%	Not Available
UT	51	21%	1%	5%
VA	293	69%	Not Available	Not Available
VT	Not Available	Not Available	Not Available	Not Available
WA	Not Available	Not Available	Not Available	Not Available
WI	287	34%	Not Available	Not Available
WV	Not Available	Not Available	Not Available	Not Available
WY	44	Not Available	12%	2%

**The total percentage calculated by weighting each percentage provided by the total number of cases per state.*

LICENSING FEES

Summary:

Approximately 70 percent of states reported collecting licensing fees for child care centers in both 2014 and 2017. Approximately 55 percent of states collect fees from small FCC homes and between 45 and 49 percent report collecting fees from large/group FCC homes though a smaller percentage of states reported they collected fees from large/group FCC homes in 2017.

In both 2014 and 2017 the fees for centers were predominantly based on maximum capacity while fees for FCC homes were more often based on a flat fee. However, there was a 71 percent increase in the number of states using flat fees for centers in 2017. There was no change between 2014 and 2017 in the number of states that used license fees to support the licensing agency or the number of states that put fees in the state's general revenue fund. There were two more states in 2014 that reported using the fees for other purposes than in 2017.

Assessing Licensing Fees

Question: What type of child care facilities does the state charge a fee for a license?

Analysis: More than 67% of states reported that their state charged a fee for licensing child care centers while 58% of states that regulate small FCC homes charge a fee for small FCC homes. Approximately 59% of states that regulate large/group FCC homes charge large/group FCC homes a licensing fee.

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	35	29	23
AK			
AL	•		•
AR			
AS		•	•
AZ	•	•	•
CA	•	•	•
CO	•	•	•
CT	•	•	•
DC			
DE	•	•	•
FL	•	•	•
GA			
HI			•
IA		•	•
ID			
IL			
IN	•	•	•
KS	•		•
KY			•
LA	•		•
MA			
MD	•		•
ME	•	•	•
MI	•	•	•
MN			
MO	•	•	•
MS			
MT	•		•
NC	•	•	•

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
ND	•	•	•
NE			
NH			•
NJ	•	•	•
NM	•	•	•
NV			
NY		•	•
OH			
OK	•	•	•
OR			
PA	•	•	•
RI	•	•	•
SC			
SD	•	•	•
TN	•	•	•
TX	•	•	•
UT	•		•
VA			
VT	•		•
WA	•		•
WI			
WV	•	•	•
WY			

Question: If licensing fees are charged, how is the fee assessed?

Analysis: For child care centers, most states charge a fee based on the maximum number of children allowed at the facility. For FCC homes, fees are more likely to be based on a flat fee.

	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Flat fee amount for all facilities	12	22	15
Fee is based on the maximum number of children allowed in the facility	23	6	7
Other	4	2	2

Question: If a fee is charged for a license, what is the amount of the fee for each type of child care facility?

Analysis: Fee amounts reported by each state are shown below.

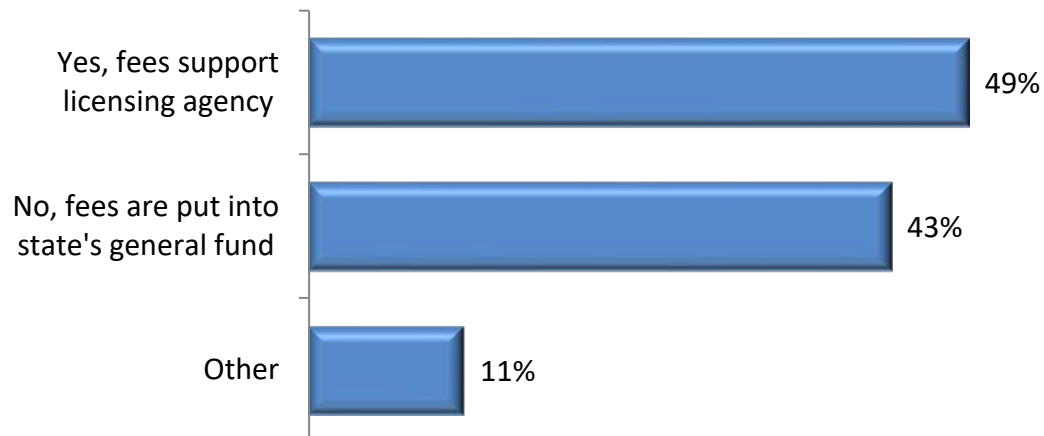
State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
AK	Not Reported	Not Reported	Not Reported
AL	Not Reported	Not Reported	Not Reported
AR	Not Reported	\$15	Do Not Regulate
AS	Not Reported		
AZ	\$7,800, \$4000	Do Not Regulate	\$1,000
CA	\$484 – \$2500+	\$73	\$140
CO	\$150 + \$2 per child capacity	\$35	\$55
CT	\$500	\$40	\$250
DC	1 – 50 Children: \$600 51 – 100 Children: \$900 101 – 175 Children: \$1,200 Over 175 Children: \$1,500	\$225	\$225
DE	Not Reported	Not Reported	Not Reported
FL	Minimum \$25 / Maximum \$100	\$50	\$60

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
	Fee \$1 per child based on capacity		
	Less than 25 children: \$50 25 – 50 children: \$100 51 – 100 children: \$150 101 – 200 children: \$200 More than 200 children: \$250	\$50	Do Not Regulate
GA			
HI	Not Reported	Not Reported	Not Reported
IA	\$50 – \$150	\$0	\$0
ID	Large \$325 / Small \$250	\$100	\$100
IL			
IN			Do Not Regulate
KS	\$75 + 1 per child capacity	\$75 + 1 per child capacity	\$75 + 1 per child capacity
	\$25 annual daycare license Type I & II \$10 every 2 years for certified daycare	\$50 annual	Do Not Regulate
KY			
	15 or fewer children: \$25 16 – 50 children: \$100 51 – 100 children: \$175 101 or more children: \$250	Not Reported	Do Not Regulate
LA			
MA	\$175 – \$450	\$100	Not Reported
MD	Not Reported	Not Reported	Not Reported
ME	\$120 for first year and \$240 subsequently	\$160 for a two year license	Do Not Regulate
MI	\$150 – \$300	\$50	100
MN	\$200 – \$1,000 per year	\$50 – \$100 per year	Not Reported
MO	Not Reported	Not Reported	Not Reported
MS	\$75 – \$400	\$75	\$150 – \$300
MT	\$0	\$0	\$0
	12 or fewer children: \$52 13 – 50 children: \$187 51 – 100 children: \$375 101 or more children: \$600	\$52	Do Not Regulate
NC			
ND	\$40	\$20	\$25
NE	\$50	25	25
NH	Not Reported	Not Reported	Not Reported
NJ	Not Reported	Do Not Regulate	Do Not Regulate
NM	\$55	\$15	\$15
NV	\$300	\$20	\$60
NY	Not Reported	Not Reported	Not Reported
OH	\$500	\$250	\$250
OK	Not Reported	Not Reported	Not Reported
OR	Initial fee \$100 + \$2 per child slot Renewal = \$2 per child slot	\$30 (reduced fee for poverty level applicants)	\$25 initial fee + \$2 per child slot Renewal = \$2 per child slot
PA	Not Reported	Not Reported	Not Reported
RI	\$500/year	\$100/2 years	\$250/year
SC	\$50 – \$125	\$15	\$30
SD	Not Reported	Not Reported	Not Reported
TN	\$200 – \$500	\$100	\$125
	Licensed operations pay an annual fee of \$35 + \$1 per child	\$35	Not Reported
TX			
UT	\$231	\$31	\$31
VA	\$14 up to \$200 annually	\$14	Do Not Regulate
VT	Not Reported	Not Reported	Do Not Regulate
	\$125 for the first 12 children then \$12 for each additional child	\$30	Do Not Regulate
WA			
	\$30.25 plus \$16.94 per child (based on capacity)	\$60.50	Do Not Regulate
WI			
WV	\$0	\$0	\$0
	\$50 initial \$25 renewal	\$50 initial \$25 renewal	\$50 initial \$25 renewal
WY			

Uses of Licensing Fee Revenues

Question: Are the revenues collected from licensing fees used to support the licensing agency?

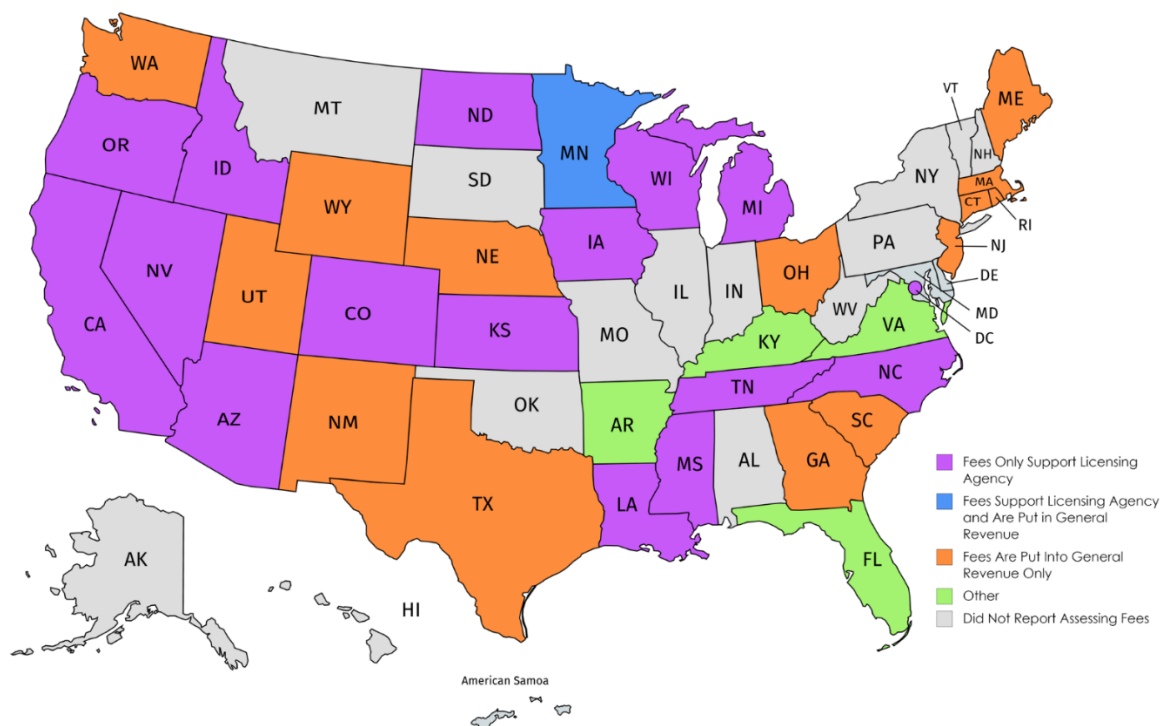
Analysis: Nearly half of states reporting (n=35) indicated that licensing fees were used to support the licensing agency while 43% reported fees were put into the state's general fund. Other included fees paying for background checks, training, and other activities for providers.



State	Yes, revenues from fees are used to support the licensing agency	No, revenues from fees are put into the state's general fund	Other
Total	17	15	4
AK			
AL			
AR			.
AS			
AZ	.		
CA	.		
CO	.		
CT		.	
DC	.		
DE			
FL			.
GA		.	
HI			
IA	.		
ID	.		
IL			
IN			
KS	.		
KY			.
LA	.		
MA		.	
MD			
ME		.	
MI	.		
MN	.	.	
MO			
MS	.		
MT			
NC	.		

State	Yes, revenues from fees are used to support the licensing agency	No, revenues from fees are put into the state's general fund	Other
ND	•		
NE		•	
NH			
NJ		•	
NM		•	
NV	•		
NY			
OH		•	
OK			
OR	•		
PA			
RI		•	
SC		•	
SD			
TN	•		
TX		•	
UT		•	
VA			•
VT			
WA		•	
WI	•		
WV			
WY		•	

Map 8 Use of Licensing Fees



LICENSING STAFF REQUIREMENTS

Summary:

In both 2014 and 2017, only one state required licensing staff to have a master's degree. In 2017, 65 percent of states reported a bachelor's degree as the minimum requirement, up one from 2014. In each year, only one state required an

associate's degree. In 2014, two states allowed some college level coursework while no states reported that as a requirement in 2017. There was an increase of two states reporting "Other" which usually means some combination of experience and education equivalent to a bachelor's degree. In 2017, two additional states reported that the degree must be in early childhood education, child development, or a field related to the care and education of children, while two fewer states reported that licensing staff were required to have experience working in a setting with children.

In 2014, only 53 percent of states required licensing staff to complete annual training while in 2017, 73% of states reported that annual training was a requirement. While less than 30 percent of all states required annual regulatory issues, regulations, or licensing policy training for staff in 2014 (approximately half of all states that required any annual training), nearly half of all states (or about two-thirds of the states requiring any annual training) required those specific annual trainings in 2017. There was an increase across the board in the number of states requiring specific types of training as well, with the largest percentage increases in business administration, disaster and emergency planning, and fire safety.

When asked what sources of training were available in their state, in both 2014 and 2017, 92 percent of states reported that the licensing agency was a source of training. In 2017, however, the number of states reporting that community resources were a training source increased by 11 percent. There was also a slight increase in the number of states that reported using outside consultants or national conferences. The number of states reporting arrangements with colleges dropped by 32 percent while the number of states using NARA online training or on-site training dropped by 12 and 17 percent respectively.

The number of states reporting that general revenue was a funding source for licensing agency hiring remained unchanged between 2014 and 2017. The number of states reporting that the Child Care and Development Fund was a source increased by two, and one additional state reported state block grants as a funding source. The number of states reporting the use of every other funding source decreased between 2014 and 2017.

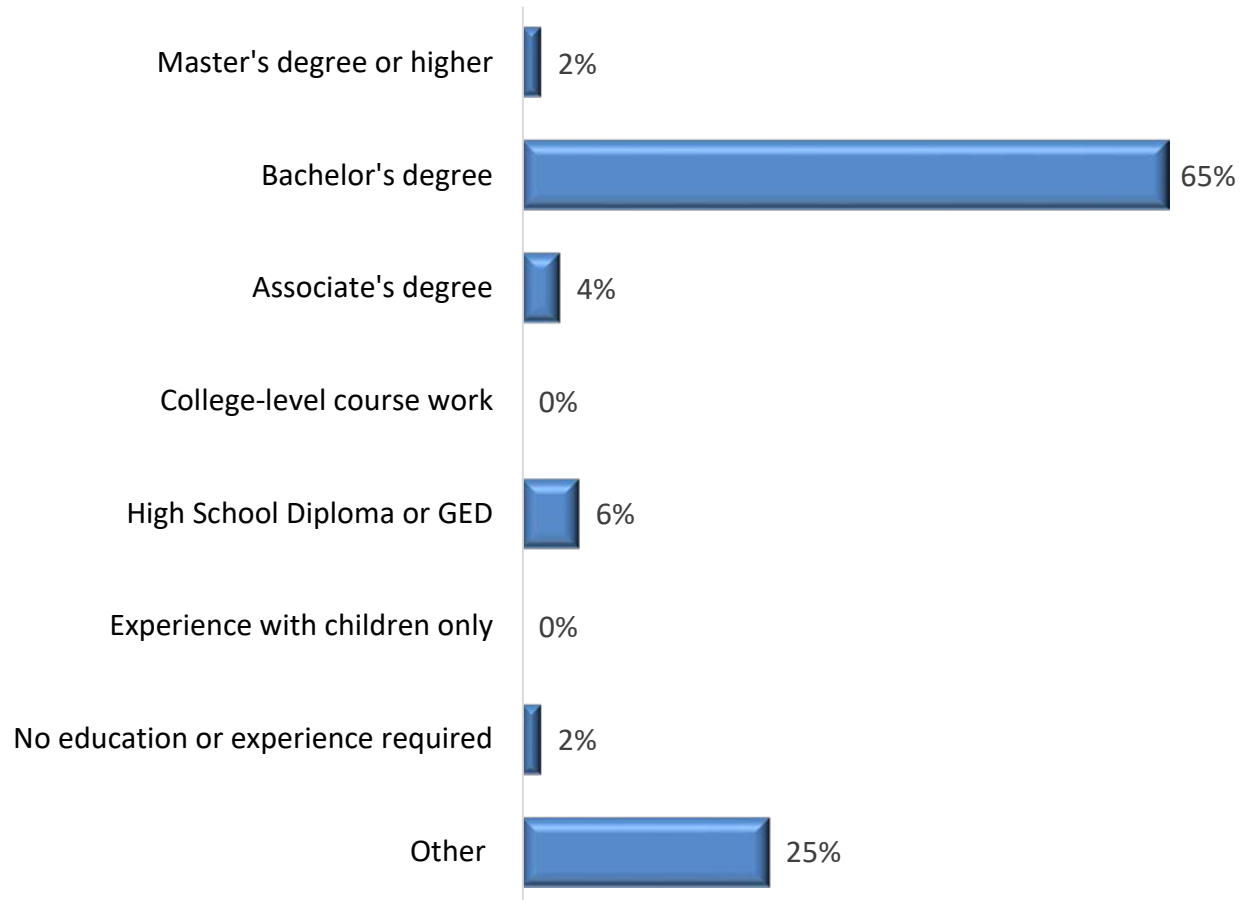
The number of states that have incorporated "interrater reliability" training or evaluation for licensing staff saw a net increase from five in 2014 to eight in 2017 and an additional two states reported that they have developed interpretive guidelines for the licensing regulations. The number of states reporting that the licensing agency has policies for disaster and emergency response for licensing staff to follow increased from 70 to 80 percent. Note that these reflect a net gain in the number of states as not all of the states that reported "Yes" to this question in 2014 responded affirmatively in 2017.

When it comes to communicating with providers, in both 2014 and 2017 between 90 and 95 percent of states reported using a website, emails, and face-to-face meetings. Overall states were more likely to use a variety of methods in 2017. The number of states reporting that they used a provider newsletter grew by 11 states and the number of states using social media increased by eight. Only printed materials were reported to be used less often with five fewer states reporting the use of that method. For making the public aware of the role of licensing every state reported using a website. States also reported using a more varied approach in communicating with the public in 2017 over 2014. The number of states using the various communication methods described in the survey increased by between five and eight states for almost every type. The only exception was printed materials which only increased by one state. As above, these changes represent net changes as states that responded one way in 2014 may have responded differently in 2017.

Education Requirements

Question: What are the minimum entry-level educational qualifications for child care licensing line staff?

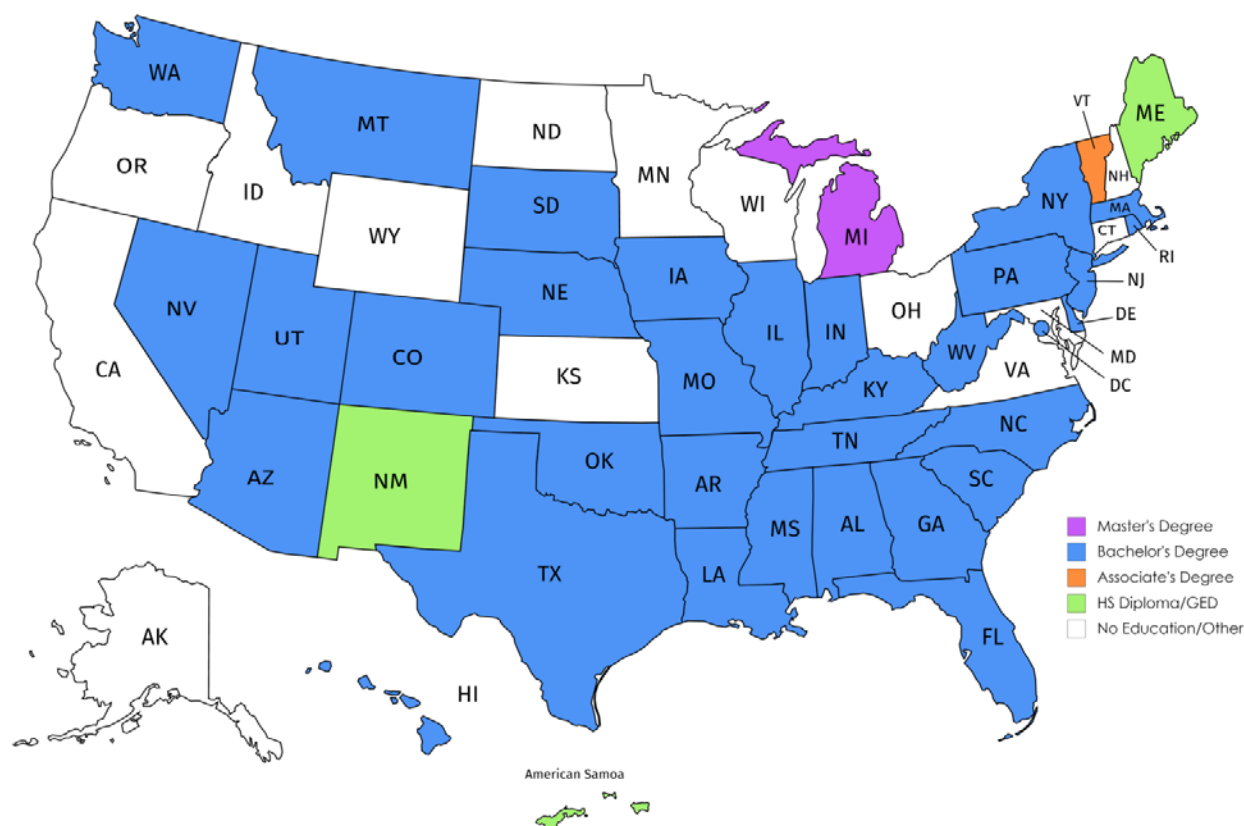
Analysis: 63% of all states reported having a bachelor's degree as the minimum entry-level educational qualifications for child care licensing line staff. 25% of states reported "Other" which usually meant experience and education equivalent to a bachelor's degree, or training and/or experience specific to the staff's position (such as administrative experience or coursework for administrative positions).



State	Master's degree or higher	Bachelor's degree	Associate's degree	College-level course work	High School Diploma or GED	Experience with children only	No education or experience required	Other
Total	1	34	2	0	3	0	1	13
AK								•
AL		•						
AR		•						
AS					•			
AZ		•						
CA								•
CO		•						
CT		•						
DC		•						
DE		•						
FL		•						
GA		•						
HI		•						
IA		•						

State	Master's degree or higher	Bachelor's degree	Associate's degree	College-level course work	High School Diploma or GED	Experience with children only	No education or experience required	Other
ID								•
IL		•						
IN		•						
KS								•
KY		•						
LA		•						
MA		•						
MD			•					
ME					•			
MI	•							
MN								•
MO		•						
MS		•						
MT		•						
NC		•						
ND								•
NE		•						
NH								•
NJ		•						
NM					•			
NV		•						
NY		•						
OH								•
OK		•						
OR							•	
PA		•						
RI		•						
SC		•						
SD		•						
TN		•						
TX		•						
UT		•						
VA								•
VT			•					
WA		•						
WI								•
WV		•						
WY								•

Map 9 Child Care Licensing Staff Education Requirements



Question: For the qualifications identified above, must the degree or courses include early childhood education, children development, or a field related to the care and education of children?

Analysis: Half of all states reported that degrees or course work required for licensing staff must include or be related to the care and education of children. 35% of states reported that licensing line staff had to have experience working in a setting with children. All but one state require staff to complete training about the licensing system and providers requirements when starting employment.

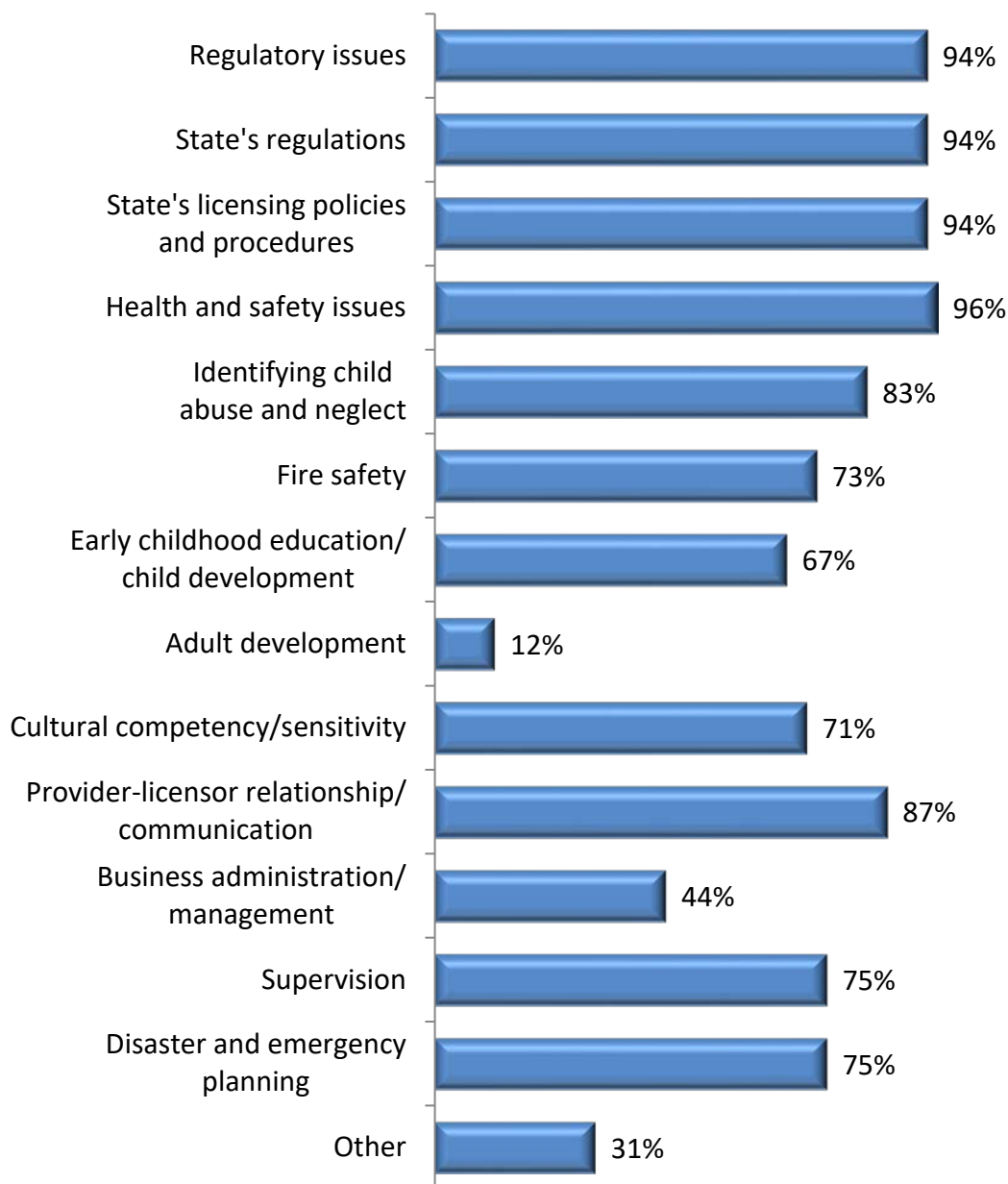
State	Degree or courses must be in early childhood education, child development, or a field related to the care and education of children	Licensing line staff required to have experience working in a setting with children	Child care licensing line staff required to complete training about the licensing system and providers requirements when starting employment
Total	26	18	51
AK			•
AL	•	•	•
AR	•		•
AS			•
AZ	•	•	•
CA			•
CO	•	•	•
CT	•	•	•
DC		•	•
DE			•
FL			•
GA	•	•	•
HI			•

State	Degree or courses must be in early childhood education, child development, or a field related to the care and education of children	Licensing line staff required to have experience working in a setting with children	Child care licensing line staff required to complete training about the licensing system and providers requirements when starting employment
IA			•
ID			•
IL	•	•	•
IN		•	•
KS	•		•
KY			•
LA			•
MA	•		•
MD	•		•
ME			•
MI	•	•	•
MN	•		•
MO	•		•
MS	•	•	•
MT			•
NC	•	•	•
ND			•
NE	•		•
NH	•		•
NJ	•		•
NM			•
NV	•	•	
NY			•
OH	•	•	•
OK			•
OR			•
PA	•	•	•
RI			•
SC			•
SD			•
TN	•	•	•
TX			•
UT	•	•	•
VA	•	•	•
VT	•		•
WA	•		•
WI			•
WV			•
WY		•	•

Training and Experience

Question: What topics are covered in the onboarding training?

Analysis: 94% of all states report that licensing counselors receive onboarding training in health and safety, regulatory issues, state regulations, and licensing policies and procedures. Approximately 67% of states provide training in early childhood education/child development. Approximately 44% offer training in business administration/management. The types of training offered across all states was quite varied and included things like Travel, Ethics, HIPPA, computers, timekeeping and other state operations, food safety, complaint investigations, illegal operations, administrative actions, professionalism, office skills, database, survey process, proper documentation on tablet, customer service, enforcement procedures, investigatory tools, writing skills, participation in administrative hearings, special needs, criminal history analysis, coordinating with other agencies, interviewing techniques, the 11 mandatory pre-service orientation topic under CCDF, Sun safety, emergency evacuation, tummy time issues, forensic interviewing, report writing, medication, nutrition, incidental medical services, water safety, worker safety, security awareness and other HR topics.



Onboarding Training Topics

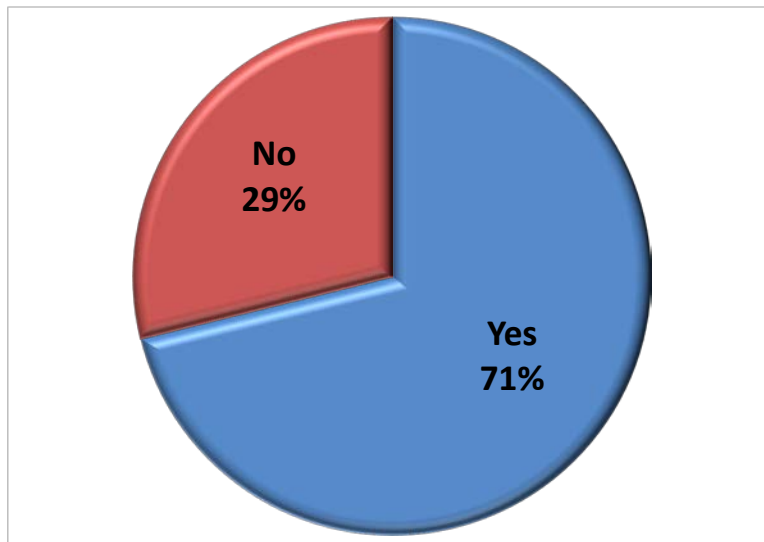
State	Regulatory issues	State's regulation	State's licensing policies and procedures	Health and safety issues	Identifying child abuse and neglect	Fire safety	Early childhood education/child development
Total	49	49	49	50	43	38	35
AK	•	•	•	•	•	•	•
AL	•	•	•	•			
AR	•	•	•	•	•	•	•
AS						•	•
AZ	•	•	•	•	•	•	•
CA	•	•	•	•	•	•	•
CO	•	•	•	•	•	•	•
CT	•	•	•	•	•		•
DC	•	•	•	•	•	•	
DE	•	•	•	•	•	•	•
FL	•	•	•	•	•	•	•
GA	•	•	•	•	•		•
HI	•	•	•	•			
IA	•			•			•
ID	•	•	•	•	•	•	
IL	•	•	•	•	•	•	•
IN	•	•	•	•	•	•	•
KS	•	•	•	•	•	•	
KY	•	•	•	•	•	•	•
LA	•	•	•	•	•		•
MA	•	•	•	•	•	•	•
MD	•	•	•	•	•	•	•
ME	•	•	•	•	•	•	•
MI	•	•	•	•	•	•	•
MN		•	•	•	•	•	
MO	•	•	•	•	•		
MS	•	•	•	•	•	•	•
MT	•	•	•	•			
NC	•	•	•	•	•	•	•
ND	•	•	•	•	•	•	
NE	•	•	•	•			
NH	•	•	•	•	•	•	•
NJ	•	•	•	•	•	•	
NM	•	•	•	•	•	•	•
NV							
NY	•	•	•	•	•	•	•
OH	•	•	•	•	•	•	•
OK	•	•	•	•	•	•	
OR	•	•	•	•	•	•	•
PA	•	•	•	•	•		•
RI	•	•	•	•	•		
SC	•	•	•	•	•		
SD	•	•	•	•	•	•	•
TN	•	•	•	•	•	•	•
TX	•	•	•	•	•	•	•
UT	•	•	•	•	•	•	
VA	•	•	•	•	•	•	•
VT	•	•	•	•	•	•	•
WA	•	•	•	•	•	•	•
WI	•	•	•	•		•	•
WV	•	•	•	•			
WY	•	•	•	•	•	•	•

Onboarding Training Topics - Continuation

State	Adult development	Cultural competency / sensitivity	Provider-licensor relationship / communication	Business administration / management	Supervision	Disaster and emergency planning	Other
Total	6	37	45	23	39	39	16
AK		•	•	•	•	•	
AL			•		•		
AR		•	•	•	•	•	
AS						•	•
AZ	•	•	•	•	•	•	•
CA		•	•	•	•	•	•
CO		•	•	•	•	•	
CT			•				•
DC	•	•	•	•	•	•	
DE		•	•	•	•	•	
FL		•	•	•	•	•	
GA	•	•	•		•		•
HI			•				
IA		•					
ID			•	•			•
IL		•	•	•	•	•	
IN		•	•	•	•	•	
KS			•		•		•
KY		•			•	•	
LA			•	•	•	•	•
MA		•	•	•	•	•	
MD		•	•		•	•	
ME		•	•	•	•	•	
MI		•	•	•	•	•	•
MN		•	•				
MO		•	•		•	•	
MS		•	•	•	•	•	•
MT	•	•	•				
NC		•	•		•	•	•
ND					•	•	
NE					•	•	
NH		•	•		•	•	
NJ		•	•	•	•	•	
NM		•	•			•	•
NV							
NY		•	•	•	•	•	•
OH		•	•		•	•	
OK			•		•	•	
OR		•	•		•	•	
PA			•				•
RI		•	•	•		•	
SC			•		•	•	
SD		•	•		•	•	
TN		•	•	•	•	•	
TX		•	•		•	•	•
UT		•	•		•	•	
VA		•	•	•	•	•	
VT		•	•		•	•	
WA	•	•	•	•	•	•	•
WI			•				
WV							
WY	•	•	•	•	•	•	

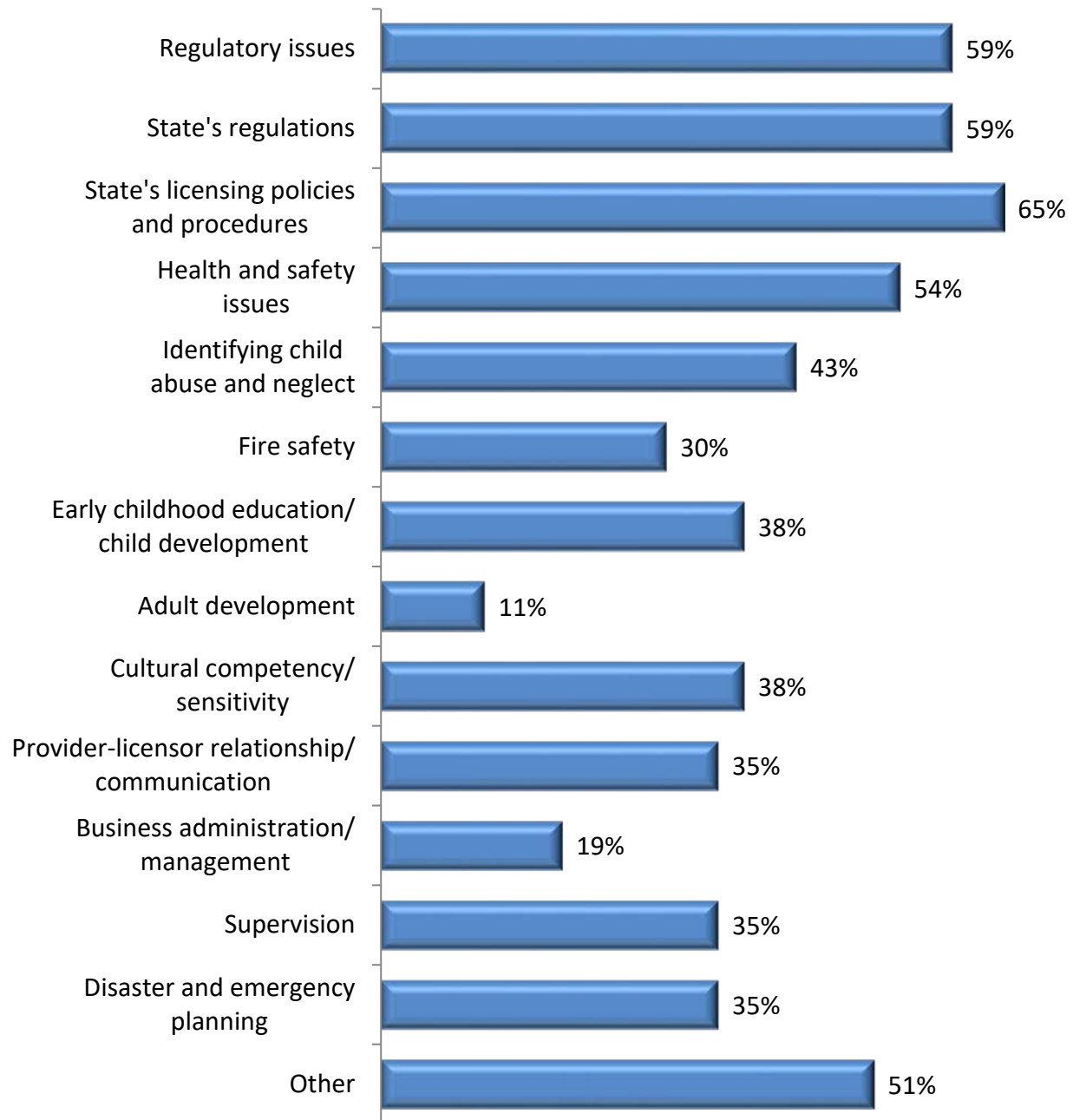
Question: Are child care licensing line staff required to complete additional training each year?

Analysis: A total of 37 states reported that they required annual training for licensing counselors in 2017.



Question: What topics must be covered in the training required each year for licensing staff?

Analysis: For the 37 states that reported requiring annual training as a requirement for licensing staff, about two-thirds reported that the training covers licensing policies and procedures. In 59% of those states, annual training covers regulations and regulatory issues. There is less emphasis in annual training on health and safety than in onboarding training with just over half of states including the topic in annual training. Like onboarding training, though, annual training included a wide variety of topics across all states. Some of the “Other” types of training included report writing, the application process, coaching and skill transfer, safe sleep, ethics and security awareness, travel, changes to federal or state law or rule, data practices, defensive driving, food safety, playground safety, investigation procedures, documentation, customer service, immunization, children with special needs, equal opportunity employment, IT security, sexual harassment, working with difficult people, curriculum and assessment, and as determined by the state based on input from licensors and areas of concern, as well as on the individual need of the staff member.



Annual Training Topics

State	Regulatory issues	State's regulation	State's licensing policies and procedures	Health and safety issues	Identifying child abuse and neglect	Fire safety	Early childhood education/child development
Total	22	22	24	20	16	11	14
AK							
AL	•		•	•			•
AR							
AS							
AZ	•	•	•	•	•	•	•
CA	•	•	•	•	•	•	•
CO	•	•	•				
CT							
DC	•	•	•	•	•	•	•
DE	•	•	•	•	•		•

State	Regulatory issues	State's regulation	State's licensing policies and procedures	Health and safety issues	Identifying child abuse and neglect	Fire safety	Early childhood education/child development
FL	•	•	•	•	•	•	
GA	•	•	•	•			•
HI							
IA							
ID							
IL		•	•				
IN	•	•	•	•			•
KS							
KY	•	•	•	•	•	•	•
LA	•	•	•	•	•		•
MA							
MD							
ME							
MI			•				
MN	•	•	•	•			
MO							
MS	•	•	•	•	•	•	•
MT	•	•	•	•	•		
NC	•	•	•	•		•	
ND							
NE					•		•
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NJ	•	•	•	•	•		
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RI	•	•	•	•	•		
SC	•	•	•	•	•	•	•
SD							
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UT	•	•	•	•	•	•	•
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VT	•	•	•	•	•	•	•
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WV							
WY	•	•	•	•	•	•	

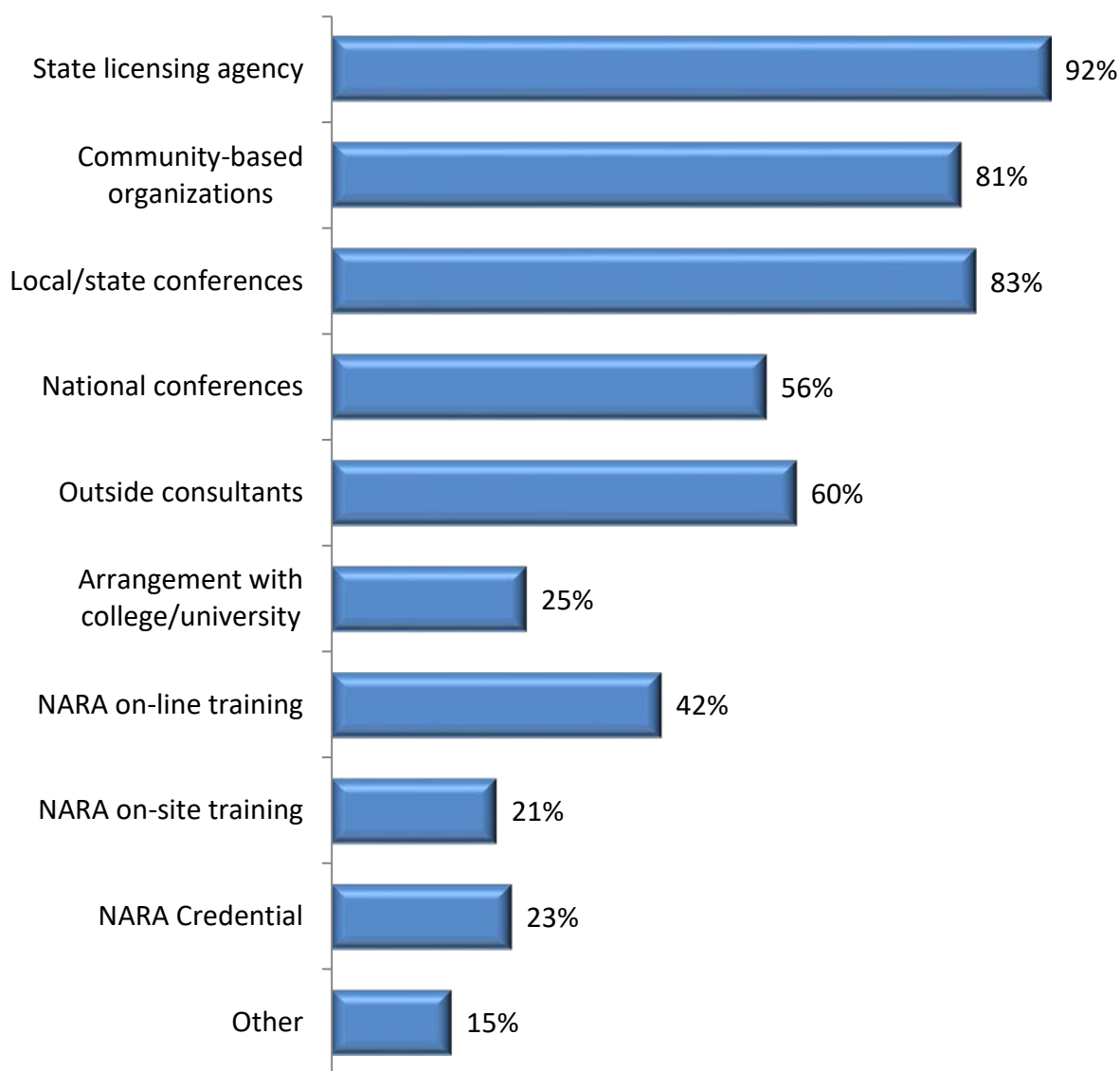
Annual Training Topics - Continuation

State	Adult development	Cultural competency / sensitivity	Provider-licensor relationship / communication	Business administration / management	Supervision	Disaster and emergency planning	Other
Total	4	14	13	7	13	13	19
AK							
AL					•		
AR							•
AS							
AZ	•	•	•	•	•	•	
CA		•	•	•	•	•	•
CO							

State	Adult development	Cultural competency / sensitivity	Provider-licensor relationship / communication	Business administration / management	Supervision	Disaster and emergency planning	Other
CT							
DC			•		•	•	
DE		•	•		•		
FL						•	
GA	•	•	•		•	•	•
HI							•
IA							
ID							
IL							•
IN							•
KS							•
KY		•	•	•	•	•	
LA		•	•	•	•	•	•
MA							
MD							
ME							
MI							•
MN		•					•
MO							•
MS		•	•	•	•	•	•
MT	•	•	•	•			
NC							
ND							•
NE	•						•
NH							
NJ		•			•	•	
NM							
NV							
NY							
OH							•
OK							
OR							
PA							•
RI		•	•	•		•	•
SC		•	•		•	•	
SD							
TN							
TX							
UT		•	•		•	•	
VA							•
VT		•	•		•	•	
WA							•
WI							
WV							
WY							

Question: What sources of training are available in your state for child care licensing staff?

Analysis: In 92% of all states, the state licensing agency is a source of training for licensing staff. Approximately 83% of states reported state and local conferences as training sources while 56% of states reported national conferences as a source.



Sources for Licensing Staff Training

State	State licensing agency	Community-based organizations	Local/state conferences	National conferences	Outside consultants
Total	48	42	43	29	31
AK	•	•	•		
AL	•	•	•	•	
AR	•	•	•	•	•
AS	•	•	•	•	•
AZ	•	•	•	•	•
CA	•	•	•		•
CO	•		•	•	•
CT	•			•	
DC	•		•	•	•
DE	•	•	•		•

FL	.	.	.	.	.
GA	.	.	.	.	.
HI	.	.	.	.	.
IA	.	.	.	.	.
ID	.	.	.	.	.
IL	.	.	.	.	.
IN	.	.	.	.	.
KS	.	.	.	.	.
KY	.	.	.	.	.
LA	.	.	.	.	.
MA	.	.	.	.	.
MD	.	.	.	.	.
ME	.	.	.	.	.
MI	.	.	.	.	.
MN	.	.	.	.	.
MO	.	.	.	.	.
MS	.	.	.	.	.
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NC	.	.	.	.	.
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NE	.	.	.	.	.
NH	.	.	.	.	.
NJ	.	.	.	.	.
NM	.	.	.	.	.
NV	.	.	.	.	.
NY	.	.	.	.	.
OH	.	.	.	.	.
OK	.	.	.	.	.
OR	.	.	.	.	.
PA	.	.	.	.	.
RI	.	.	.	.	.
SC	.	.	.	.	.
SD	.	.	.	.	.
TN	.	.	.	.	.
TX	.	.	.	.	.
UT	.	.	.	.	.
VA	.	.	.	.	.
VT	.	.	.	.	.
WA	.	.	.	.	.
WI	.	.	.	.	.
WV	.	.	.	.	.
WY	.	.	.	.	.

Sources for Licensing Staff Training – Continuation

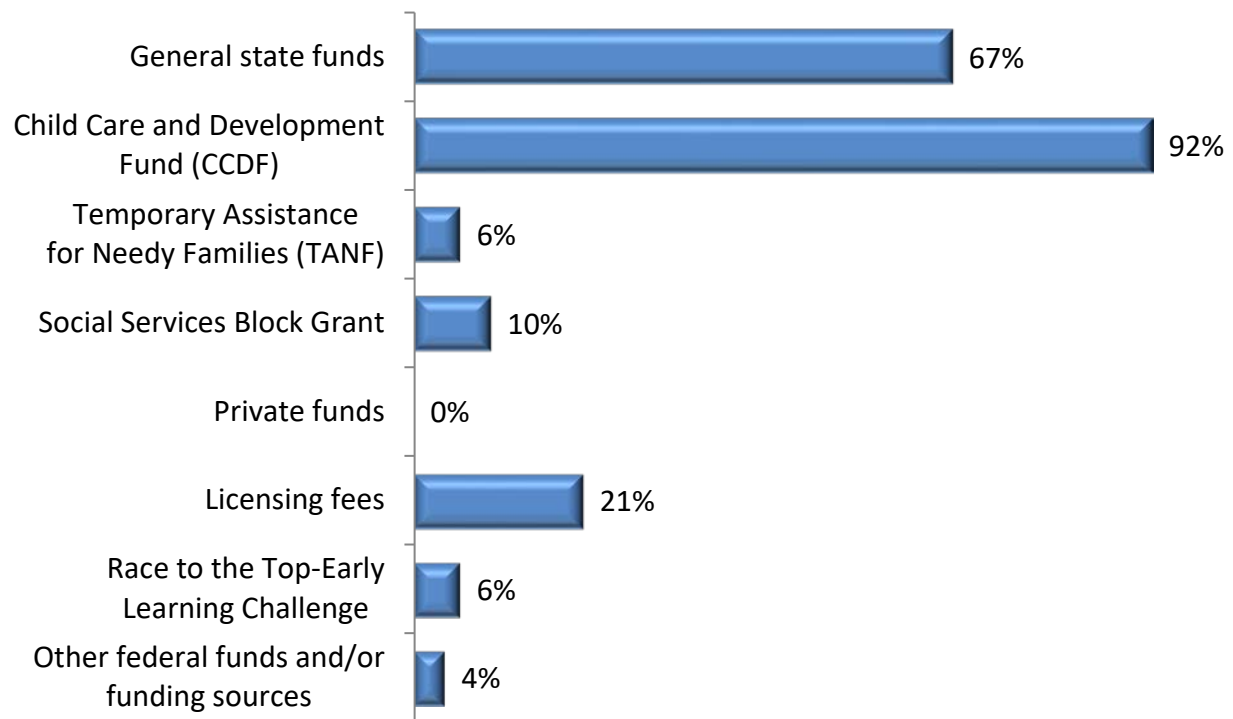
State	Arrangement with college/university	NARA on-line training	NARA on-site training	NARA Credential	Other
Total	13	22	11	12	8
AK		.	.	.	.
AL		.	.	.	.
AR	.				
AS			.		
AZ	.				
CA	.	.			
CO		.		.	
CT					.
DC		.	.	.	
DE					
FL					

State	Arrangement with college/university	NARA on-line training	NARA on-site training	NARA Credential	Other
GA		•			•
HI					
IA					
ID					
IL					
IN		•	•		•
KS		•		•	
KY	•	•	•	•	
LA		•		•	
MA					
MD					
ME			•	•	
MI			•		
MN					
MO		•		•	
MS	•	•		•	•
MT	•		•		
NC	•	•			
ND	•				
NE					
NH					
NJ	•				
NM					
NV					
NY	•				•
OH					
OK					
OR		•			
PA					
RI		•			
SC			•		•
SD		•		•	•
TN					
TX	•	•	•		
UT		•		•	
VA	•	•	•		
VT		•		•	
WA	•	•		•	
WI					
WV					
WY		•			•

Hiring Revenue Sources

Question: What sources of funding are used in your state to hire and support (including providing training) child care licensing staff?

Analysis: Just over 92% of all states reported that the CCDF was a source of funding for hiring and support of licensing staff. Two-thirds of states reported receiving funding from their state's General Revenue funds. No states reported using any private funding.



State	General state funds	Child Care and Development Fund (CCDF)	Temporary Assistance for Needy Families (TANF)	Social Services Block Grant	Private funds	Licensing fees	Race to the Top-Early Learning Challenge	Other federal funds and/or funding sources
Total	35	48	3	5	0	11	3	2
AK		•						
AL		•						
AR	•	•						
AS		•						
AZ	•	•				•		
CA	•	•				•		
CO	•	•				•		
CT	•			•				
DC	•	•				•		
DE	•	•	•	•				
FL	•	•		•				
GA	•	•						
HI	•	•						
IA	•							
ID		•						
IL	•	•						
IN	•	•						
KS	•	•						

State	General state funds	Child Care and Development Fund (CCDF)	Temporary Assistance for Needy Families (TANF)	Social Services Block Grant	Private funds	Licensing fees	Race to the Top-Early Learning Challenge	Other federal funds and/or funding sources
KY		•						
LA		•				•	•	
MA	•	•						
MD	•	•						
ME	•	•						
MI		•						•
MN	•	•				•		
MO	•	•						
MS		•				•		
MT	•	•						
NC	•	•						
ND	•	•				•		
NE		•						
NH	•	•		•				
NJ	•							
NM	•	•						
NV		•				•		
NY		•						
OH	•	•	•					
OK		•						
OR	•	•				•		
PA		•					•	
RI		•					•	•
SC		•						
SD	•	•						
TN		•						
TX	•	•						
UT	•	•						
VA	•	•						
VT	•							
WA	•	•						
WI	•	•				•		
WV		•	•	•				
WY	•	•						

Interrater Reliability Training and Interpretive Guidelines

Question: Has your state incorporated “interrater reliability” training or evaluation for licensing staff? Has your state developed interpretive guidelines for the licensing regulations?

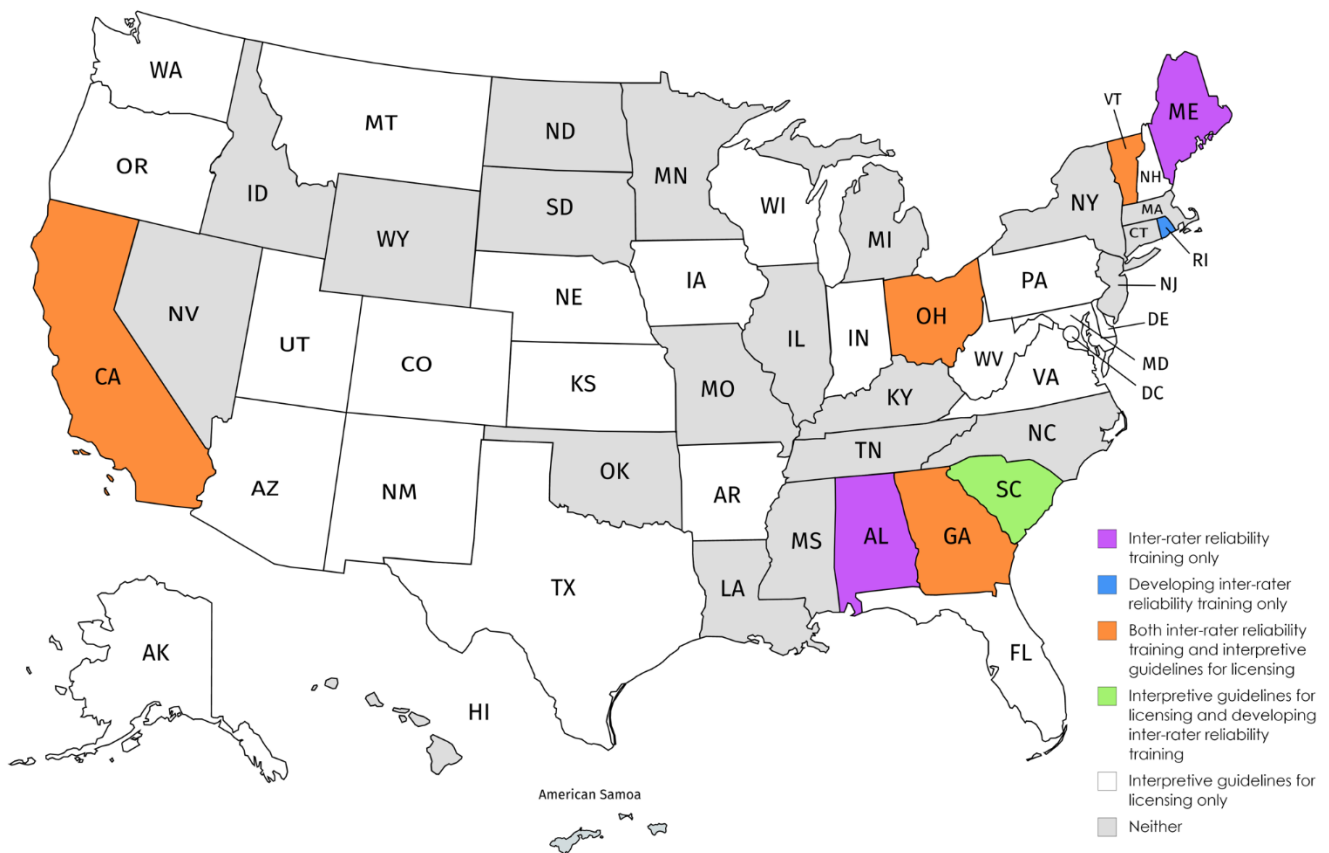
Analysis: Six states have incorporated “interrater reliability” training or evaluation for licensing staff, while two more say they are in the process of developing it. Slightly fewer than 54% have developed interpretive guidelines for the licensing regulations.

State	State has incorporated “interrater reliability” training or evaluation for licensing staff	State has developed interpretive guidelines for licensing regulations
Total	8	28
AK		•
AL	•	
AR		•
AS		
AZ		•
CA	•	•
CO		•
CT		
DC		•
DE		•
FL		•
GA	•	•
HI		
IA		•
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MT		•
NC		
ND		
NE		•
NH		•
NJ		
NM		•
NV		
NY		
OH	•	•
OK		
OR		•
PA		•
RI	*	
SC	*	•
SD		
TN		

State	State has incorporated "interrater reliability" training or evaluation for licensing staff	State has developed interpretive guidelines for licensing regulations
TX		•
UT		•
VA		•
VT	•	•
WA		•
WI		•
WV		•
WY		

*While these states answered that they had incorporated interrater reliability training, as of 2017 they were still in the process of developing the training.

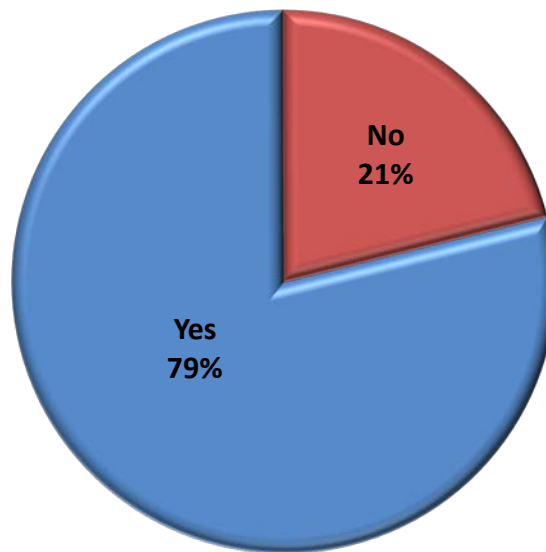
Map 10 Interrater Reliability and Interpretive Guidelines



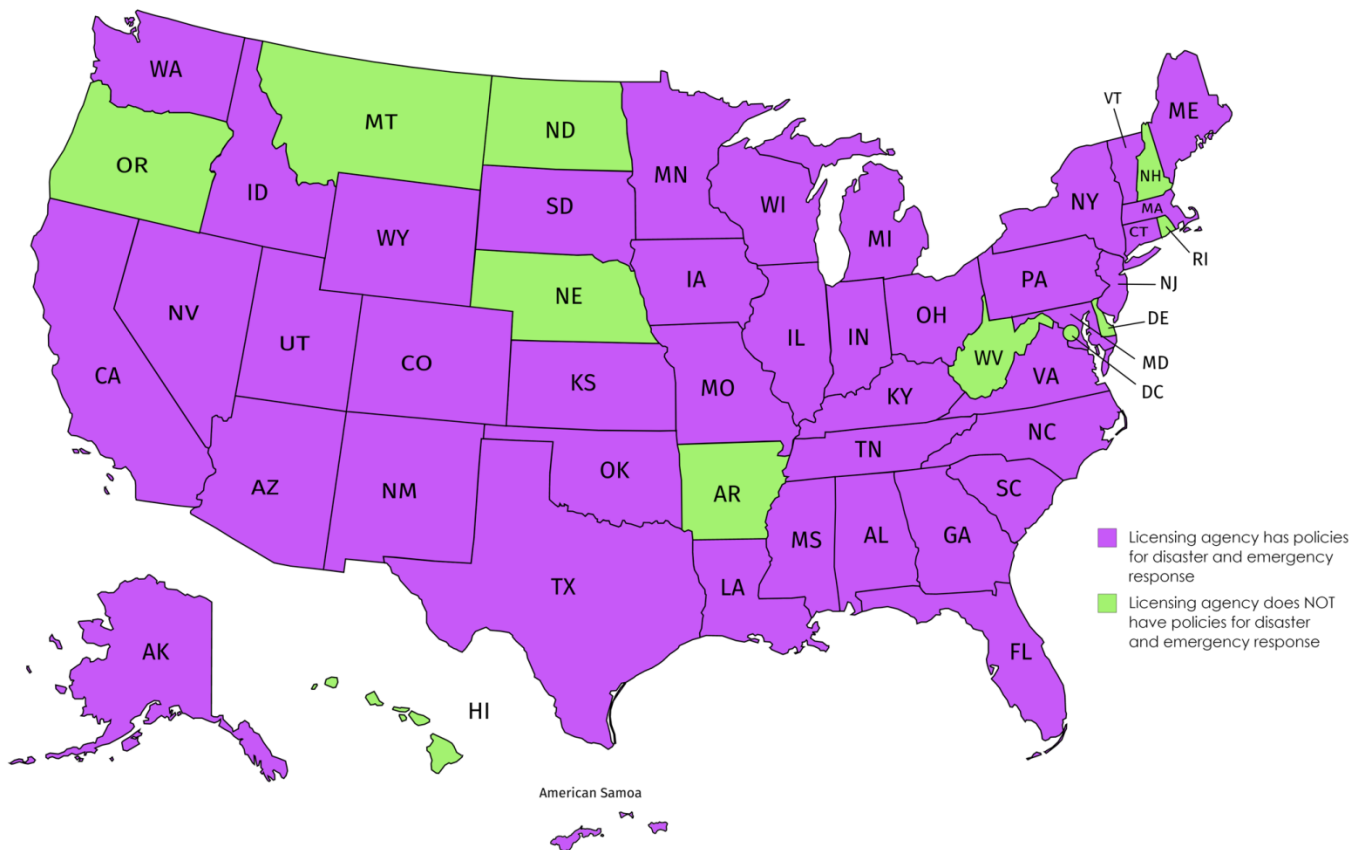
Disaster and Emergency Response Policies

Question: Does the licensing agency have policies for disaster and emergency response for licensing staff to follow?

Analysis: Nearly 80% of states have disaster and emergency response policies.



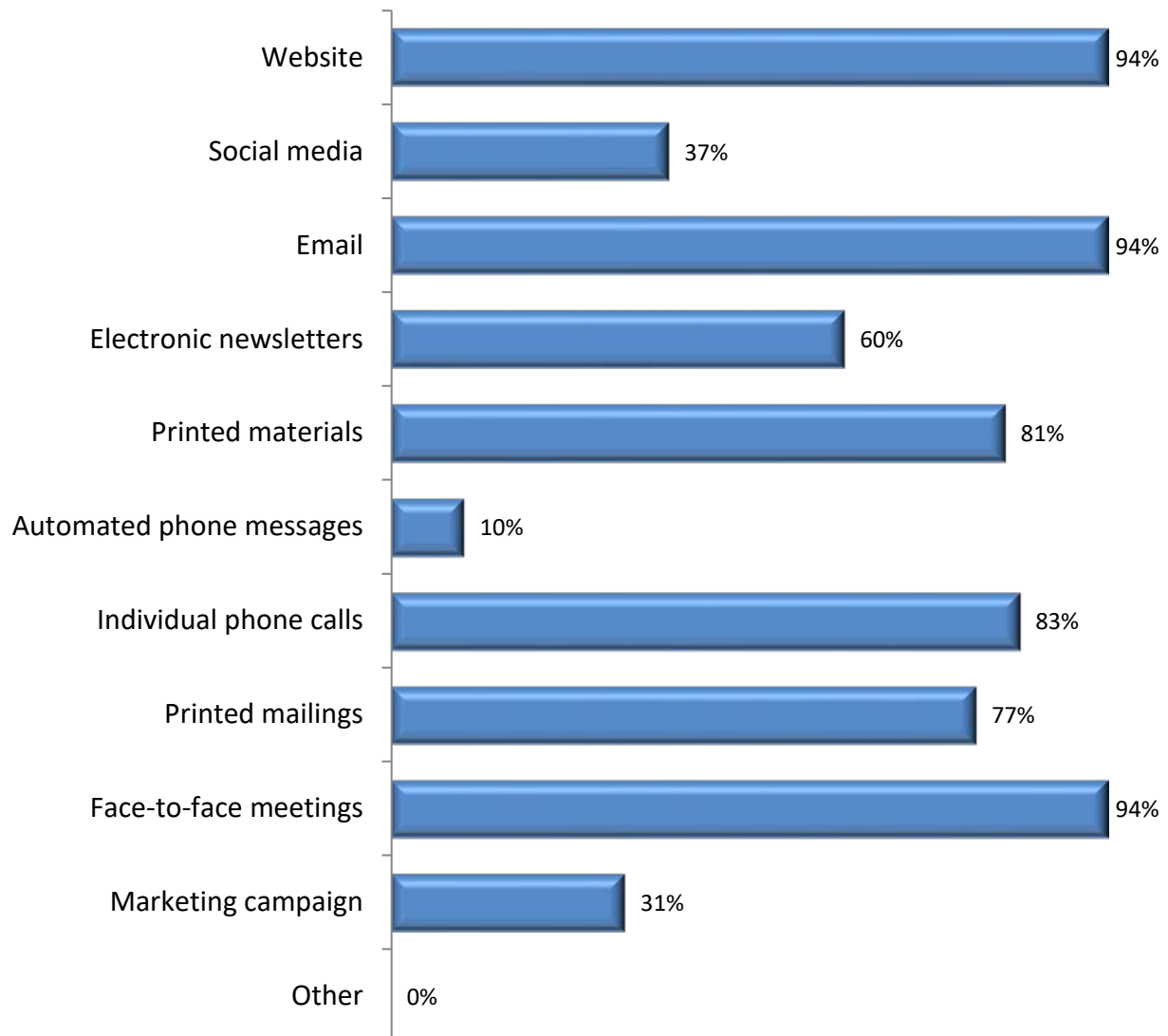
Map 11 Disaster and Emergency Response Policies



Communicating With Providers and the Public

Question: What methods does the licensing agency use to communicate with providers?

Analysis: States use a variety of methods to communicate with providers with most states reportedly using websites, email, printed material, individual phone calls, printed mailings, and face-to-face meetings. Electronic newsletters are used in about 60% of states. Marketing campaigns and social media are used in about one-third of all states while just under 10% of states reported using automated phone messages.

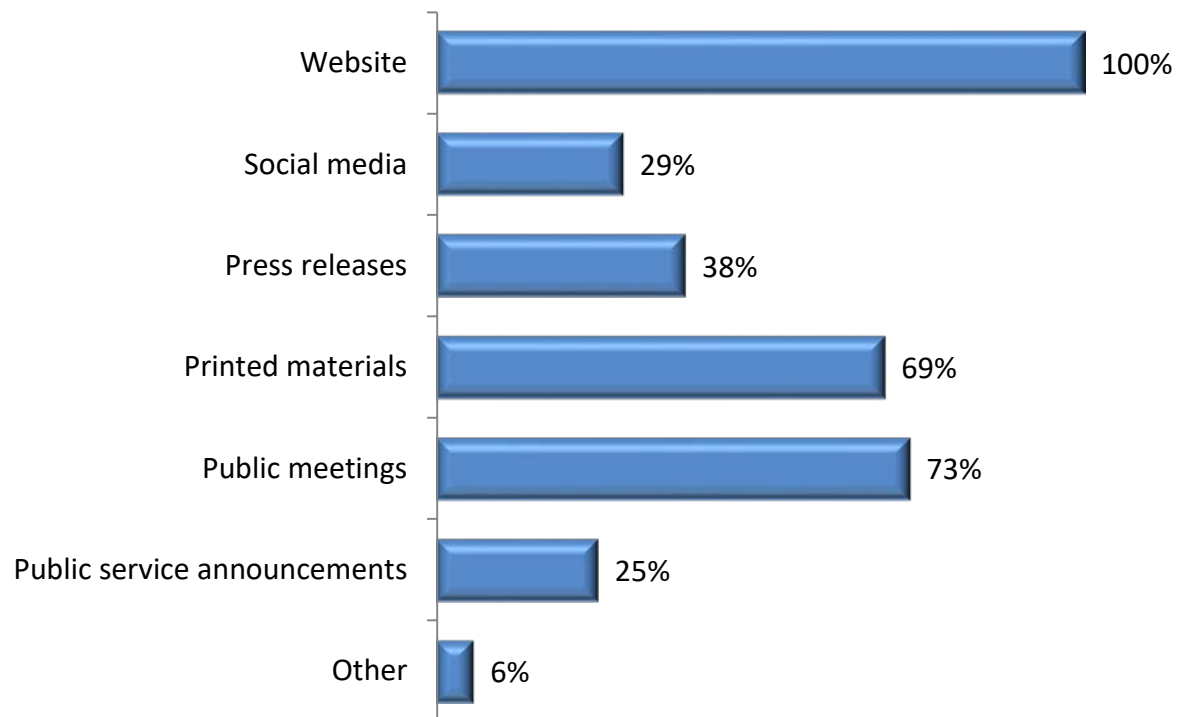


State	Website	Social media	Email	Electronic newsletters	Printed materials	Automated phone messages	Individual phone calls	Printed mailings	Face-to-face meetings	Marketing campaign	Other
Total	49	19	49	31	42	5	43	40	49	16	0
AK			•		•		•	•	•		
AL	•						•	•	•		
AR	•	•	•		•		•	•	•	•	
AS	•	•	•		•		•	•	•	•	
AZ	•	•	•	•	•		•	•	•		
CA	•		•	•	•		•	•	•	•	
CO	•	•	•	•	•		•	•	•	•	

State	Website	Social media	Email	Electronic newsletters	Printed materials	Automated phone messages	Individual phone calls	Printed mailings	Face-to-face meetings	Marketing campaign	Other
CT	•		•		•	•	•	•	•		
DC	•		•	•	•			•	•		
DE	•		•		•		•		•		
FL	•	•	•	•	•			•	•		
GA	•	•	•	•	•		•		•	•	
HI	•		•				•	•	•		
IA			•	•	•				•		
ID	•				•		•				
IL	•	•	•		•		•	•	•		
IN	•	•	•	•	•			•	•	•	
KS	•		•	•			•	•	•		
KY	•		•		•		•	•	•		
LA	•		•	•			•	•	•	•	
MA	•	•	•		•		•		•	•	
MD	•	•	•	•	•	•	•	•	•	•	
ME	•		•		•		•		•		
MI	•		•	•	•		•	•	•		
MN	•		•	•				•	•		
MO	•	•	•	•	•		•		•		
MS	•	•	•	•	•		•	•	•	•	
MT	•		•	•			•	•	•		
NC	•		•		•	•	•	•	•		
ND	•		•		•		•	•	•		
NE			•		•		•	•	•		
NH	•		•	•	•		•	•	•		
NJ	•		•		•		•				
NM	•		•				•	•	•		
NV	•	•	•	•	•	•		•	•	•	
NY	•	•	•	•	•		•	•	•	•	
OH	•		•	•	•	•	•	•	•	•	
OK	•			•	•			•	•		
OR	•	•	•	•	•		•	•	•	•	
PA	•		•	•					•		
RI	•		•					•	•		
SC	•		•	•	•		•	•	•		
SD	•		•	•	•		•	•	•		
TN	•	•	•	•	•		•	•	•	•	
TX	•	•	•		•		•		•	•	
UT	•		•	•			•	•	•		
VA	•		•		•		•		•		
VT	•		•	•	•		•	•	•		
WA	•	•	•	•	•		•		•		
WI	•		•	•	•		•	•	•		
WV	•		•		•		•	•			
WY	•	•	•	•	•		•	•	•		

Question: What methods does the licensing agency use to make the public aware of the role of licensing?

Analysis: Every state reported using websites as a method for public awareness by licensing agencies. Public meetings and printed materials were the next most common form of notifying the public.



State	Website	Social media	Press releases	Printed materials	Public meetings	Public service announcements	Other
Total	52	15	20	36	38	13	3
AK	•			•	•		
AL	•				•		
AR	•						
AS	•	•	•	•	•		
AZ	•	•	•	•	•		
CA	•		•	•	•		
CO	•	•	•	•	•	•	
CT	•		•	•	•		
DC	•		•	•	•	•	•
DE	•			•	•	•	
FL	•	•	•	•	•	•	
GA	•	•	•	•	•	•	
HI	•		•		•		•
IA	•			•	•		
ID	•			•	•		
IL	•	•		•	•		
IN	•	•	•	•	•	•	
KS	•			•	•		
KY	•			•	•	•	
LA	•	•	•	•	•		
MA	•						
MD	•	•		•			
ME	•			•	•		
MI	•		•	•	•		
MN	•		•				

State	Website	Social media	Press releases	Printed materials	Public meetings	Public service announcements	Other
MO	•			•			
MS	•	•	•	•	•	•	
MT	•				•	•	
NC	•						
ND	•		•	•	•		
NE	•				•		
NH	•			•	•		
NJ	•			•	•	•	
NM	•				•		
NV	•	•			•	•	
NY	•	•	•	•	•		•
OH	•			•	•		
OK	•						
OR	•	•	•	•			
PA	•		•	•	•		
RI	•						
SC	•			•	•		
SD	•						
TN	•		•	•	•		
TX	•	•		•	•	•	
UT	•				•		
VA	•			•		•	
VT	•			•	•		
WA	•	•	•	•	•		
WI	•			•			
WV	•						
WY	•						

QUALITY IMPROVEMENT INITIATIVES

Summary:

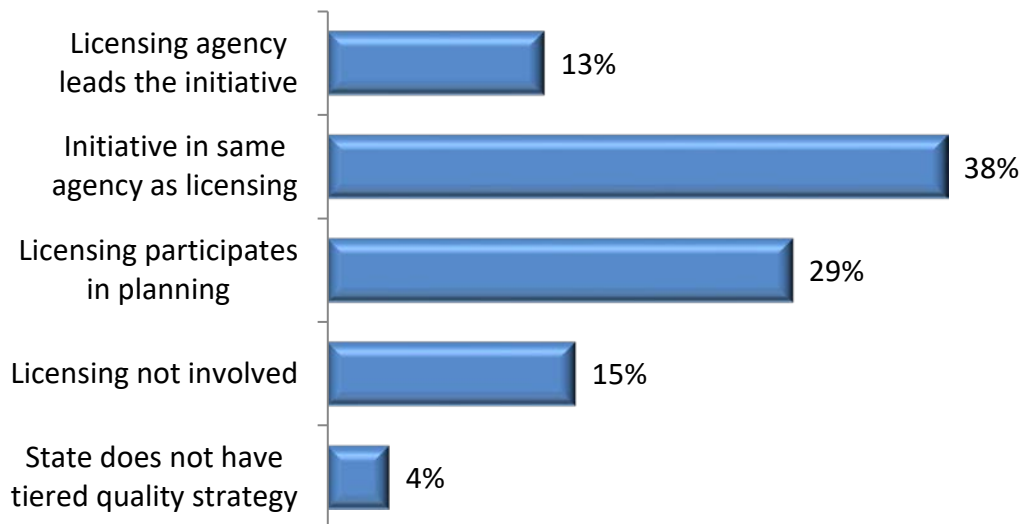
Fewer states reported quality improvement initiatives overall in 2017 than in 2014. One additional state reported a professional development system initiative in 2017, though there was an increase of three states who reported leading the professional development initiative. One less state reported involvement in a tiered quality strategy initiative in 2017 though the number of states that reported a tiered quality strategy initiative within their agency increased by four. One additional state reported participating in planning for an environmental rating scale initiative, but there were three fewer states that reported leading an environmental rating scale initiative.

Question: What is the state child care licensing's level of involvement in the following initiatives to improve the quality of child care facilities?

Summary of Initiative Participation

	Leads the initiative	Initiative within same agency	Participates in planning	Not involved	No current initiative
Tiered quality strategy	7	20	15	8	2
Accreditation facilitation project	1	7	7	15	16
Professional development system	8	14	23	6	1
Assessing quality with an environment rating scale	4	14	10	12	11

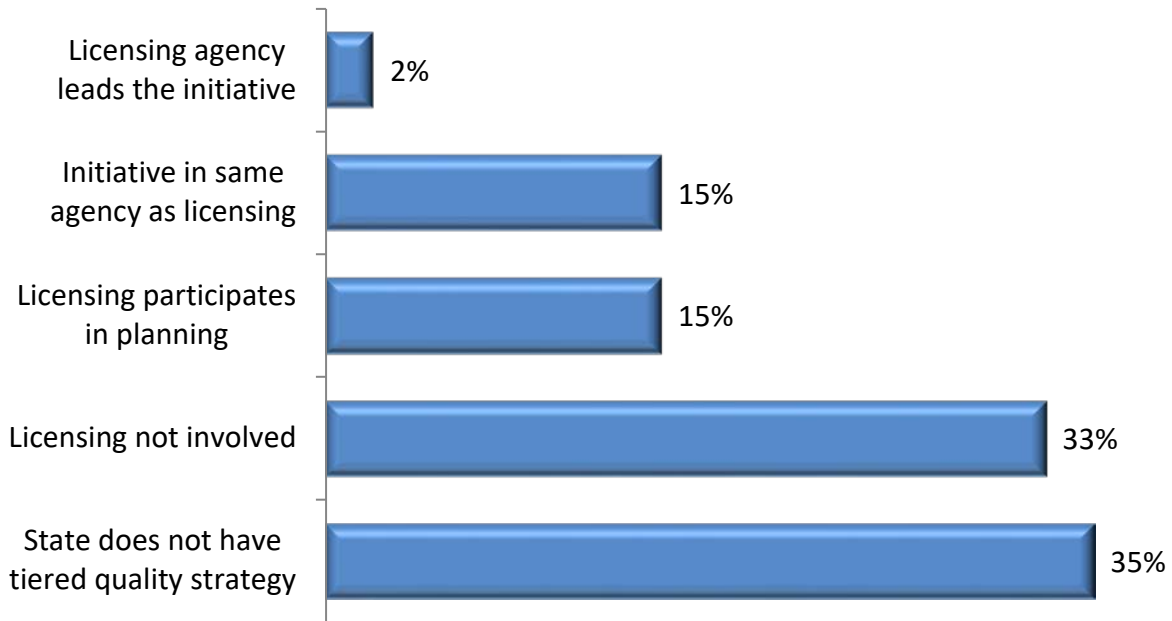
Initiative: Tiered Quality Strategy



State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
Total	7	20	15	8	2
AK			•		
AL		•			
AR			•		
AS	•				
AZ			•		
CA			•		
CO	•				
CT		•			
DC		•			

State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
DE			•		
FL				•	
GA		•			
HI		•			
IA		•			
ID				•	
IL			•		
IN		•			
KS					•
KY				•	
LA		•			
MA		•			
MD		•			
ME			•		
MI				•	
MN		•			
MO				•	
MS				•	
MT				•	
NC	•				
ND	•				
NE			•		
NH			•		
NJ				•	
NM		•			
NV			•		
NY			•		
OH		•			
OK	•				
OR		•			
PA		•			
RI			•		
SC			•		
SD	•				
TN		•			
TX			•		
UT			•		
VA		•			
VT		•			
WA	•				
WI		•			
WV		•			
WY					•

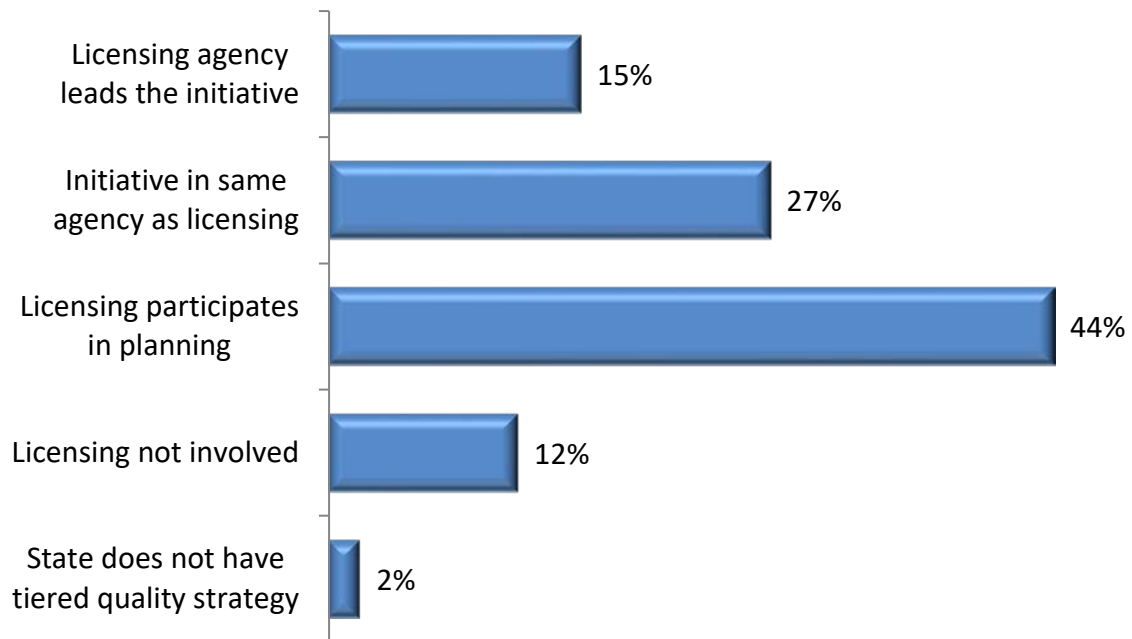
Initiative: Accreditation Facilitation Project



State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
Total	1	7	7	15	16
AK			•		
AL					
AR			•		
AS					•
AZ			•		
CA			•		
CO					•
CT		•			
DC		•			
DE					•
FL				•	
GA					•
HI		•			
IA					•
ID				•	
IL			•		
IN		•			
KS					•
KY				•	
LA		•			
MA					•
MD		•			
ME				•	
MI				•	
MN				•	
MO				•	
MS					•
MT				•	
NC					•
ND	•				
NE				•	

State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
NH					•
NJ				•	
NM		•			
NV			•		
NY			•		
OH					
OK					•
OR				•	
PA				•	
RI					•
SC					•
SD					
TN					•
TX					•
UT				•	
VA				•	
VT					
WA					
WI					
WV				•	
WY					•

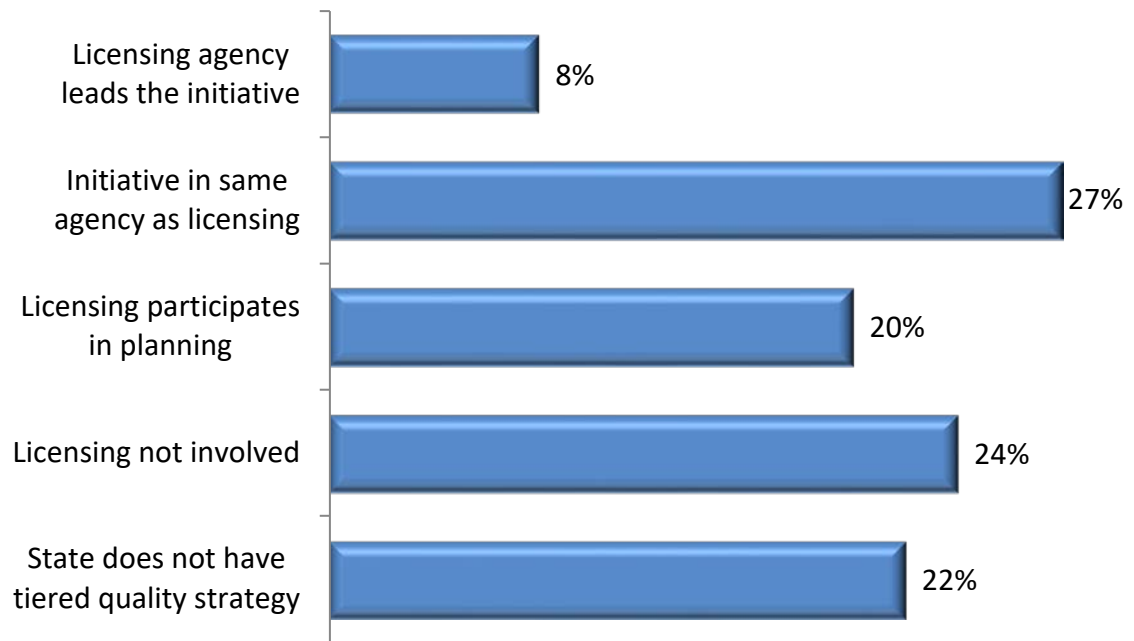
Initiative: Professional Development System



State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
Total	8	14	23	6	1
AK			•		
AL			•		
AR		•			
AS	•				
AZ			•		
CA			•		
CO	•				

State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
CT		•			
DC		•			
DE			•		
FL			•		
GA		•			
HI			•		
IA			•		
ID				•	
IL			•		
IN		•			
KS					•
KY				•	
LA		•			
MA		•			
MD		•			
ME			•		
MI			•		
MN		•			
MO	•				
MS				•	
MT				•	
NC			•		
ND	•				
NE				•	
NH			•		
NJ				•	
NM		•			
NV			•		
NY			•		
OH			•		
OK	•				
OR		•			
PA		•			
RI			•		
SC			•		
SD	•				
TN			•		
TX			•		
UT			•		
VA		•			
VT		•			
WA	•				
WI			•		
WV			•		
WY	•				

Initiative: Assessing Quality with an Environmental Rating Scale



State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
Total	4	14	10	12	11
AK			•		
AL					
AR		•			
AS					•
AZ				•	
CA			•		
CO	•				
CT		•			
DC		•			
DE				•	
FL				•	
GA		•			
HI					•
IA			•		
ID				•	
IL			•		
IN		•			
KS					•
KY				•	
LA		•			
MA		•			
MD		•			
ME				•	
MI				•	
MN					•
MO					•
MS					•
MT				•	
NC	•				
ND	•				
NE				•	

State	Licensing agency leads the initiative	Initiative in same agency as licensing	Licensing participates in planning	Licensing not involved	State does not have initiative
NH					•
NJ				•	
NM		•			
NV			•		
NY			•		
OH			•		
OK					•
OR					•
PA			•		
RI				•	
SC			•		
SD	•				
TN		•			
TX					•
UT			•		
VA		•			
VT		•			
WA		•			
WI		•			
WV				•	
WY					•

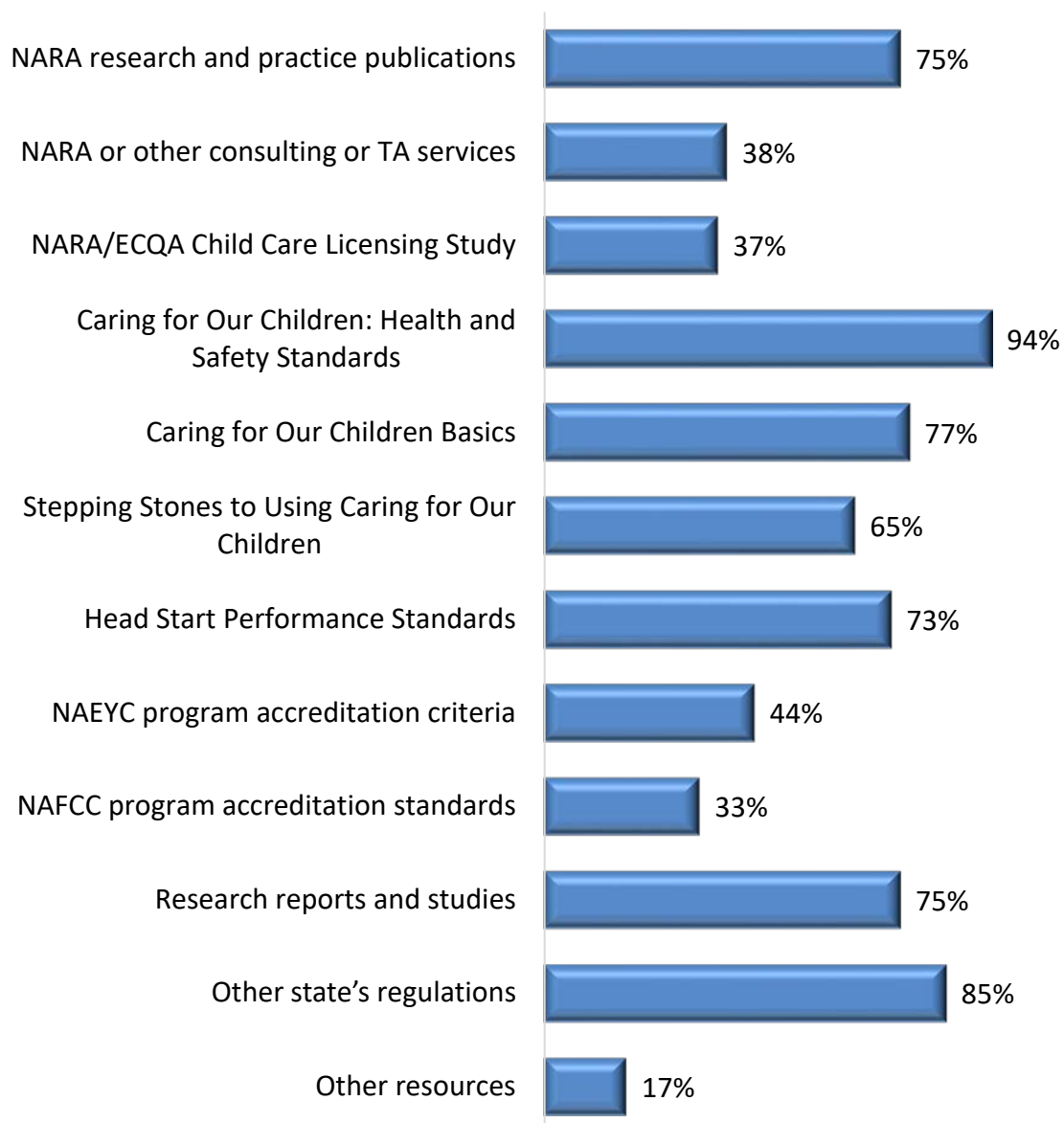
RULE AND REGULATION RESOURCES

Summary:

In both 2014 and 2017 states relied primarily on *“Caring for Our Children: Health and Safety Standards”* for formulating rules and regulations for licensing child care facilities. States were much more likely to use Head Start standards and NARA research and practice publications in 2017 than in 2014. States were less likely to rely on NAEYC or NAFCC accreditation criteria. The number of states using the NARA/ECQA/NCCCCQI child care licensing study dropped by more than 31 percent.

Question: What resources does the state use when formulating rules and regulations for licensing child care facilities?

Analysis: More than 94% of states reported using *Caring for Our Children: Health and Safety Standards* when formulating rules and regulations. Almost 85% of states using other state’s regulations and 75% use NARA research and practice publications and other research reports and studies. Just over 44% of states use NAEYC accreditation criteria.



Resources for Formulating Rules and Regulations

State	NARA research and practice publications	NARA or other consulting or TA services	NARA/ECQA Child Care Licensing Study	Caring for Our Children: Health and Safety Standards	Caring for Our Children Basics	Stepping Stones to Using Caring for Our Children
Total	39	20	19	49	40	34
AK	•			•		•
AL	•	•		•	•	
AR	•	•	•	•	•	•
AS	•	•		•	•	•
AZ	•	•	•	•	•	•
CA	•	•	•	•	•	•
CO	•	•	•	•	•	•
CT	•	•		•		
DC	•	•		•	•	
DE	•			•	•	•
FL	•	•	•	•	•	•
GA	•	•	•	•	•	•
HI	•	•	•	•		•
IA	•			•	•	
ID		•				
IL				•	•	•
IN	•	•	•	•	•	•
KS	•		•	•	•	•
KY						
LA	•			•		
MA	•	•		•		
MD				•	•	
ME	•			•	•	
MI				•	•	
MN		•			•	
MO	•		•	•	•	•
MS	•		•	•	•	•
MT				•	•	•
NC	•			•	•	•
ND	•			•		•
NE	•		•	•	•	•
NH	•	•	•	•		•
NJ	•		•	•	•	
NM	•			•	•	•
NV	•			•		
NY	•			•	•	•
OH	•	•	•	•	•	•
OK	•		•	•	•	•
OR	•			•	•	•
PA	•	•		•		•
RI	•		•	•	•	
SC				•		•
SD	•			•	•	
TN				•	•	•
TX				•	•	•
UT	•		•	•	•	•
VA				•	•	
VT	•	•	•	•	•	•
WA	•	•		•	•	•
WI				•	•	•
WV	•			•	•	•
WY				•	•	

Resources for Formulating Rules and Regulations – Continuation

State	Head Start Performance Standards	NAEYC program accreditation criteria	NAFCC program accreditation standards	Research reports and studies	Other state's regulations	Other resources
Total	38	23	17	39	44	9
AK	•	•		•	•	
AL	•	•	•		•	
AR	•	•	•	•	•	
AS	•	•	•			
AZ	•			•	•	
CA	•			•	•	
CO	•	•	•	•	•	
CT					•	•
DC	•			•	•	
DE	•		•	•	•	
FL				•	•	
GA	•	•	•	•	•	
HI				•	•	
IA				•	•	
ID	•			•	•	
IL		•	•	•	•	
IN	•	•	•	•	•	
KS	•	•	•	•	•	
KY						
LA	•	•		•	•	
MA	•	•	•	•		
MD	•	•	•			
ME	•	•	•	•	•	
MI	•	•			•	
MN	•			•	•	•
MO	•			•	•	
MS	•	•	•	•	•	•
MT					•	•
NC	•			•	•	
ND	•	•				•
NE	•			•	•	
NH	•			•	•	
NJ	•	•	•	•	•	•
NM					•	•
NV	•	•			•	
NY	•			•	•	•
OH	•	•	•	•	•	
OK	•				•	
OR	•			•	•	
PA	•				•	
RI				•	•	
SC	•			•	•	•
SD		•		•	•	
TN	•			•	•	
TX				•	•	
UT		•		•		
VA	•	•	•	•	•	
VT	•			•		
WA				•		
WI					•	
WV	•	•	•	•	•	
WY	•			•	•	

FIRE SAFETY, ENVIRONMENTAL HEALTH, AND BUILDING CODE INSPECTIONS

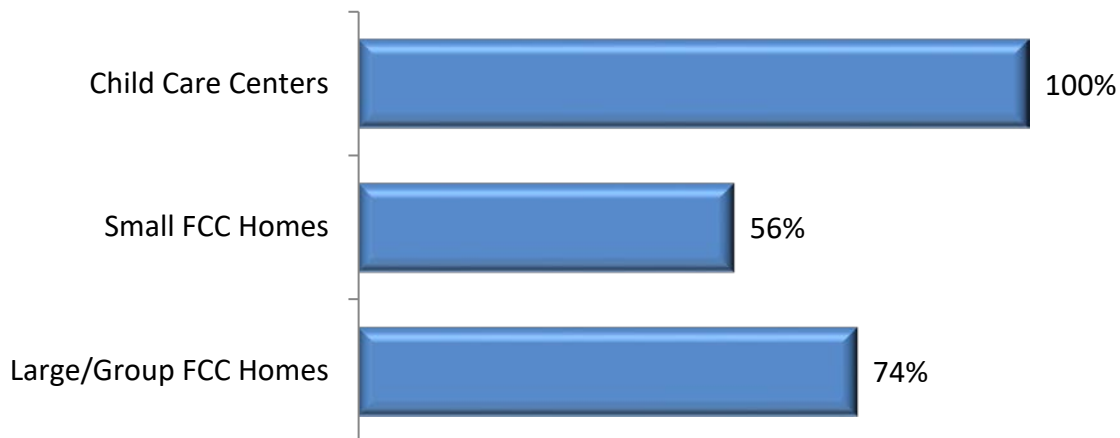
Summary:

Every state required a fire inspection for child care centers in both 2017 and 2014. For the states reporting that they regulate small FCC and large/group FCC homes, the percentage requiring fire inspections decreased by 1% and 5% respectively between 2014 and 2017. The number of states reporting that they required health inspections dropped by 7% between 2014 and 2017 and there was an overall increase of 5% in the number of states reporting that they did not require a health inspection. Building code inspections did not change for centers with 75% of states reporting that building code inspections were required. For states that regulate small FCC homes, there was an increase of 9% in the number of states requiring a building code inspection. There was one less state in 2017 than 2014 that regulates large/group FCC homes that required building code inspections. Overall there was a 5% decrease in the number of states saying they did not require any building code inspections.

Fire Safety

Question: Fire safety inspections are required for which type of licensed child care facilities?

Analysis: Every state requires fire safety inspections for child care centers. Just over half of all states require fire safety inspections for small FCC homes and almost three-fourths of states require them for large/group FCC homes.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total	52	28	29
AK	•	•	•
AL	•	•	•
AR	•	•	
AS	•	•	
AZ	•		
CA	•		•
CO	•		
CT	•		•
DC	•	•	•
DE	•	•	•
FL	•		•
GA	•	•	
HI	•		•
IA	•		
ID	•		•

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
IL	•	•	•
IN	•		
KS	•	•	•
KY	•	•	
LA	•		
MA	•		
MD	•	•	•
ME	•	•	
MI	•		
MN	•	•	•
MO	•	•	•
MS	•	•	•
MT	•		
NC	•		
ND	•	•	•
NE	•	•	•
NH	•	•	•
NJ	•		
NM	•	•	•
NV	•	•	•
NY	•	•	•
OH	•		•
OK	•		
OR	•		
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX	•		
UT	•	•	•
VA	•		
VT	•		
WA	•		
WI	•		
WV	•	•	•
WY	•	•	•

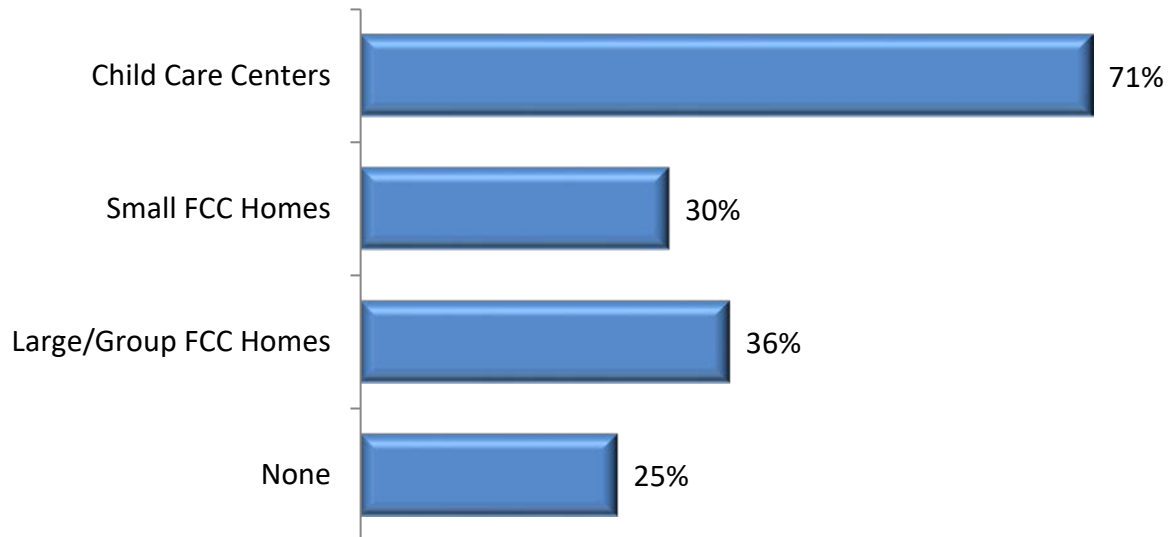
Question: What is the frequency of fire safety inspections?

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Prior to licensure	45	23	26
Once a year	29	13	16
Once every two years	9	3	3
Once every three years	2	1	2

Environmental Health

Question: Environmental health inspections are required for which type of licensed child care facilities?

Analysis: Environmental health inspections are required in about 71% of states for child care centers while these types of inspections are required in less than 30% of states for FCC homes of any size. In 25% of states, no environmental health inspections are required for any facility type.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	None
Total Number of States that Regulate				
	52	50	39	N/A
Total	37	15	14	13
AK	•	•	•	
AL	•			
AR	•	•		
AS	•	•		
AZ	•			
CA				•
CO	•			
CT	•		•	
DC	•	•	•	
DE				•
FL	•	•	•	
GA	•	•		
HI	•		•	
IA				•
ID				•
IL	•			
IN				•
KS				•
KY				•
LA				•
MA	•			
MD				•
ME				•
MI	•	•	•	
MN	•			
MO	•	•	•	

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	None
MS				•
MT	•			
NC	•			
ND	•			
NE	•			
NH	•	•	•	
NJ	•			
NM	•			
NV	•	•	•	
NY	•			
OH	•			
OK	•			
OR	•		•	
PA				
RI				•
SC	•	•	•	
SD	•			
TN	•	•	•	
TX	•			
UT	•	•	•	
VA	•			
VT				
WA	•	•		
WI				•
WV	•			
WY	•	•	•	

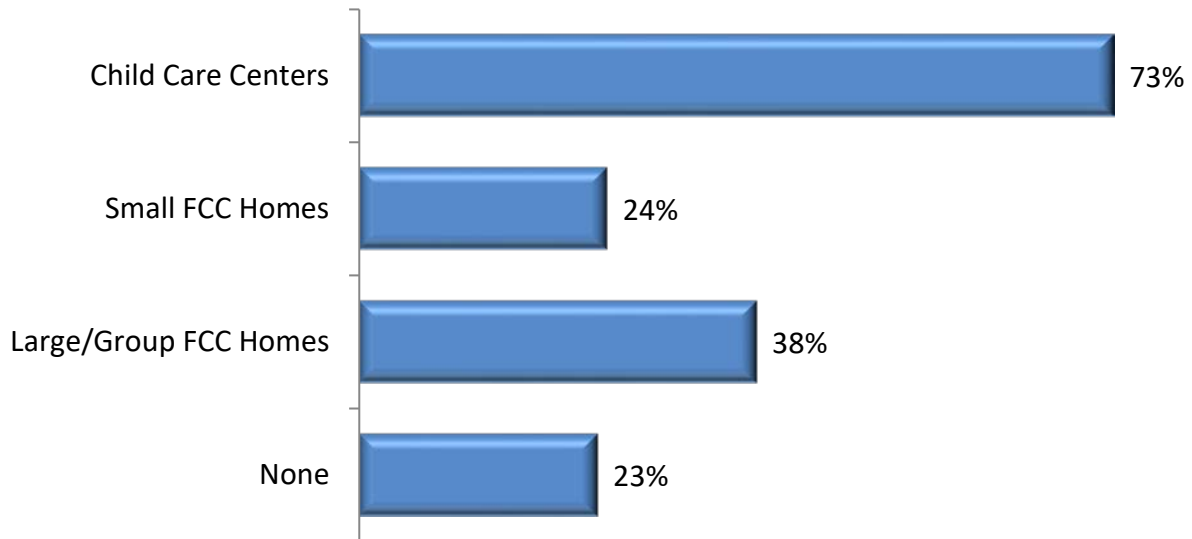
Question: What is the frequency of environmental health inspections?

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Prior to licensure	35	14	13
Once a year	21	9	8
Once every two years	8	3	4
Once every three years	3	2	1

Building Code Inspections

Question: Building Code Inspections are required for which type of licensed child care facilities

Analysis: 73% of states require building codes inspections for child care centers. 38% of states require them for large/group FCC homes and 24% of states require them for small FCC homes. 23% of states reported not requiring any building code inspections.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	None
Total Number of States that Regulate				
	52	50	39	N/A
Total	38	12	15	12
AK	•	•	•	
AL	•	•	•	
AR				•
AS				•
AZ	•			
CA	•			
CO	•			
CT	•		•	
DC	•	•	•	
DE	•	•	•	
FL	•	•	•	
GA	•	•		
HI	•		•	
IA				•
ID	•		•	
IL				•
IN	•			
KS	•			
KY				•
LA				•
MA	•			
MD	•		•	
ME	•	•		
MI				•
MN	•			
MO	•		•	

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes	None
MS				
MT	•			
NC	•			
ND	•			
NE				•
NH				•
NJ	•			
NM	•			
NV	•	•	•	
NY	•			
OH	•		•	
OK				•
OR				•
PA	•	•	•	
RI	•			
SC	•			
SD	•			
TN	•	•	•	
TX				•
UT	•	•	•	
VA				
VT	•			
WA	•			
WI	•	•		
WV	•			
WY	•			

Question: What is the frequency of building code inspections?

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Prior to licensure	35	12	15
Once a year	3	1	2
Once every two years	3	0	2
Once every three years	1	0	0

BACKGROUND CHECKS

Summary:

Every state required background checks for centers in both 2014 and 2017 with all states including criminal history checks in 2017, up from 94 percent in 2014. The number of states that regulate small FCC homes requiring those same checks was approximately 88% in 2017 (down from 100% of states in 2014) and 97% for states that regulate large/group FCC homes in both years. The number of states requiring either state or federal fingerprint checks was up for all facility types. States requiring Child Abuse & Neglect (CAN) Registry checks for all staff in centers grew by eight percent and while it decreased for all staff in both FCC home types, there was a significant increase in the number of states requiring CAN registry checks for staff having contact with children and volunteers. There were still six states that reported not requiring fingerprint checks in 2017, down from eight in 2014, and eight states that did not require sex offender registry checks, down from 13 in 2014. The number of states requiring sex offender registry checks for all program types grew by 10 to 12 percent.

The number of states requiring staff to sign a statement about criminal status remained largely unchanged between 2014 and 2017, though there was a 9% in the number of states requiring statements for small FCC homes. The percentage of states reporting that background checks were conducted prior to licensure or working in a child care facility remained decreased by almost 15% for centers and large/group FCC homes and by 19% in small FCC homes. In 2017, approximately 80 percent of states reported that staff in centers had background checks prior licensure or working in a facility, down from just over 94 percent of states in 2014. The number of states who regulate small FCC homes conducting initial background screening in small FCC homes was approximately 70 percent in 2017, down from 89% in 2014, while for large/group FCC homes it was approximately 82% in 2017, down from 95% in 2014.

States were more likely to report conducting background checks annually in 2014 than in 2017. About 38 percent of states reported that checks were completed for centers at least every three years in 2017, down from about 44 percent in 2014. Though those numbers dropped by almost 20 percent for small FCC homes between 2014 and 2017 and by about 12 percent in large/group FCC homes. In 2017, more than half the states reported conducting background checks for centers every five years which was also true for approximately 44 percent of small FCC homes and about 49 percent of large/group FCC homes. In 2014, approximately 15 percent of states conducted background checks every five years for any program type.

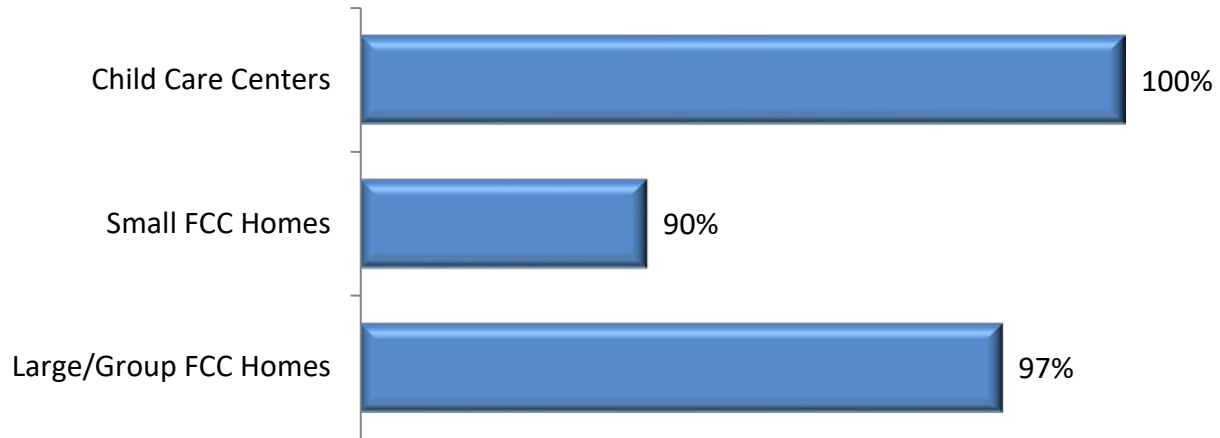
In 2014, approximately 60 percent of states reported that a new background check was conducted for all provider types if child care facility staff changed jobs, moved to another facility, or had a break in employment. In 2017, only 31 percent of states reported that a new background check was conducted for center and large/group FCC home staff and approximately one-fourth of states conduct new investigations on FCC homes. In 2014 about 30 percent of states had portable background check policies for center staff and about 25 percent of state had portable background checks for FCC home staff. In 2017, more than half the states reported that background checks were portable for each facility type and would move with the staff. This marks an increase from about one-third of states for all program types in 2014. There was little change in the percent of states reporting that licensing staff was automatically notified of a change in criminal record.

Finally, in 2017, nine states reported that the state paid for background screening, up from 7 in 2014. Seven states reported in both years that the facility paid, and the individual paid in 10 states, down from 12 in 2014, corresponding to the two states that reported paying for background checks. Almost half the states in both years reported some other arrangements for paying for background screenings.

States Requiring Background Checks

Question: The state requires background checks for which type of licensed child care facilities?

Analysis: All states require background checks for child care centers. Checks are required in 90% of states for small FCC homes and in 97% of states for large/group FCC homes.



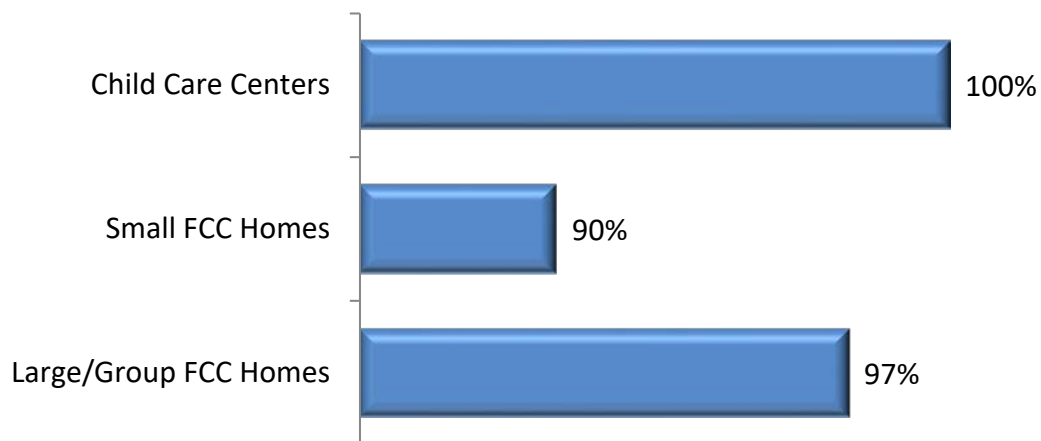
State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	52	45	38
AK	•	•	•
AL	•	•	•
AR	•	•	
AS	•	•	
AZ	•		•
CA	•	•	•
CO	•	•	•
CT	•	•	•
DC	•	•	•
DE	•	•	•
FL	•	•	•
GA	•	•	
HI	•	•	•
IA	•	•	•
ID	•		•
IL	•	•	•
IN	•		•
KS	•	•	•
KY	•	•	
LA	•		
MA	•	•	
MD	•	•	•
ME	•	•	
MI	•	•	•
MN	•	•	•
MO	•	•	•
MS	•	•	•
MT	•	•	•
NC	•	•	
ND	•	•	•

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
NE	•	•	•
NH	•	•	•
NJ	•		
NM	•	•	•
NV	•	•	•
NY	•	•	•
OH	•		•
OK	•	•	•
OR	•	•	•
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX	•	•	•
UT	•	•	•
VA	•	•	
VT	•	•	
WA	•	•	
WI	•	•	
WV	•	•	•
WY	•	•	•

Criminal History Records

Question: Criminal history record (CHR) checks are required for which type of licensed child care facilities?

Analysis: All states require CHR checks for child care centers. Checks are required in 90% of states for small FCC homes and in 97% of states for large/group FCC homes.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	52	45	38
AK	•	•	•
AL	•	•	•
AR	•	•	
AS	•	•	
AZ	•		•

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
CA	•	•	•
CO	•	•	•
CT	•	•	•
DC	•	•	•
DE	•	•	•
FL	•	•	•
GA	•	•	
HI	•	•	•
IA	•	•	•
ID	•		•
IL	•	•	•
IN	•		•
KS	•	•	•
KY	•	•	
LA	•		
MA	•	•	
MD	•	•	•
ME	•	•	
MI	•	•	•
MN	•	•	•
MO	•	•	•
MS	•	•	•
MT	•	•	•
NC	•	•	
ND	•	•	•
NE	•	•	•
NH	•	•	•
NJ	•		
NM	•	•	•
NV	•	•	•
NY	•	•	•
OH	•		•
OK	•	•	•
OR	•	•	•
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX	•	•	•
UT	•	•	
VA	•	•	
VT	•	•	•
WA	•	•	
WI	•	•	
WV	•	•	•
WY	•	•	•

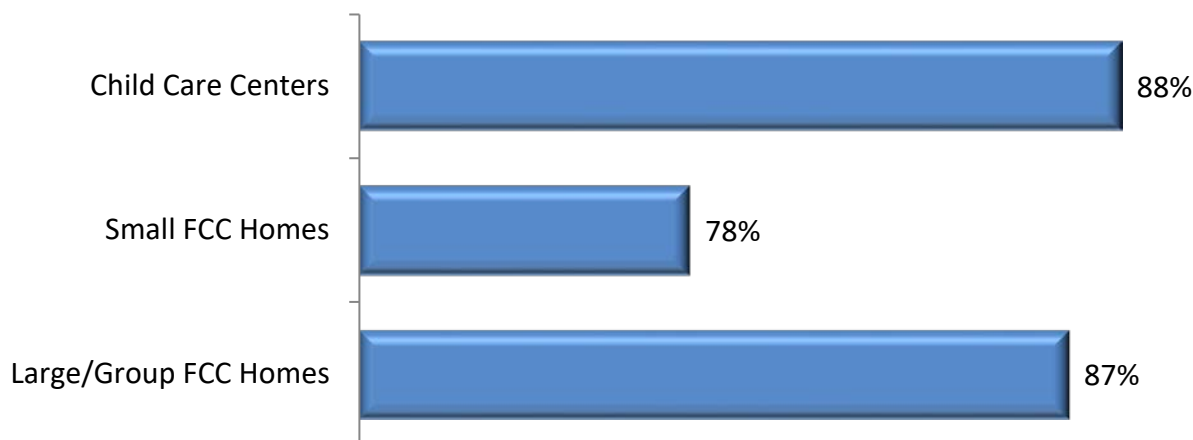
Question: For each facility type, please identify the type of criminal history record (CHR) required and by whom.

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
State CHR required	52	45	38
Federal CHR required	44	37	32
CHR required for all staff in facility	35	29	26
CHR required only for staff having contact with children	28	25	20
CHR required for volunteers	37	32	28
CHR required for household members (for FCC homes)	24	45	36
CHR required under certain conditions	16	13	11

Fingerprint Record Checks

Question: Fingerprint record checks are required for which type of licensed child care facilities?

Analysis: Fingerprint record checks are required in 88% of states for child care centers, 78% of states for small FCC homes, and in 87% of states for large/group FCC homes.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	46	39	34
AK	•	•	•
AL	•	•	•
AR	•	•	
AS	•	•	
AZ	•		•
CA	•	•	•
CO	•	•	•
CT	•	•	•
DC	•	•	•
DE	•	•	•
FL	•	•	•
GA	•	•	
HI	•	•	•

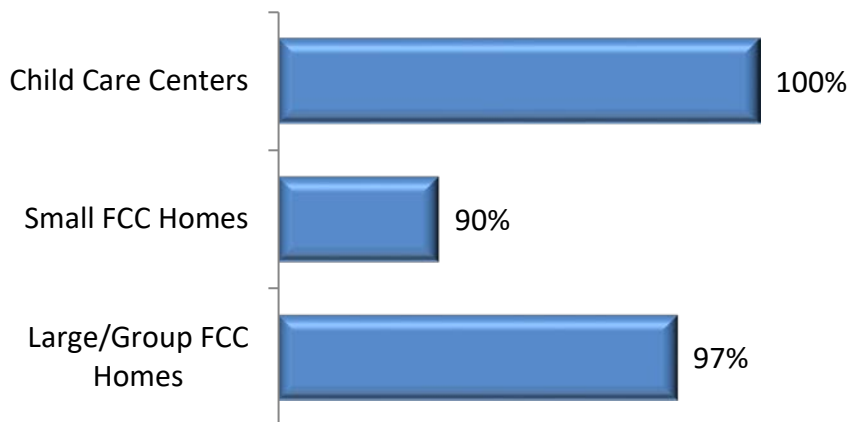
State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
IA	•	•	•
ID	•		•
IL	•	•	•
IN	•		•
KS			
KY	•	•	
LA	•		
MA	•	•	
MD	•	•	•
ME			
MI	•	•	•
MN	•	•	•
MO			
MS	•	•	•
MT			
NC	•	•	
ND	•	•	•
NE			
NH	•	•	•
NJ	•		
NM	•	•	•
NV	•	•	•
NY	•	•	•
OH	•		•
OK	•	•	•
OR	•	•	•
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX	•	•	•
UT	•	•	•
VA	•	•	
VT	•	•	
WA	•	•	
WI			
WV	•	•	•
WY	•	•	•

Question: For each facility type, please identify the type of fingerprint record (FR) check required by whom.

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
State FR required	39	34	31
Federal FBI FR required	45	38	33
FR required for all staff in facility	30	24	22
FR required only for staff having contact with children	25	21	20
FR required for volunteers	28	22	22
FR required for household members (for FCC homes)	21	36	31
FR required under certain conditions	16	13	11
Electronic fingerprint imaging (LIVE SCAN) required	29	25	22

Question: Child abuse and neglect registry checks (CAN) are required for which type of licensed child care facilities?

Analysis: CAN checks are required in every state for child care centers while they are required in 90% of states for small FCC homes and in 97% of states for large/group FCC homes.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	52	45	38
AK	•	•	•
AL	•	•	•
AR	•	•	
AS	•	•	
AZ	•		•
CA	•	•	•
CO	•	•	•
CT	•	•	•
DC	•	•	•
DE	•	•	•
FL	•	•	•
GA	•	•	
HI	•	•	•
IA	•	•	•
ID	•		•
IL	•	•	•
IN	•		•
KS	•	•	•
KY	•	•	
LA	•		
MA	•	•	
MD	•	•	•
ME	•	•	
MI	•	•	•
MN	•	•	•
MO	•	•	•
MS	•	•	•
MT	•	•	•
NC	•	•	
ND	•	•	•
NE	•	•	•
NH	•	•	•

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
NJ	•		
NM	•	•	•
NV	•	•	•
NY	•	•	•
OH	•		•
OK	•	•	•
OR	•	•	•
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX	•	•	•
UT	•	•	•
VA	•	•	
VT	•	•	
WA	•	•	
WI	•	•	
WV	•	•	•
WY	•	•	•

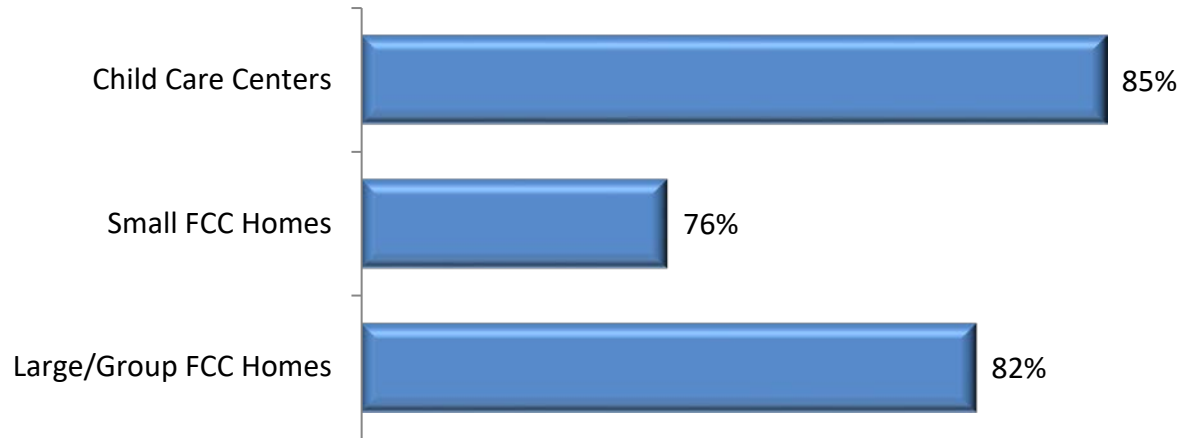
Question: For each facility type, when and/or for what staff are CAN checks required?

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
CAN required for all staff in facility	36	30	26
CAN required only for staff having contact with children	29	25	22
CAN required for volunteers	39	33	28
CAN required for household members (for FCC homes)	27	43	34
CAN required under certain conditions	13	10	9

Sex Offender Registry

Question: Sex offender registry (SOR) checks are required for which type of licensed child care facilities?

Analysis: SOR checks are required for child care centers in 85% of states while they are required for small FCC homes in 76% of states and for large/group FCC homes in 82% of states.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	44	38	32
AK	•	•	•
AL	•	•	•
AR	•	•	
AS	•	•	
AZ	•		•
CA	•	•	•
CO	•	•	•
CT			
DC	•	•	•
DE	•	•	•
FL	•	•	•
GA	•	•	
HI	•	•	•
IA	•	•	•
ID	•		•
IL	•	•	•
IN	•		•
KS			
KY	•	•	
LA	•		
MA	•	•	
MD	•	•	•
ME		•	
MI	•	•	•
MN	•	•	•
MO			
MS	•	•	•
MT			
NC	•	•	
ND	•	•	•

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
NE	•	•	•
NH	•	•	•
NJ	•		
NM	•	•	•
NV	•	•	•
NY			
OH	•		•
OK	•	•	•
OR	•	•	•
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX			
UT	•	•	•
VA	•	•	
VT	•	•	
WA			
WI	•	•	
WV	•	•	•
WY	•	•	•

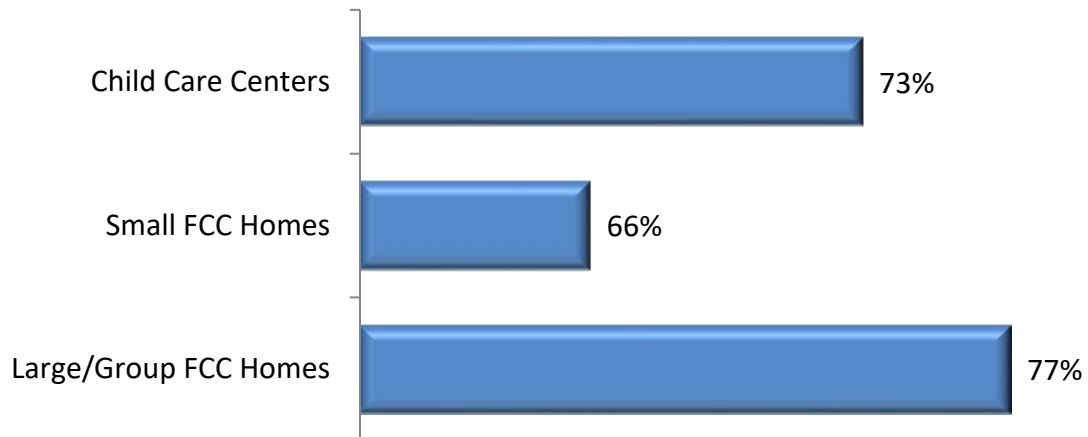
Question: For each facility type, please identify who is required to complete a sex offender registry check (SOR).

	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
SOR required for all staff in facility	29	25	21
SOR required only for staff having contact with children	24	20	18
SOR required for volunteers	29	25	23
SOR required for household members (for FCC homes)	22	37	31
SOR required under certain conditions	12	9	8

Staffing Background Checks

Question: Facility staff are required to sign a statement about criminal status in which type of licensed child care facilities?

Analysis: Criminal status statements are required by child care centers in 73% of states and required for small FCC homes in 66% of states and for large/group FCC homes in 77% of states.



State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate			
	52	50	39
Total	38	33	30
AK	•	•	•
AL	•	•	•
AR	•	•	
AS			
AZ	•		•
CA	•	•	•
CO	•	•	•
CT			
DC	•	•	•
DE	•		•
FL	•	•	•
GA	•	•	
HI	•	•	•
IA	•	•	•
ID	•		•
IL	•	•	•
IN	•		•
KS			
KY			
LA			
MA			
MD			
ME			
MI	•	•	•
MN			
MO			
MS			
MT			
NC	•	•	

State	Child Care Centers	Small FCC Homes	Large/Group FCC Homes
ND	•	•	•
NE	•	•	•
NH	•	•	•
NJ			
NM	•	•	•
NV	•	•	•
NY	•	•	•
OH			
OK	•	•	•
OR	•	•	•
PA	•	•	•
RI	•	•	•
SC	•	•	•
SD	•		
TN	•	•	•
TX	•	•	•
UT	•	•	•
VA	•	•	
VT	•	•	
WA	•	•	
WI	•	•	
WV	•	•	•
WY	•	•	•

Question: How often are background checks conducted on staff in licensed child care centers and licensed family child care home providers?

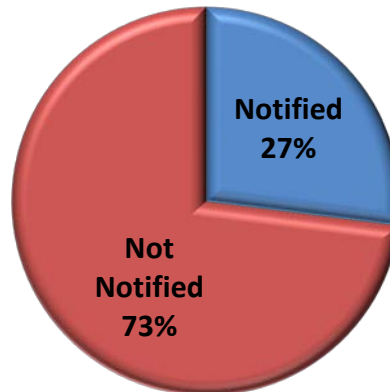
	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
Prior to licensure/working in a child care facility	42	36	32
Annually	6	7	4
Every 2 years	6	5	5
Every 3 years	8	6	4
Every 4 years	1	1	1
Every 5 years	27	22	19
Less than every 5 years	0	0	1
Other Frequency	12	11	9

Question: What is the state's policy on background checks if child care facility staff change jobs, move to another facility, or have a break in employment?

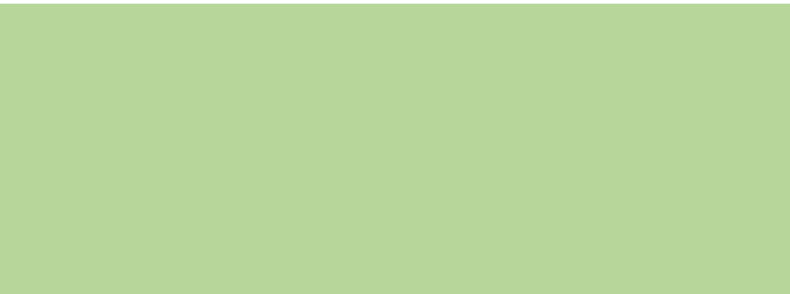
	Child Care Center	Small FCC Homes	Large/Group FCC Homes
Total Number of States that Regulate	52	50	39
New background check is conducted	16	12	12
Current background check is portable and moves with the individual	27	26	19
Other policy	18	16	13

Question: Does the background check system in your state notify your agency when an individual's criminal record has changed? Does the state pay the costs for individuals to obtain background checks to work in licensed child care facilities?

Analysis: Only 27% of states have a background check system that notifies the licensing agency when an individual's criminal record has changed. In 17% of states, the state pays for background checks, in 21% of states the individual pays for the check and in 13% of states the facility pays. 48% of states report some other payment arrangement for background checks. Other payment arrangements including the state or facility paying for different parts of the background checks, in some states who paid was dependent on the type of licensee, and some states do not charge fees for "Name Only" searches. Other included where there was a combination of the state and facilities paying.



State	Background check system notifies agency when an individual's criminal record has changed	Yes, the state pays for background check	No, facilities pay for background checks for their staff	No, individuals pay for their own background checks	Other
Total	14	9	7	11	25
AK		.			
AL					.
AR					.
AS				.	
AZ					.
CA			.		
CO			.		
CT					.
DC		.			
DE		.			
FL					.
GA					.
HI					.
IA					.
ID				.	
IL	.	.			
IN					.
KS					.
KY	.	.			
LA			.		
MA					.
MD	.				.
ME					.
MI	.				.
MN	.			.	
MO					.
MS			.		



Learning about Infant and Toddler Early Education Services (LITES): Summarizing the Research and Gaps on Compelling Models



December 2015

Learning about Infant and Toddler Early Education Services (LITES): Summarizing the Research and Gaps on Compelling Models

December 2015

Patricia Del Grosso, Christopher Jones, Diane Paulsell, and Shannon Monahan

Contract Number: HHSP23320095642WC

Mathematica Reference Number: 40301.132

Submitted to:

Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, S.W, Washington, DC 20201
Project Officers: Lisa Trivits and Lindsey Hutchison

Submitted by:

Mathematica Policy Research
P.O. Box 2393
Princeton, NJ 08543-2393
Telephone: (609) 799-3535
Facsimile: (609) 799-0005
Project Director: Diane Paulsell

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Suggested citation:

Del Grosso, P., Jones, C., Paulsell, D., and Monahan, S. "Learning about Infant and Toddler Early Education Services (LITES): Summarizing the Research and Gaps on Compelling Models." Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2015.

Disclaimer

The views expressed in this publication do not necessarily reflect the views or policies of the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Administration for Children and Families (ACF), or the U.S. Department of Health and Human Services (DHHS).

ACKNOWLEDGMENTS

The authors wish to thank Lindsey Hutchison and Lisa Trivits, our federal project officers at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), as well as Amy Madigan, Meryl Barofsky, and T’Pring Westbrook at the Office of Planning, Research and Evaluation (OPRE) in the Administration for Children and Families (ACF), for their oversight, guidance, and vision. We would also like to thank Jeanne Brooks-Gunn, Margaret Burchinal, and Ellen Kisker for their contributions to this project. In addition, we were fortunate to have the expertise of our expert panel members, whose guidance on program models for infants and toddlers was invaluable.

We also gratefully acknowledge our colleagues at Mathematica Policy Research, including Jaime Thomas and Lauren Murphy, who contributed their time, effort, and expertise to this project. Sally Atkins-Burnett and Sarah Avellar provided thoughtful quality assurance.

While acknowledging the contributions of these individuals, the authors take responsibility for any errors or omissions that remain. The views expressed in this report do not necessarily reflect those of ASPE or the U.S. Department of Health and Human Services.

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EXPERT PANEL MEMBERS

We would like to thank the following members of our expert panel for their assistance with the LITES compelling models task. The views expressed in this publication do not necessarily reflect the views of these members.

Clancy Blair
New York University

James Elicker
Purdue University

Diane Horm
University of Oklahoma

Brenda Jones Harden
University of Maryland

Julia Isaacs
Urban Institute

Pamela Morris
New York University

Kathy Thornburg
University of Missouri

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EXECUTIVE SUMMARY

Purpose and scope of LITES

A growing body of research indicates that high quality early learning experiences can promote young children’s development (Camilli et al. 2010; Duncan and Magnuson 2013). Recent research bringing together neuroscience, child development, and economics has made the case that children’s early experiences are deeply influenced by poverty and have impacts on their cognitive, social-emotional, and physical health outcomes that extend into the school years and beyond (Camilli et al. 2010; National Scientific Council on the Developing Child 2007; Halle et al. 2009; Yoshikawa et al. 2013). These findings have emphasized the need for high quality early learning experiences for disadvantaged children that can promote development and reduce achievement gaps. Research is building about the effectiveness of preschool programs for preparing disadvantaged children for entry into kindergarten and beyond, yet less is known about effective program models to support infant and toddler early learning. Therefore, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in partnership with the Office of Planning, Research and Evaluation, within the U.S. Department of Health and Human Services, funded Mathematica Policy Research and its partners to conduct the Learning about Infant and Toddler Early Education Services (LITES) project. LITES aimed to identify replicable program models that support infant and toddler early learning in out-of-home early care and education (ECE) settings to inform future research, policy, and program directions at the federal, state, and local levels.

LITES includes two main components: (1) a systematic review to identify effective program models in out-of-home ECE settings that support infant and toddler early learning, and (2) a scan of the field for program models that are of interest (or “compelling”) for supporting these domains of infant/toddler development, but lack rigorous research examining impacts on children’s outcomes. For both components, we examined infant and toddler early learning models that targeted children’s cognitive, language, and/or social-emotional/behavioral development. For the systematic review, we conducted a comprehensive literature review to identify studies with eligible research designs, rated the quality of the studies, and examined evidence of effectiveness on children’s outcomes. In contrast, for the compelling models scan, we identified models through a nomination process and discussion with a small group of experts in the field¹ This report focuses on the compelling models identified in that scan. To learn more about the scope, methodology, and findings for the systematic review, please refer to Monahan et al. 2015

Together, the two components provide a picture of available models to support infant and toddler early learning, including those with rigorous evidence of effectiveness on child outcomes and those considered compelling in the field but lacking rigorous research evidence. This latter

¹ We developed the compelling models nomination process to identify models considered compelling by ECE experts. Because it was a nomination process, this report does not provide a representative or exhaustive list of all possible replicable program models that support infant and toddler early learning in out-of-home ECE settings and lack rigorous research.

component is a unique contribution of LITES since most systematic reviews do not include a category of models without rigorous research on the identified outcomes of interest. LITES, however, does not provide an all-inclusive review of all available infant and toddler early learning models nor the full range of descriptive research conducted on them. An exhaustive scan for all potential programs was beyond the scope of this report. For example, models in the systematic review whose studies were all rated as low quality were *not* considered for or included in the compelling models report. The models with only low-rated studies are described in Appendixes A and B of Monahan et al. 2015.

Methods

We defined “compelling models” as models that are viewed by the ECE field as having potential for promoting infant and toddler early learning in out-of-home settings, but have not yet been rigorously evaluated. The primary distinction between the models included in this report and those included in the LITES systematic review is the availability of research examining the impact of the models on child outcomes in the domains of language, cognition, and/or social emotional/behavioral development. To identify potential compelling models, we disseminated a call for nominations to electronic mailing lists for practitioners and researchers in ECE and related fields, and we solicited nominations directly from ECE experts. We sought well-specified models² that included a defined package of components to support infant and toddler early learning, or professional development to help caregivers support infant and toddler early learning. Services had to broadly target infants and toddlers and/or their out-of-home caregivers; programs that narrowly targeted children with specific diagnosed disabilities or medical conditions were not included.

The nomination process yielded 21 relevant models. To prioritize them, we applied four criteria: (1) the model had at least one descriptive study of child outcomes with potentially positive findings; (2) the model had at least one impact study with positive findings on *interim* outcomes (structural features of care, caregiver-child interaction, caregiver skills or knowledge of child development, or global ECE quality); (3) the model had documentation to support replication (such as training manuals or implementation guidelines); or (4) the model had been used in at least two independent sites or, for curricula, in at least five percent of Early Head Start programs.³ In consultation with ASPE, ACF, and an expert work group, we selected models that met at least two of these criteria for further examination⁴

² We defined *well-specified models* as those that had: (1) clear inclusion and exclusion criteria that define the population for which the model is intended, (2) a clear description of the model components or features that must be present, and (3) clear practice guidance to promote consistency of service delivery (such as the availability of implementation guides and staff training materials, requirements for staff qualifications, or the availability of ongoing technical assistance; Fixsen et al. 2013).

³ We deemed five percent to be a reasonable cut point as the number of programs using each curricula dropped considerably below the cut point.

⁴ For the LITES systematic review (see Monahan et al. 2015), models were included if their studies used an eligible research design and examined impacts on specified child outcomes. Studies in the systematic review were rated based on the internal validity of the research. Studies were rated ‘low’ if they had an eligible design but did not meet review standards. Models included in the systematic review were *not* eligible for consideration in this compelling

Results

Based on the prioritization criteria, LITES identified 13 compelling models to support infant and toddler early learning in out-of-home ECE settings that show potential for the field but have not yet been rigorously evaluated (Box 1). Two of the models provide direct early learning services⁵ to infants and toddlers; six models focus primarily on working with caregivers through coaching, modeling, or consultation to help them support infant and toddler early learning; and five models are infant/toddler curricula.⁶ Although the 13 models are distinct enough to warrant sorting them into these three categories, there is some unavoidable overlap. For example, the direct early learning models, as well as some curriculum models, include coaching or consultation for caregivers.

Box 1. Compelling models prioritized for inclusion in the report

Models that provide direct early learning services to children:

- Early Learning Readiness Program for Informal Family, Friend, and Neighbor Caregivers
- Educare

Models that primarily focus on professional development for caregivers:

- Early Childhood Consultation Partnership
- Expanding Quality in Infant Toddler Care course and EQ RELATE Model of Coaching
- First Beginnings (Philadelphia Inclusion Network)
- Infant Caregiver Mentoring Project
- Seeds to Success
- Smart Support

Curricula models:

- Assessment, Evaluation, and Programming System, Second Edition, Curriculum for Birth to Three Years
- The Creative Curriculum for Family Child Care, Second Edition
- The Creative Curriculum for Infants, Toddlers & Twos, Third Edition
- Hawaii Early Learning Profile 0-3
- HighScope Infant-Toddler Curriculum

Across the 13 models, the range of target outcomes include children's development (9 models), caregiver knowledge and skills (3 models), and environment quality (3 models; Appendix B, Table B.1). Of the nine models targeting children's development, seven (including

(continued)

models report. None of the models that only had studies rated low in the systematic review were nominated for the compelling models component. In addition, the project schedule did not allow time for the research team to add models with only low-rated studies to the list of models under consideration for the compelling models scan.

⁵ For LITES, we considered direct early learning services to be services targeted directly to infants and toddlers to support their early learning and intended to influence children's cognitive, language, and/or social-emotional/behavioral development.

⁶ For purposes of this project, we used the definition of *curriculum* Epstein et al. (1996) used in their review of models of early childhood education. They defined curriculum as a set of education practices that are recommended from a specific theoretical viewpoint. Further, we focused on models that included documentation to support implementation of the practices.

all five curriculum models) target multiple domains of development, including language, cognition, and social emotional/behavioral development and two (both mental health consultation models) target only children's social emotional/behavioral development. Although only three models specifically target caregivers' knowledge and skills, all 13 models include supports for caregivers (such as offering training, coaching, or consultation or implementation guides and other materials) to help them support children's development and/or improve program quality.

Within categories of models we identified common features. Specifically, the models primarily focused on professional development for caregivers were most often relationship-based, one-on-one interventions that were offered to caregivers in ECE settings and were focused on achieving specific and articulated objectives. Most of the models were intensive with services offered weekly or biweekly and substantial in duration lasting from four to six months. According to the research literature, these features may represent effective practices in professional development (U.S. Department of Education 2010). All five curricula models are linked to child assessment tools; the assessments are designed to guide caregivers in how they individualize services for children. These models also include preschool versions (some of which have been rigorously evaluated) allowing for continuity of approaches from birth to age 5 years.

The 13 compelling models we profile in this report are in different stages of development. The level of specification in the compelling models we profiled varied, both across models and across implementation components (Table ES.1). For example, all 13 models specified target populations of infants, toddlers, and/or their caregivers, as well as target outcomes for those populations. Most also had available implementation guides, training materials, and qualified trainers. Almost half of the models had fidelity standards and systems for monitoring fidelity. However, even the models with written materials to support implementation could benefit from additional guidance about the components that need to be in place to implement the model with fidelity. This would require developing standards that include minimum specifications for the model to provide consistent service delivery. For example, developers might consider not only making training available, but also setting minimum specifications for the types and levels of training required by staff implementing the model. Without this information, researchers and practitioners may not have the information they need to understand whether the model is being implemented in adherence with the developer's specifications. In addition, in some instances a practitioner may want to adapt an existing model for use with a different population (for example, dual language learners) but have little guidance or support on how to do this.

Table ES.1. Overview of documented implementation components

Implementation component	Number of compelling models
The model developer has specified the following:	
Target outcomes	13
Target population	13
Dosage of services	8
Program length	9
Staff education requirements	3
Staff training requirements	6
Supports for implementation	13
Implementation/operation manuals	11
Training materials	12
Qualified trainers	12
Fidelity standards	6
Systems for monitoring fidelity	6

Because we focused on identifying models that had not yet been part of an impact study to examine children’s outcomes, we anticipated finding primarily implementation or descriptive research on these models. Eight of the 13 models had at least one research study, although most had only one study (Table ES.2).⁷ None of the curricula models had existing research. Four models had studies examining implementation (Early Childhood Consultation Partnership [ECCP], Early Learning Readiness Program [ELR], Smart Support, and Seeds to Success); two models had descriptive studies measuring children’s outcomes (Educare and Smart Support); and four models had descriptive studies of *interim* outcomes (ELR, Educare, First Beginnings, and Smart Support). The research also included three randomized controlled trials (RCTs) measuring *interim* outcomes (Expanding Quality in Infant Toddler Care and EQ RELATE coaching model, Infant Caregiver Mentoring Project, and Seeds to Success)⁸ At the time this report was written, impact studies examining child outcomes were also under way for two models: ECCP and Educare. Because results were not yet available for these impact studies, however, these two models were not included in the LITES systematic review. Across the five descriptive and three impact studies of interim outcomes, the outcome domains measured included observed quality

⁷ We only report findings from studies that focused on infants and toddlers and their caregivers. Specifically, we report findings on children’s outcomes for infants and toddlers, or interim outcomes for infant and toddler caregivers or settings where infants and toddlers received care (structural features of care, caregiver-child interaction, caregiver skills or knowledge of child development, or global ECE quality). We include findings from implementation studies if they reported on care settings for infants and toddlers.

⁸ These models were *not* eligible for the LITES systematic review because the impact studies measured only interim outcomes. To be eligible for the systematic review, the models had to have eligible research designs examining the impact of the models on child outcomes in the domains of language, cognition, and/or social emotional/behavioral development.

(seven studies) and caregiver knowledge and skills (four studies)⁹ Across the two descriptive studies of child outcomes both measured social-emotional/behavioral development and one also measured school readiness and vocabulary. The three models with impact studies of interim outcomes were all professional development models; the findings pointed to the potential of these models to improve observed quality and increase caregiver knowledge and skills.

Table ES.2. Overview of research on compelling models, by study type

Model	Implementation study	Descriptive study: child outcomes	Descriptive study: interim outcomes ^a	Impact study: interim outcomes	Impact study underway: child outcomes
Early Childhood Consultation Partnership (ECCP)	✓				✓ ^b
Early Learning Readiness (ELR) Program	✓		✓		
Educare		✓	✓		✓ ^c
Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching				✓ ^d	
First Beginnings ^e			✓		
Infant Caregiver Mentoring Project ^e				✓ ^f	
Seeds to Success ^e	✓			✓	
Smart Support	✓	✓ ^g	✓ ^g		

^aInterim outcomes are those *other than* child outcomes that are thought to be related to child development. For LITES, this included the following domains: global ECE quality, structural features of care, caregiver-child interaction, and caregiver knowledge of child development.

^bResults from a small pilot impact evaluation of ECCP became publically available in December 2014, after the analyses for the LITES systematic review and compelling models profiles were complete.

^cData collection is in progress for the first phase of an impact study on Educare, which follows children through age 3; the youngest children in the study turn 3 in September 2015.

^dThe study of EQIT included comparison groups of convenience. Within the EQIT intervention group, participants were randomly assigned to receive different amounts of coaching.

^eFirst Beginnings and the Infant Caregiver Mentoring Project are not currently active. After the Seeds to Success demonstration period concluded, it was used to develop a new system called Early Achievers, which is currently in operation.

^fThe study of the Infant Caregiver Mentoring Project used a randomized design, but reported analyses of pre-post differences within groups.

^gSmart Support presented study results in an infographic provided by the developer rather than a research report.

Although many of the models have begun the process of building a research base, additional research on out-of-home ECE models for infants and toddlers is essential for moving the field

⁹ The total number of descriptive studies measuring interim outcomes is five because one model, First Beginnings, has two studies.

forward. The compelling models that are well-specified and have some existing research evidence might be ready for impact studies that examine their effects on children's outcomes. The two models that are currently the focus of impact studies could be tested with different subgroups of caregivers (for example, family child care providers and center-based providers) or children (for example, dual language learners and monolingual English speakers) to identify the groups for which particular strategies are most effective. Others might require a full spectrum of research, including implementation studies, outcome studies, and rapid cycle evaluations, to test the feasibility of staff training and implementation procedures, develop standards for high-fidelity implementation and measures to monitor fidelity, and assess whether the models show potential for producing intended outcomes. In addition, research is needed on the components of the models that are most important to achieving desired child outcomes. Such a process of model development and initial testing could lay the groundwork for rigorous evaluation to identify effective models and model components that have strong potential to improve outcomes for infants and toddlers and prepare them for further learning as they transition into preschool.

Since the process of developing and testing models requires time and resources, several innovative strategies should be considered for supporting model development. Recent attention has been given to the use of rapid cycle evaluations as a cost-effective strategy for guiding decision making (Cody and Asher 2014; Metz et al. 2015). By leveraging data available in administrative records, model developers can test interventions more quickly than evaluations that require collecting data. Because the outcomes need to be observable in a short period of time, it is most useful in looking at outputs and impacts on intermediate outcomes. Rapid cycle evaluations can be particularly useful in testing potential solutions to implementation difficulties. For example, this type of evaluation could be used to test interventions for increasing ongoing attendance rates of informal caregivers participating in ELR (such as altering the time of day events are offered, offering transportation, or using text message reminders); ELR administrative data could serve as a data source for tracking whether the interventions led to increased attendance. In this way, it is a powerful tool for informing decision makers about ways to continually improve program models.

Model developers and other decision-makers may also be able to collaborate with networks of researchers to implement these types of evaluations. For example, the Network for Infant/Toddler Researchers (NITR) sponsored by OPRE, collaborative innovation and improvement networks (CoIINs), and Early Learning Labs could serve as forums for supporting development of ECE models for infants and toddlers. These networks bring together practitioners, researchers, and experts for mutual learning. Early Learning Labs aim to accelerate experimentation and development of scalable early learning interventions.

Key Findings

- LITES defined “compelling models” as models that are viewed by the ECE field as having potential to promote infant and toddler early learning in out-of-home settings, but have not yet been rigorously evaluated. LITES prioritized models that met at least two of the following four criteria:
 1. At least one descriptive study of child outcomes with potentially positive findings (2 models met this criteria)
 2. At least one impact study with positive findings on *interim* outcomes (3 models met this criteria)
 3. Documentation to support replication (all 13 models met this criteria)
 4. Used in at least two independent sites or, for curricula, in at least five percent of Early Head Start programs (all 13 models met this criteria)
- LITES examined infant and toddler early learning models that targeted children’s cognitive, language, or social-emotional/behavioral development. LITES identified compelling models through a nomination process and discussion with a small group of experts in the field. Together with the systematic review, the two components provide an extensive picture of available models to support infant and toddler early learning, including those with rigorous evidence of effectiveness on child outcomes and those considered compelling in the field but lacking rigorous research evidence. LITES, however, does not provide an exhaustive review of all available infant and toddler early learning models nor the full range of descriptive research conducted on them.
- LITES identified 13 compelling models to support infant and toddler early learning in out-of-home ECE settings that have potential for the field but not yet rigorously evaluated.
 - 2 models provide direct early learning services to infants and toddlers.
 - 6 models provide coaching, modeling, or consultation to help caregivers support infant and toddler early learning.
 - 5 models are infant/toddler curricula.
- The outcomes targeted by the compelling models include children’s development (9 models), caregiver knowledge and skills (3 models), and environment quality (3 models).
 - Of the nine models targeting children’s development, seven (including all five curriculum models) target multiple domains of development including language, cognition, and social emotional/ behavioral development and two (both mental health consultation models) target only children’s social emotional/ behavioral development.
 - Although only three models specifically target caregivers’ knowledge and skills, all 13 models include supports for caregivers (such as offering training, coaching, or consultation to caregivers, or implementation guides and other materials).
- The level of specification of the compelling models varied. All models could benefit from additional guidance on how to implement with fidelity. Staff in many infant and toddler ECE settings may be using models with limited training or support, potentially resulting in wide variation in implementation.
- Eight of the 13 models had at least some research, usually a single implementation or descriptive study. Two models had descriptive studies measuring child outcomes and four had descriptive studies measuring interim outcomes. Three models had impact studies examining interim outcomes, and impact studies examining child outcomes were under way for two models. None of the curricula models had existing research.
 - Across the five descriptive and three impact studies of interim outcomes, the outcome domains measured included observed quality (seven studies) and caregiver knowledge and skills (four studies).
 - Across the two descriptive studies of child outcomes both measured social-emotional/behavioral development and one also measured school readiness and vocabulary.
 - The three models with impact studies of interim outcomes were all professional development models; the findings pointed to the potential of these models to improve observed quality and increase caregiver knowledge and skills.
- A full spectrum of implementation and outcome research is needed to develop well-specified ECE models, test the feasibility of implementation, develop fidelity standards and measures, and assess whether the models show potential for improving infant/toddler early learning outcomes. This research would lay the groundwork for rigorous evaluation to test model effectiveness.

I. INTRODUCTION

A growing body of research indicates that high quality early learning experiences can promote young children's development and help to reduce achievement gaps (Camilli et al. 2010; Duncan and Magnuson 2013). Recent research bringing together neuroscience, child development, and economic perspectives has made the case that children's prenatal and early experiences are deeply influenced by poverty, with impacts on cognitive, social-emotional, and physical health outcomes that extend into the school years and beyond (Camilli et al. 2010; National Scientific Council on the Developing Child 2007; Halle et al. 2009; Yoshikawa et al. 2013). These findings have emphasized the need for high quality early learning experiences for disadvantaged children that can promote young children's development and reduce achievement gaps. Research is building about the effectiveness of preschool programs for preparing children for entry into kindergarten and beyond, yet less is known about effective program models to support infant and toddler early learning. Therefore, to help inform research, policy, and program directions at the federal, state, and local levels, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in partnership with the Office of Planning, Research and Evaluation (OPRE), within the U.S. Department of Health and Human Services, funded Mathematica Policy Research and its partners to conduct the Learning about Infant and Toddler Early Education Services (LITES) project.

The project includes a systematic review to identify effective out-of-home early care and education (ECE) models for infants and toddlers (Monahan et al. 2015). The systematic review is designed to identify models for infants and toddlers with the strongest evidence of effectiveness in improving children's outcomes in the domains of cognitive, language, and social emotional/behavioral development. The LITES project also includes a scan of the field for infant-toddler ECE models that are of interest (or "compelling") for supporting infant/toddler development in these domains, but currently lack rigorous research examining impacts on children's developmental outcomes. For both components, we examined infant and toddler early learning models that targeted children's cognitive, language, and/or social-emotional/behavioral development. For the systematic review, we conducted a comprehensive literature review to identify studies with eligible research designs, rated the quality of the studies, and examined evidence of effectiveness on children's outcomes. In contrast, for the compelling models scan, we identified models through a nomination process and discussion with experts in the field.¹⁰ This report focuses on the compelling models scan.

Together, the two components provide a picture of available models to support infant and toddler early learning, including those with rigorous evidence of effectiveness on child outcomes and those considered compelling in the field but lacking rigorous research evidence. This later component is a unique contribution of LITES since most systematic reviews do not include a category of models without rigorous research on the identified outcomes of interest. LITES, however, does not provide an all-inclusive review of all available infant and toddler early

¹⁰ We developed the compelling models nomination process to identify models considered compelling by ECE experts. Because it was a nomination process, this report does not provide a representative or exhaustive list of all possible replicable program models that support infant and toddler early learning in out-of-home ECE settings and lack rigorous research.

learning models nor the full range of descriptive research conducted on them. An exhaustive scan for all potential programs was beyond the scope of this report. For example, we did not consider models with only studies rated as low quality in the systematic review for the compelling models scan. The models with only low-rated studies are described in Appendixes A and B of Monahan et al. 2015.

Recognizing that some ECE models for infants and toddlers have only preliminary evidence, this report focuses on what can be learned from these compelling models that are of interest to the field. The purpose of this scan for compelling program models is to identify and highlight models that warrant further consideration by researchers, policymakers, and practitioners due to their potential for contribution to the field. These include models with studies that do not have sufficiently rigorous designs, such as descriptive outcome studies; models for which rigorous evaluations are under way but not yet completed; models with high quality implementation studies but no impact evaluations; and other models that lack rigorous evidence but are compelling to the field and warrant further study. In this report, we describe these compelling models, examine and summarize the evidence supporting each of them, and identify associated research gaps. The report provides an overview of newly developed and existing models in the field that may be ready for more rigorous evaluation. An understanding of these models and gaps in the research can move the field toward more rigorous, high quality research designs to better assess the effectiveness of program models designed to support infant and toddler early learning.

For this project, we defined *compelling models* as models that are viewed by the ECE field as having potential for promoting infant and toddler early learning in the domains of cognitive, language, or social-emotional/behavioral development, but have not yet been rigorously evaluated to examine impacts on these outcomes. To ensure potential replication in new settings, we focused the project on well-specified models that included a defined package of components of infant and toddler early learning services or professional development to help caregivers support infant and toddler early learning.¹¹ We defined *well-specified models* as those that had: (1) clear inclusion and exclusion criteria that define the population for which the model is intended, (2) a clear description of the model components or features that must be present, and (3) clear practice guidance to promote consistency of service delivery (such as the availability of implementation guides and staff training materials, requirements for staff qualifications, or the availability of ongoing technical assistance; Fixsen et al. 2013).

This report profiles 13 compelling infant and toddler ECE models that were identified through the LITES search methodology (see section B below), summarizes available research on these models, and suggests additional research needed to inform model development and support replication, and ultimately to demonstrate evidence of effectiveness (see Box I.1). Many of these models have been replicated but have not yet been rigorously evaluated. A few of the models have descriptive studies examining children's outcomes or rigorous evaluations examining

¹¹ Out-of-home early learning services for infants and toddlers often draw on a series of theoretical approaches, such as Reggio Emilia and Montessori, and practices, such as continuity of care and primary caregiving. These approaches and practices are implemented in a range of configurations and intensities across settings, thus making them difficult to replicate consistently without further specification. Therefore, LITES does not feature these approaches and practices in this report, even though they are prevalent in the field.

interim outcomes,¹² but all lacked publically available rigorous evaluations examining effects on children's outcomes.¹³ Two are models that provide direct early learning services to infants and toddlers. Six models focus primarily on working with caregivers through coaching, modeling, and/or collaborative consultation to help them support children's early learning,¹⁴ and an additional five models are curricula implemented in programs for infants and toddlers.¹⁵ Although the models broadly fall into the three categories described, in practice, there is overlap across the categories. For example, most of the direct early learning models and curriculum models we profiled include staff training, and some include ongoing support in the form of coaching or other consultation. In addition, two of the models focused on working with caregivers include a curriculum model that participants implemented in their ECE settings.

¹² Interim outcomes are those *other than* child outcomes that are thought to be related to child development. For LITES, this included the following domains: global ECE quality, structural features of care, caregiver-child interaction, and caregiver knowledge of child development.

¹³ To be eligible for the systematic review, the models had to have eligible research designs examining the impact of the models on child outcomes in the domains of language, cognition, and/or social emotional/behavioral development.

¹⁴ The models profiled employ varying approaches to ongoing support, including coaching, mentoring, and consultation beyond a one-time training. *Coaching* is a relationship-based process led by an expert with specialized skills and knowledge, who often serves in a different professional role than the recipient(s) (National Association for the Education of Young Children and National Association of Child Care Resource and Referral Agencies 2011). *Mentoring* involves guidance from a more experienced teacher to a less-experienced mentee to increase professional capacity and effectiveness. *Consultation* is a collaborative problem-solving process typically focused on addressing a specific issue or topic. Mentoring and coaching are often used interchangeably to describe individualized professional development interventions that involve establishing a relationship between a mentor or coach and learners, conducting observation and assessment, demonstration and practice, and on-the-job guidance (Head Start Bureau, 2001; Hanft et al., 2005). Throughout this report, we use the model developers' own language when referring to these models.

¹⁵ For purposes of this project, we used the definition of *curriculum* Epstein et al. (1996) used in their review of models of early childhood education. They defined a curriculum as a set of education practices that are recommended from a specific theoretical viewpoint. Further, we focused on models that included documentation to support implementation of the practices.

Box I.1. Compelling models prioritized for inclusion in the report

Models that provide direct early learning services to children:

- Early Learning Readiness Program for Informal Family, Friend, and Neighbor Caregivers
- Educare

Models that primarily focus on professional development with caregivers:

- Early Childhood Consultation Partnership
- Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching
- First Beginnings (Philadelphia Inclusion Network)
- Infant Caregiver Mentoring Project
- Seeds to Success
- Smart Support

Curricula models:

- Assessment, Evaluation, and Programming System, Second Edition, Curriculum for Birth to Three Years
- The Creative Curriculum for Family Child Care, Second Edition
- The Creative Curriculum for Infants, Toddlers & Twos, Third Edition
- Hawaii Early Learning Profile 0-3
- HighScope Infant-Toddler Curriculum

Across the 13 models, the range of target outcomes include children’s development (9 models), caregiver knowledge and skills (3 models), and environment quality (3 models; Appendix B, Table B.1). Of the nine models targeting children’s development, seven (including all five curriculum models) target multiple domains of development, including language, cognition, and social emotional/behavioral development and two (both mental health consultation models) target only children’s social emotional/behavioral development. Although only three models specifically target caregivers’ knowledge and skills, all 13 models include supports for caregivers (such as offering training, coaching, or consultation for caregivers, or implementation guides and other materials) to help them support children’s development and/or improve program quality.

Within categories of models we identified common features. Specifically, the models primarily focused on professional development for caregivers were most often relationship-based, one-on-one interventions that were offered to caregivers in ECE settings and were focused on achieving specific and articulated objectives. Most of the models were intensive with services offered weekly or biweekly and substantial in duration lasting from four to six months. According to the research literature, these features may represent effective practices in professional development (U.S. Department of Education 2010). All five curricula models are linked to child assessment tools; the assessments are designed to guide caregivers in how they individualize services for children. These models also include preschool versions (some of which have been rigorously evaluated) allowing for continuity of approaches from birth to age 5 years.

In the remainder of this chapter, we describe the criteria we used to identify and select compelling models. Chapter II includes detailed profiles of the 13 models that we identified, including information about model implementation and existing research. In Chapter III, we describe the research gaps and recommend directions for future research to fill these gaps and build the knowledge base.

A. Defining out-of-home infant and toddler ECE services

We focused this scan of the field on models designed to improve children's outcomes either directly by providing out-of-home early learning services to children, or indirectly by working with children's out-of-home caregivers to help them support early learning.¹⁶ We considered models that focused on multiple domains of children's development, such as cognitive, language, or social-emotional/behavioral domains, as well as targeted interventions that could be layered on top of another model and focused on improving children's outcomes in a single domain or improving caregiver practice in a single area.

As discussed earlier, we focused on well-specified models. We set this requirement because the translation from science to practice is a critical step for practitioners to implement models consistently and in adherence with a developer's intent (Wandersman et al. 2008). In addition to translating science into practice, support systems (such as pre-service and in-service training) are needed to help practitioners replicate models as intended (Wandersman et al. 2008). Well-specified, replicable models can be rigorously evaluated, and if found to be effective, can be adopted by other ECE service providers to support children's healthy development. Defining a model so that it can be replicated by others requires a degree of model specification, as well as the development and use of measures to assess whether it was implemented with fidelity, in adherence with model specifications (Dane and Schneider 1998; O'Donnell 2008).

To be considered eligible for LITES, models also had to meet the following inclusion criteria:

- The target population for the model had to include infants and toddlers, defined as children from birth to age 36 months.¹⁷ Models could include other age groups as well; for example, they could target children from birth to age 5.
- Models had to be targeted broadly to infants and toddlers and/or their adult out-of-home caregivers. Models targeted narrowly to infants and toddlers with diagnosed disabilities or specific medical conditions were not included in the review.¹⁸ However, models targeted

¹⁶ Program models that provide infrequent or supplemental home visits were considered for inclusion in the review, but only if the primary service setting was out-of-home care. Program models that provide supplemental services in areas such as nutrition, health and developmental screening, supports for parents, and referrals to other community resources were considered for inclusion in the review, but only if the primary focus was on services delivered outside the child's home to support infant and toddler early learning. Program models that provide professional development to adult out-of-home caregivers were considered for inclusion in the review as long as the professional development involved intervening directly with caregivers, took place in the caregiving setting or a similar setting, and focused on helping caregivers support infant and toddler early learning. Other indirect services—such as parenting, family self-sufficiency, or referral services—were not included, because they do not target children's early learning in out-of-home care settings.

¹⁷ Programs that enroll families before the child's birth were considered in the review, as long as the primary focus of the model was supporting children's early learning in out-of-home ECE settings.

¹⁸ The federal government makes specific investments in special education and to support the development of children with disabilities. The focus of this review is to identify effective program models for supporting early learning among a broad range of infants and toddlers.

toward broad groups of at-risk infants and toddlers (for example, children from low-income families or low-birth weight children) were eligible for inclusion.

- The majority of services had to be provided outside of the child’s own home. Models could be implemented in center-based settings, such as ECE classrooms or child care centers, or in home-based settings such as family child care homes or informal caregivers’ homes.

The primary distinction between the models included in this report and those included in the LITES systematic review is the availability of eligible research examining the impact of the models on child outcomes in the domains of language, cognition, and/or social emotional/behavioral development. For compelling models, we were interested in models that showed potential for promoting the early learning of infants and toddlers, but lack studies with eligible designs examining impacts on children’s outcomes from which causality can be inferred.¹⁹ The systematic review, in contrast, included only models that had at least one impact study examining children’s outcomes. More information about the specific eligibility criteria for the systematic review can be found in the systematic review report (Monahan et al. 2015).

B. Identifying and selecting the 13 compelling models

In consultation with ASPE and an expert work group, Mathematica developed a process for identifying and selecting models for inclusion. The process involved two steps: (1) identifying compelling models through a call for nominations and outreach to experts, and (2) selecting models to profile by applying prioritization criteria.

1. To identify models, we relied on input from the field solicited through a call for nominations and outreach to experts

We relied on two primary strategies for identifying compelling models. First, we disseminated a call for nominations to a selected group of electronic mailing lists for practitioners and researchers in ECE and related fields (Appendix Table A.1). The call for nominations described the purpose of the project and the types of models of interest, and provided instructions for submitting a nomination. We disseminated the call for nominations on May 30, 2014. It was open for eight weeks, with an end date of July 25, 2014.

We also solicited nominations from a range of experts in ECE and related fields. The primary role of the expert work group was advising us on our approach to identifying and selecting compelling models (Table I.1). We also asked them for suggestions of models we should consider. We worked with ASPE and the expert work group to identify other practice and research experts to contact. We ultimately conducted brief, informal telephone discussions with three additional experts to ask for their input (see Table I.1). Finally, our federal project officers solicited recommendations from colleagues within ASPE and ACF.

Multiple experts recommended that we include curriculum models used in infant and toddler ECE. To identify curricula commonly used by infant/toddler caregivers, we examined two

¹⁹ Consistent with the LITES systematic review, we defined impact studies as those with an RCT, matched comparison group design, regression discontinuity design, or single-case design.

sources. First, we reviewed findings from the Early Head Start Family and Child Experiences Survey (known as Baby FACES), a descriptive study of a representative sample of Early Head Start programs and the children and families they serve. Second, we reviewed data from the Head Start Program Information Report, which contains self-reported administrative data from all Early Head Start programs nationally. Across both sources, we identified relevant curricula used by at least 5 percent of Early Head Start programs.

Finally, we reviewed models that were screened out of the LITES systematic review because they lacked impact studies examining children's outcomes. Together, these processes yielded a total of 64 nominated models (Appendix Table A.2 lists each model and the nomination source).

Table I.1. LITES compelling models expert work group members

Expert	Affiliation
Expert work group members	
Clancy Blair	New York University
James Elicker	Purdue University
Diane Horm	University of Oklahoma-Tulsa
Julia Isaacs	Urban Institute
Brenda Jones Harden	University of Maryland
Pamela Morris	New York University
Kathy Thornburg	University of Missouri
Practice and research experts	
Jennifer Boss	Early Head Start National Resource Center, ZERO TO THREE
Rachel Chazan Cohen	University of Massachusetts, Boston
Sandra Petersen	Early Head Start National Resource Center, ZERO TO THREE

Next, we reviewed information on each model identified to determine whether it fit within the scope of the LITES project. Using the inclusion criteria described above as our guide (age of target population; broadly targeted all infants/toddlers or non-parental caregivers of infants/toddlers; most services provided outside of the child's own home), we screened out 43 of the 64 models. See Appendix Table A.2 for more detailed information about the reasons models were screened out. Models were screened out for a variety of reasons, primarily because they were implemented in the child's home or targeted parents rather than out-of-home caregivers. In the case of curricula, if they did not meet the prevalence requirement (used in at least 5 percent of Early Head Start programs as determined by examining data from the Head Start Program Information Report and Baby FACES), they were also screened out.

2. We prioritized models for review that had suggestive favorable evidence and strong potential for replication

We applied four criteria to prioritize which of the remaining 21 models to profile. These criteria address different ways in which a model could be considered compelling. The first two criteria highlight models with suggestive favorable evidence on child outcomes or interim outcomes. The second two criteria emphasize models that have strong potential for replication. The four criteria are:

- 1. Descriptive Research:** The model had at least one descriptive study (meaning a study without a comparison group) that measured children's outcomes. Of particular interest were

studies that showed potentially positive findings in at least one of the following child outcome domains: cognitive, language, or social-emotional/behavioral development.

2. **Interim Outcomes:** The model had at least one study measuring impacts on interim outcomes thought to be closely related to children’s early learning in out-of-home ECE settings, including the following:
 - Structural features of out-of-home ECE settings, including child-to-staff ratios; group size; caregiver qualifications; professional development; the physical environment and furnishings; schedules/routines; and health, safety, and nutrition practices
 - Caregiver–child interaction in out-of-home ECE settings, including sensitivity/responsiveness, learning and language supports/instruction, positive regard/warmth, behavior guidance, support for peer interaction, and areas of concern in interactions
 - Out-of-home caregiver skills or knowledge of infant-toddler caregiving practices
 - Global ECE quality
3. **Well-Specified:** The model was well-specified and had documentation available to support replication; documentation could come from at least one study of any design or model materials, such as implementation or training guides or a model’s website.²⁰
4. **Prevalent:** The model was prevalent in the field. For curricula, we set a threshold of reported use in at least 5 percent of Early Head Start programs (see above). For other models, we set a minimal threshold of use in at least two independent sites.

The LITES team ranked models based on the number of criteria they met. In consultation with ASPE, ACF, and an expert work group of researchers, we determined that models that met two or more of these criteria would be most compelling to the field and should be highlighted in this report. This process resulted in a final list of 13 models. Table I.2 lists all 21 models and shows which of the four criteria each met, and also indicates the 13 that met more than one criterion and were therefore profiled in this report. The 13 selected models that met more than one criterion are also described in detail in Chapter II.

²⁰ As described earlier in this chapter, we defined *well-specified models* as those that had: (1) clear inclusion and exclusion criteria that define the population for which the program is intended, (2) a clear description of the program components or features that must be present, and (3) clear practice guidance to promote consistency of service delivery (such as the availability of implementation guides and staff training materials, requirements for staff qualifications, or the availability of ongoing technical assistance; Fixsen et al. 2013).

Table I.2. Screened in models and prioritization criteria

Model	Descriptive study measuring children's outcomes	Study measuring impacts on interim outcomes	Well-specified with documentation to support replication	Prevalent
Models that met more than one criterion and were selected for inclusion				
Models that provide direct early learning services to children				
1. Educare	✓		✓	✓
2. Early Learning Readiness (ELR) Program for Informal Family, Friend and Neighbor Caregivers			✓	✓
Professional development models				
3. Early Childhood Consultation Partnership			✓	✓
4. Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching		✓	✓	✓
5. First Beginnings (Philadelphia Inclusion Network)			✓	✓
6. Infant Caregiver Mentoring Project		✓	✓	✓
7. Seeds to Success		✓	✓	✓
8. Smart Support	✓		✓	✓
Curricula models				
9. Assessment, Evaluation, and Programming System			✓	✓
10. The Creative Curriculum for Family Child Care			✓	✓
11. The Creative Curriculum for Infants, Toddlers & Twos			✓	✓
12. Hawaii Early Learning Profile 0-3			✓	✓
13. HighScope Infant-Toddler Curriculum			✓	✓
Models that met one or no criteria and were excluded				
14. Ball State University Child Study Center				
15. Comprehensive Child Development, Inc.				✓
16. Cuyahoga County Early Childhood Initiative				✓
17. Emotional Beginnings				
18. Piper Center for Family Studies and Child Development at Baylor University				
19. Promethean Foundation (Pro-Kids)				✓
20. Responsive Infant/Toddler Practice within a Suite of Inquiry				
21. San Diego State University Children's Center				

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II. COMPELLING MODELS: COMPONENTS AND EXISTING RESEARCH

In this chapter, we present profiles of the 13 models we identified as compelling to the field and prioritized for inclusion in this report. Each profile includes as much information as possible about model implementation, including an overview of the model and its core components, the target population, targeted outcomes, dosage and program length, requirements for staff, and the types of supports available for replication. The profiles also discuss existing and ongoing research, if any was identified. Appendix B lists the model components and implementation guidelines across all 13 models.

To gather information about the models for the profiles, we conducted a literature search and reviewed publically available materials. We conducted a targeted literature search on the names of selected models to identify any existing research. Relevant research included causal studies that measured only interim outcomes, descriptive studies that measured children's outcomes, and implementation studies. Appendix C describes the literature search methods and results. We also conducted Internet searches to identify publically available information about model implementation, such as websites, implementation guides, and training materials. To ensure the accuracy of the information about implementation, we sent the profiles to the model developers for review and inquired about any research that was conducted on the models or as part of model development.²¹

We begin by presenting the two models that provide direct early learning services to children:

1. Early Learning Readiness Program for Informal Family, Friend, and Neighbor Caregivers
2. Educare

We then present profiles for the six models that primarily focus on professional development for caregivers:

1. Early Childhood Consultation Partnership
2. Expanding Quality in Infant Toddler Care course and EQ RELATE Model of Coaching
3. First Beginnings (Philadelphia Inclusion Network)
4. Infant Caregiver Mentoring Project
5. Seeds to Success
6. Smart Support

²¹ We specifically asked developers for information that we were missing about models (for example, dosage and program length). In the model profiles, we note if the developers did not clarify information that was missing when they responded to our inquiries.

Finally, we profile the five curricula models:

1. Assessment, Evaluation, and Programming System, Second Edition, Curriculum for Birth to Three Years
2. The Creative Curriculum for Family Child Care, Second Edition
3. The Creative Curriculum for Infants, Toddlers & Twos, Third Edition
4. Hawaii Early Learning Profile 0-3
5. HighScope Infant-Toddler Curriculum

DIRECT EARLY LEARNING SERVICES MODELS

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EARLY LEARNING READINESS (ELR) PROGRAM FOR INFORMAL FAMILY, FRIEND, AND NEIGHBOR CAREGIVERS

A. Overview

1. Overview, model components, and content

The Early Learning Readiness (ELR) Program for Informal Family, Friend, and Neighbor Caregivers is designed to promote the healthy development and school readiness of children, both directly and by increasing the skills and knowledge of their caregivers. It is targeted to children receiving care in informal child care settings, and their informal caregivers. These children and their caregivers participate together in the program through sessions that are facilitated and held in a group setting. Sessions are held at a community location selected for its accessibility, such as a church, community center, public housing or apartment building, YMCA, or library. A typical session consists of the following: (1) an opening circle time where the children and caregivers read stories and sing songs together; (2) time to explore a range of activities at 13 interest centers; and (3) a closing circle to review the day's learning. During the sessions, facilitators talk with caregivers about the interest centers, how the activities encourage learning in children, and the role caregivers can play in promoting learning and development using the activities. In addition, activities at each center include written guidance for caregivers that list learning concepts, vocabulary words, and questions caregivers can ask the children. Session content features monthly, culturally sensitive themes and is designed to align with local standards for school readiness. Volunteers assist sites with several aspects of running the program, including recruiting participants, setting up the sessions, and translating for participating caregivers whose primary language is not English. The program also collaborates with local community partners to provide additional resources and supports. The ELR program is run by the YMCA of the USA (Y-USA) and is based on the Tutu and Me program model that was developed by the Partners in Development Foundation to work with informal caregivers (primarily grandparents) in Hawaii (Partners in Development Foundation 2014).

2. Target population, including available languages

- The ELR program serves children from birth to age 5 who receive informal care from family members, friends, and neighbors, as well as their informal caregivers. The program targets low-income families and populations, although it is not clear whether income requirements are used to determine eligibility.
- The program serves children whose families speak one or more of a variety of languages at home. The majority of ELR participants speak Spanish, but in some communities other languages are also represented, including Russian, Chinese, Somali, Arabic, Vietnamese, Japanese, and Hindi. Volunteers and fellow caregivers help translate when caregivers experience language barriers related to program participation.

3. Targeted outcomes

- The ELR program is designed to promote the healthy development and school readiness of children, both directly and by increasing the skills and knowledge of their caregivers.

4. Dosage and program length

- The program is offered twice per week and each session is two hours. In most sites, the program is offered for 38 to 42 weeks during the school year.

5. Staff requirements, including staff type, education, and experience

- In each site, the program is led by a local ELR supervisor and is implemented by one or more facilitators.
- Y-USA recommends that local ELR supervisors and facilitators have a background in early childhood, education, or social work. Specific skills vary by site, with hiring decisions made at the local level.

6. Supports for implementation

- The program has a training plan for newly hired local staff that includes in-person training sessions, online modules on broader topics such as development and achievement gaps, and webinars on specific program components. These materials are posted to an online community that all ELR staff can access.
- Y-USA technical advisors are available to coach, monitor, and support local staff.
- National program staff (from Y-USA) conduct site visits to local programs to assess program fidelity and quality, especially for new sites and groups. Local staff also monitor and report on key fidelity and quality indicators to national program staff each month during the program year. Fidelity standards address the materials/environment, circle time, interest centers, and administration. Quality measures assess the quality of interactions, engagement, and content covered during sessions. Training for new staff covers fidelity measures and evaluation; this information is also available for local sites on the online community maintained by Y-USA for local ELR staff.
- Y-USA is piloting a mentoring program that partners local YMCA leaders who have successfully implemented the program with staff at sites that are new or have struggled with the program.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- The program operates at local YMCA sites in 26 states across the country. Sites are located in neighborhoods with low educational achievement, high concentrations of poverty, or a large population of new U.S. residents.

B. Summary of existing research

Y-USA conducts an annual internal evaluation of the ELR program, using data collected from local ELR sites. The evaluation assesses program implementation and participant outcomes and is used to inform program improvement efforts. Table 1 provides an overview of the 2013–2014 ELR program evaluation (Y-USA 2014). Below we discuss the findings from the 2013–2014 study.

- Each month, local ELR supervisors reported whether their site met a series of program-developed fidelity indicators and quality measures. Fidelity items determine the extent to

which the local site's program aligns with the original Tutu and Me model for materials/environment, circle time, the 13 interest centers, and program administration. The quality items rate the program content, the engagement of participating children and caregivers, and the interactions between children, caregivers, and facilitators. The median percentage of fidelity indicators met each month ranged from 86 to 95 percent, and the median percentage of quality measures met each month ranged from 94 to 100 percent. Site visits from national program staff in the fall and spring of the program year found that sites met a median of 86 percent of the same fidelity indicators and 94 percent of the same quality indicators in both the fall and spring.

- Attendance data showed that 15 percent of caregivers attended more than 40 sessions (the median number of sessions offered was 72), whereas 48 percent attended fewer than 10 sessions.
- Caregivers were surveyed during the program year and at the end of the year. Although only 23 percent of participating caregivers responded to the end-of-year survey, most of these respondents reported that the program improved their caregiving knowledge and behaviors, and that they were very satisfied with the program. For example, 90 percent of the 415 caregivers responding to the survey agreed that the program helped them understand more about how to have positive relationships and interactions with young children in their care, and another 9 percent said they somewhat agreed with this statement. Seventy-seven percent of caregivers rated program activities as excellent, with the remaining 23 percent rating them as good.
- Finally, ELR staff reported on outcomes of children ages 3 to 5 in five developmental domains (physical well-being and development, social and emotional development, language and literacy development, cognition and general knowledge, and approaches to learning) at the beginning and end of the year using a program-developed observation form. In addition, caregivers of children ages 3 to 5 were surveyed on how the program had helped the skills and behavior of children in their care. However, we did not review these findings because they applied to preschool-age children only, which made them outside the scope of this report.

C. For more information

Jennifer Mortensen, Ph.D.
Specialist, Program Evaluation-Early Learning Readiness
YMCA of the USA
101 N. Wacker Drive, Chicago IL 60606
800-872-9622 ext. 8388
jennifer.mortensen@ymca.net

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YMCA of the USA. “Sharing Our Success: 2013-2014 Early Learning Readiness Evaluation Report.” Chicago, IL: September 30, 2014.

Table 1. Overview of existing research, ELR

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Y-USA 2014	Implementation; pre-post	1,986 children and 1,820 caregivers in 94 groups at 36 local sites attended at least once	<i>Characteristics of caregivers who attended at least three times</i> (range of n = 1,021 to 1,298 with data): Median age 32; 94 percent female; 59 percent Hispanic/Latino, and 10 percent African American/Black; 56 percent language other than English primarily spoken at home; 50 percent high school education or less	Program-developed indicators of fidelity (materials/environment, activities, administration) and quality (program content, participant engagement, participant/facilitator interactions)	Program-reported administrative data from monthly self-reports by local sites and data collected during local site visits conducted by Y-USA staff in fall and spring of the program year
		1,640 children and 1,414 caregivers attended at least three times		Program attendance	Program-reported administrative data
		415 caregiver end-of-year survey respondents	<i>Characteristics of children who attended at least three times</i> (range of n = 1,413 to 1,533 with data): Mean age 2.7; 4 percent under age 1, 39 percent age 1-2, and 57 percent age 3-5; 51 percent female, 56 percent Hispanic/Latino, and 11 percent African American/Black; 56 percent language other than English primarily spoken at home	Caregiver self-report on the role of the program on caregiving knowledge and behavior and, for caregivers of children ages 3 to 5 only, on child skills and behavior; caregiver satisfaction with program	Survey of caregivers

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EDUCARE

A. Overview

1. Overview, model components, and content

The Educare Learning Network is a national network of schools that provide full-day, full-year early care and education to low-income children from birth to age 5. The Educare model contains several core features, which are grouped into four domains: (1) data utilization, (2) high quality teaching practices, (3) embedded professional development, and (4) intensive family engagement.

Under a system of continuity of care, children stay with the same teaching team and cohort of children from program entry until they transition to Educare's Head Start services at age 3. Children then stay with a second team until they transition out of Educare and into elementary school at age 5. Within each teaching team, every child has a primary caregiver who is assigned no more than four infants and toddlers or nine preschoolers, which is designed to allow caregivers to develop a close rapport with each child and family. Three adults are assigned to each classroom of eight infants and toddlers or 17 preschoolers. Groups of staff from up to four classrooms are supervised by master teachers who provide mentoring, coaching, and support to classroom teachers.

The Educare network does not use any one early childhood curriculum; rather, local Educare sites choose their own curriculum. It must be research-based and focus on pre-literacy, early math, and social-emotional skills, and integrate development of these skills with arts activities. In addition to direct early care and education, Educare schools offer on-site family engagement services, provided by full-time family support supervisors and specialists, to promote parent involvement. These staff also coordinate referrals for parents to other services. The Educare model emphasizes an interdisciplinary approach in which staff from different roles work together to promote child and family well-being, and the use of reflective practice and supervision among staff.

Each Educare school is a public-private partnership and blends private dollars with funding from federal Early Head Start and Head Start, and state and local education and child care funding. Some Educare schools offer prenatal services through Early Head Start.²² The Ounce of Prevention Fund and Buffett Early Childhood Fund oversee and support the Educare Learning Network of schools.

2. Target population, including available languages

- Educare serves at-risk children from birth to age 5 and their families. Families must meet Head Start income requirements to qualify for enrollment (this means the family's gross

²² The Early Head Start model is included in the LITES systematic review (Monahan et al. 2015). Although some Educare programs may receive funding from Early Head Start, Educare is a distinct model of early education services and does not yet have rigorous research examining its impacts on children's outcomes. Therefore, we profile it as a compelling model in this report.

income must not be more than 100 percent of the federal poverty guidelines). Children with special needs are encouraged to apply.

- In addition to children from monolingual English-speaking homes, many Educare schools serve dual language learners, which mostly includes children from homes where Spanish is the primary language used.

3. Targeted outcomes

- Educare aims to prepare low-income children to succeed in school, career, and life. Each local site selects a research-based curriculum focused on the development of skills as they relate specifically to language and literacy, social-emotional development, early math concepts, problem-solving, and motor development.
- Family engagement work aims to strengthen parents' abilities to support their child's learning as an educator and nurturer, as a leader and advocate for their child, and to promote family well-being after they leave Educare.

4. Dosage and program length

- Educare provides full-day, full-year services. Children attend Educare schools a minimum of six hours per school day; specific operational hours of a school are determined based on the feedback from each school's community needs assessment and parents' work and school schedules. Children can participate for up to five years (from 6 weeks old to kindergarten entry).

5. Staff requirements, including staff type, education, and experience

- Each classroom has a lead teacher with a minimum of a bachelor's degree in early childhood education; an assistant teacher with a minimum of an associate degree in early childhood education; and a teacher aide with a high school diploma/GED and a credential in child development or training in infant and toddler development.
- Master teachers have master's degrees in early childhood education; for birth-to-age-3 classrooms, they have special training in infant and toddler development.
- Family support supervisors have master's degrees in social work or a related field, and family support specialists have bachelor's or master's degrees in social work, health, or a related field.

6. Supports for implementation

- Groups interested in starting an Educare school in their community must work with the Ounce of Prevention Fund and Buffett Early Childhood Fund to plan and implement the school.
- The national Educare staff help local partners fully implement the model over time through strategies that include intensive technical assistance, consultation, training, and a professional learning community of leaders at Educare schools.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- There are 20 Educare schools located in 17 communities across 13 states and the District of Columbia. Within each community, the schools are operated by local partnerships of philanthropic organizations, Head Start and Early Head Start providers, school districts, and other partners.

B. Summary of existing research

Since 2005, Educare has partnered with the Frank Porter Graham Child Development Institute at the University of North Carolina at Chapel Hill and local research institutions in Educare communities to conduct an ongoing implementation study of the Educare model. Every Educare school participates in this study, for which a brief was published in 2012 containing findings for the 2007–2008 to 2010–2011 school years (Yazejian and Bryant 2012). The brief included findings on overall infant/toddler classroom quality based on the Infant/Toddler Environment Rating Scale-Revised (ITERS-R; Harms et al. 2003). For preschool classrooms, the corresponding measure was the Early Childhood Environment Rating Scale (Harms et al. 2005), and the Classroom Assessment Scoring System (Pianta et al. 2008) is also used in preschool classrooms to measure the quality of emotional support, instructional support, and classroom organization. The brief’s findings on children’s outcomes include school readiness from the Bracken Basic Concepts Scale (Bracken 1998, 1984); vocabulary based on the Peabody Picture Vocabulary Test (PPVT; Dunn and Dunn 2007); and social and emotional skills using the Devereux Early Childhood Assessment (DECA; LeBuffe and Naglieri 1999). Outcomes for children were measured at the end of their participation in the program (as they were leaving for kindergarten), whether they started in Educare at an earlier or later age.

Table 1 provides an overview of this study, whose main findings are discussed below.

- Across 12 Educare schools studied in 2010–2011, 70 percent of infant and toddler classrooms scored a 5 or above on the ITERS-R scale of 1 to 7, with an average quality rating of 5.3. In comparison, 24 percent of classrooms in the nationally representative Early Childhood Longitudinal Study-Birth Cohort scored a 5 or above on the ITERS-R (Mulligan and Flanagan 2006).
- The average Bracken school readiness score for English-speaking children upon exiting Educare for kindergarten from 2007–2008 to 2010–2011 was 95.8, compared to a national average of 100 for all children (not just at-risk children). The average Bracken score for children from Spanish-speaking homes was 88.5. For both language groups, children who entered Educare earlier had higher average scores at program exit than children who entered later. For example, English- and Spanish-speaking children who entered Educare at age 1 had average Bracken scores of 98.5 and 98.1, respectively, at program exit compared with 93.6 and 87.8 for children who entered at age 4. These differences by age of entry were statistically significant at the 0.001 level.
- The average PPVT scores for English- and Spanish-speaking children upon exiting Educare for kindergarten from 2007–2008 to 2010–2011 was 95 and 82.5, respectively, compared with a national average of 100 for all children. As with school readiness, children had higher average PPVT scores if they enrolled in Educare at younger ages. Of those who entered

Educare at age 1, English- and Spanish-speaking children had average PPVT scores of 98.2 and 95.1, respectively, at program exit, while the scores for children who entered at age 4 were 94 and 81.5 at program exit. These differences by age at entry were also statistically significant at the 0.001 level.

- Educare children entering kindergarten demonstrated social-emotional skills on the DECA that were average or above average. The brief containing implementation study findings did not include more detailed information on the DECA results.

Another study (Du 2014) used a qualitative research design to explore the nature of public-private partnerships in early care and education, using Educare as an example. The study interviewed seven respondents involved with developing a partnership to create an Educare school in California about their perceptions of the use of these partnerships, as well as about teacher quality and supports. Because the study used an exploratory approach and did not directly examine Educare implementation or outcomes, it fell outside the scope of this report.

Finally, an RCT of the Educare model began in 2010 and is currently under way, but is not yet complete. Five Educare schools and 225 children are participating in the study, which randomly assigns children to either attend or not attend an Educare school. The first phase of the study will collect data on children's outcomes through age 3; a planned second phase would assess outcomes in preschool and first grade. The youngest children in the study will turn 3 in September 2015.

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Educare Schools: <http://www.educareschools.org/home/contactus.php>

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Table 1. Overview of existing research, Educare

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Yazejian and Bryant 2012	Implementation; descriptive outcome	More than 1,800 children total through spring 2011; 12 schools and 78 infant-toddler classrooms in 2010–2011; approximately 1,140 children with data on child outcomes from 2007–2008 to 2010–2011	Children from 2007–2008 to 2010–2011: 66 percent English speaking and 34 percent dual language learners	Classroom quality: ITERS-R School readiness: Bracken Basic Concepts Scale Vocabulary: PPVT Social and emotional skills: DECA	Classroom observations Child assessments Child assessments Child assessments

CAREGIVER PROFESSIONAL DEVELOPMENT MODELS

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EARLY CHILDHOOD CONSULTATION PARTNERSHIP (ECCP)

A. Overview

1. Overview, model components, and content

The Early Childhood Consultation Partnership (ECCP) is an early childhood mental health consultation program that operates statewide in Connecticut. The program is designed to build the capacity of caregivers (primarily non-parental caregivers such as center-based educators and family child care providers, but in some cases parental caregivers as well) by offering support, education, and on-site consultation to help them meet the social-emotional needs of children in their care. It is designed to address a continuum of care that includes promotion, prevention, and early intervention.

Services provided by ECCP consultants range in scope and can consist of (1) child-specific services, which help non-parental caregivers and family members meet the needs of a particular child; (2) core classroom services, which help a teacher or caregiver meet the needs of their classroom (and include some child-specific services); or (3) intensive center services, which help center staff build capacity to address the needs of the full center (and may include child-specific and classroom services). These services are primarily provided to child care centers and their caregivers and staff, but family child care providers can also receive child-specific services. Child-specific services also involve some work with family members, both directly through in-home observation and support and indirectly through facilitating the partnership between the child's non-parental caregivers and family members.

ECCP consultants are embedded in the communities they serve. They act as a mental health resource to a variety of early childhood community groups, conduct mental health consultation groups that meet each month, and provide specific training on social-emotional, behavioral, and mental health topics. The monthly meetings and trainings, as well as brief telephone consultations, are also available to family child care providers or other community providers. Finally, ECCP publishes brief resources (structured as postcards or one-page documents) for use by caregivers.

To guide this work, ECCP developed a set of six competencies that define the knowledge, skills, and attributes consultants need to possess:

1. Demonstrated knowledge of early childhood development, mental health, and early care and education
2. Engagement, relationship building, and collaboration with families and non-parental caregivers
3. Observation, screening, and data collection skills
4. Technical assistance that involves action plan development and strategy implementation
5. Knowledge of community systems, partnerships, and resources
6. Reflective practice

ECCP is funded by the Connecticut Department of Children and Families. Advanced Behavioral Health, Inc., a nonprofit behavioral health and management company, developed the model and oversees program implementation.

2. Target population, including available languages

- ECCP serves children from birth to age 5 and their non-parental caregivers in early care and education settings, which include both center-based care and family child care homes. In some cases, the program also provides services to children's families, including services within children's homes. ECCP aims to support children who are at risk of developing a mental health disorder or of being suspended or expelled.
- All families, non-parental caregivers, and programs of children birth to age 5 are eligible for ECCP services. To be eligible specifically for intensive center services, a center must be located in an urban area and serve more than 150 children.
- ECCP services are available in English and Spanish. Postcards and one-page resources for caregivers are available in English and Spanish, and some are also available in Chinese.

3. Targeted outcomes

- The ECCP model is designed to build the capacity of non-parental caregivers and families so they can improve outcomes for their children. These outcomes include social, emotional, and mental wellness, preventing at-risk children from developing mental health disorders, and avoiding suspensions or expulsions of at-risk children.

4. Dosage and program length

- The length of consultation services ranges from 6 weeks for child services to 12 to 14 weeks for classroom services to 9 months for center services.
- All services are conducted on a weekly basis; the length of each visit varies based on the visit type, ranging from 1.5 to 3 hours.

5. Staff requirements, including staff type, education, and experience

- ECCP consultants must have a master's-level degree in a human services field, such as social work, counseling, or child development, and preferably are licensed mental health providers. They also must have previous experience involving early childhood and mental health, including at least two years of field experience in one of these areas.
- Consultants are supervised by the ECCP leadership team, who are licensed mental health professionals and have experience with early childhood mental health consultation.

6. Supports for implementation

- ECCP's infrastructure includes a program manual used to ensure fidelity to the model and uniform service delivery. ECCP also uses a centralized information system for program operations, data collection, and reporting. The data from this system are used to create plans for delivering services, for quality assurance, and to promote fidelity to the model.
- New consultants go through an orientation and receive an initial series of trainings in early childhood mental health consultation during their first six months. After this initial phase, consultants are provided additional trainings as continuing education and receive regular

supervision from the ECCP leadership team that has clinical, reflective, and administrative components. Training modules are based on the set of six competencies developed by ECCP to guide consultants' work.

- ECCP is a copyrighted and proprietary model. The ECCP model and license, including the information system, manual, consultant training, and support for implementation, are available through Advanced Behavioral Health, Inc.
- 7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies**
- ECCP is provided statewide in Connecticut by partnering with community-based child behavioral health agencies throughout the state. These agencies employ the ECCP consultants, who provide services in their local communities.
 - ECCP is also provided in Nassau County, New York, through NASSAU THRIVES, a program offering support to early care and education settings affected by Hurricane Sandy. Advanced Behavioral Health, Inc. contracts with Docs for Tots, a nonprofit, pediatrician-led organization focused on policy issues involving young children, for the administration of the ECCP component of NASSAU THRIVES.

B. Summary of existing research

ECCP's first year of implementation was the subject of a process evaluation (Fink and Wakai 2003). This evaluation collected program administrative data on fidelity and services delivered, surveyed consultants who provided services and the classroom teachers who received them, and conducted qualitative case studies to describe results from program implementation. Table 1 provides an overview of this study, whose main findings are discussed below.

- ECCP administrative data showed that consultants delivered approximately as many intensive center and core classroom services as planned. Consultants delivered intensive center services to 11 centers, compared with 11 anticipated, and delivered core classroom services to 50 classrooms in those centers, compared with 55 anticipated. Core classroom services were also projected to be delivered to 44 classrooms in additional centers that were not receiving intensive center services, and 43 classrooms actually received these services. Overall, 93 classrooms received classroom-level services, compared to a projection of 99 classrooms. However, only 171 children received child-specific services (either in conjunction with center or classroom services or as stand-alone services), compared to a projected service level of 385 children.
- Most teachers reported on a survey that ECCP activities were very helpful to them. For example, 79 percent reported that making decisions about which children needed individual assessment and intervention was very helpful, with 21 percent reporting it was somewhat helpful. Because surveys were mailed four to six weeks after the program ended, teachers were asked about their sustained use of information from two project activities: their classroom ratings on the Infant/Toddler Environment Rating Scale (Harms et al. 1990), and the goals and steps in their classroom action plan. Eighty percent replied they used the classroom ratings and 87 percent replied they used the action plan goals and steps at least once per week.

- Teachers also gave positive responses on the survey in several other areas. For example, in response to questions about children's behavior, 38 percent of teachers reported great improvement in children about whom they were concerned, and another 43 percent reported modest improvement. Teachers reported similar results for improvements in behavior by their class as a whole. When asked about improvement in the responsiveness of their classroom practice to their children's social and emotional needs, 41 to 57 percent of teachers reported a great improvement depending on the area mentioned (such as supporting interactions or promoting staff resilience). Finally, 88 percent of teachers said they believed the program would reduce the chance that children exhibiting difficult behaviors would be terminated or suspended in the future.

ECCP has also undergone three evaluations led by Dr. Walter Gilliam (Yale University) that used RCT designs; however, two of these (Gilliam 2007 and Gilliam 2014) involved children ages 3 and 4, so they are out of the scope of this report. The third pilot evaluation (Gilliam 2014) involved a small number of two-year-olds (15 treatment and 17 control) in infant/toddler settings (birth to age 2) and examined children's outcomes. Because the results of this small pilot evaluation were not publically available until December 2014, this model was not included in the LITES systematic review. The pilot study found suggestive evidence of decreased hyperactivity for toddlers; the small sample size may have impeded the authors' ability to detect a statistically significant impact. The study also found that ECCP resulted in greater levels of home-school collaboration and family involvement for toddlers receiving child-specific services. The study did not find statistically significant impacts on classroom quality or teacher-child interactions, as measured by the Classroom Assessment Scoring System (CLASS; Pianta et al. 2008).

C. For more information

Elizabeth Bicio, LCSW
Director, ECCP and Early Childhood Programs
Advanced Behavioral Health, Inc.
213 Court Street
Middletown, CT 06457
Email: ebicio@abhct.com
<http://www.eccpct.com/>

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Table 1. Overview of existing research, ECCP

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Fink and Wakai 2003	Process/implementation	11 consultants (8 respondents)	Children receiving specific services: “vast majority” previously engaged in physically aggressive behaviors; 28 percent previously referred for special education or other specialized services; 4 percent for whom behavior led to end of most recent child care arrangement	Services planned and provided	Program administrative data
		89 lead teachers of classrooms receiving services (39 respondents)		Self-reports involving classroom environment and practices, child behavior, sustainability of program activities, referrals to mental health services, and child terminations and suspensions	Surveys of consultants and teachers
		11 sites, 93 classrooms, and 171 children receiving services (either linked with other levels of services or stand-alone)		Qualitative description of implementation	Case studies (featuring interviews and observations of program activities by research team)
		3 case studies			

EXPANDING QUALITY IN INFANT TODDLER CARE (EQIT) COURSE AND EQ RELATE MODEL OF COACHING

A. Overview

1. Overview, model components, and content

As part of a broader Colorado initiative on expanding the quality and availability of care for infants and toddlers (known as the Expanding Quality in Infant Toddler Care [EQ] Initiative), the Expanding Quality in Infant Toddler Care (EQIT) course provides training for caregivers of infants and toddlers to improve their knowledge and skills. Course content covers the importance of brain development in the first three years of life; the social-emotional, cognitive, language, and physical development of infants and toddlers; relationship-based care and relationship-based approaches to guiding children's behavior; partnerships with families; quality curriculum and environments; and health, safety, and nutrition. Completion of the course meets some state licensing requirements, and, when possible, partnerships with local community colleges allow for course participation to result in college credit. These partnerships are also used to encourage participants to consider additional formal coursework. Class sizes are intended to be 20 or fewer caregivers. An orientation may be held before the course begins to introduce instructors, provide an overview of the course, set course expectations, and provide additional information. Participants are also offered the option of receiving on-site coaching through the EQ RELATE coaching model to supplement the course.²³ The coaching supports participants in reflecting on the skills and knowledge learned in the course and integrating this information into the care they provide to their infants and toddlers.²⁴

The larger EQ Initiative's goals involve strengthening the skills and knowledge of caregivers and other professionals working with infants and toddlers by facilitating the professional development of these caregivers, as well as building capacity, leadership, and collaboration at the local level. In addition to the EQIT course, the initiative offers training, coordination, and other support on the Touchpoints approach, the Cradling Literacy curriculum, infant and toddler assessments, and other professional development opportunities. Along with the rest of the EQ Initiative, the EQIT course and EQ RELATE coaching model are overseen by the Colorado Department of Education.

2. Target population, including available languages

- The EQIT course and EQ RELATE coaching model are designed to help any Colorado caregiver or other individual who works with infants and toddlers in group settings, whether in center-based care, family child care, or another setting. Participants must be able to speak

²³ The title "RELATE" is not an acronym, but emphasizes the importance of relationships in the coaching model.

²⁴ We included the EQIT course because it has a clearly defined coaching component, which was delivered in the caregiving setting. This report profiles caregiver professional development models only if they took place in a care setting. Therefore, we did not conduct a full search for all professional development courses offered to infant and toddler caregivers in all setting types.

and write in the language in which the class is offered (English and Spanish). They are not required to have previously completed any formal college coursework.

- The course is offered in English and Spanish. Course handouts are available in English and Spanish.

3. Targeted outcomes

- As part of the EQ Initiative, the EQIT course and EQ RELATE coaching model aim to increase the quality of care for infants and toddlers by improving the knowledge and skills of their caregivers in multiple areas, including supporting children's social-emotional, cognitive, and physical development.

4. Dosage and program length

- The EQIT course consists of 16 three-hour modules, for a total of 48 hours of direct class time. It is most commonly conducted as a six-hour class taught on every other Saturday over a 16-week period, but can be scheduled differently depending on local needs and preferences. To facilitate the integration of course content into participants' work, no more than six hours may be taught per week unless there are extenuating circumstances.
- Coaching is offered during the period of the course, and for course graduates, for up to one year following course completion. The number of hours offered to each participant is determined on an individual basis and may depend on the availability of funding.

5. Staff requirements, including staff type, education, and experience

- The EQIT course features team teaching, and at least two qualified instructors must be present at every session.
- Course instructors must complete an 80-hour train-the-trainer course, which includes additional written work, and have previously completed the EQIT course or a similar infant-toddler course. They must obtain approval to be an intermediate-level trainer from Colorado's trainer approval system. Other requirements include having at least one year of experience working with infants and toddlers; having experience working with families of infants and toddlers; having experience teaching, coaching, or supervising adults; and having knowledge of local programs and resources related to infants and toddlers.
- Coaches must complete an additional two days of training on the EQ RELATE coaching model and tools before offering any coaching. All instructors are encouraged to take this training, even if they do not plan to actively provide coaching. Additional follow-up support is available after completing the coaching training.
- Instructors are expected to continue their professional development by participating in training seminars and other learning opportunities offered by the EQ Initiative. They must attend a minimum of six hours of these opportunities annually to continue teaching the course.

6. Supports for implementation

- The EQ Initiative has an implementation handbook for use by course instructors and other local staff. The course has a detailed written curriculum, materials, and supporting resources. Each training team receives a resource library of DVDs, videos, and books.

- For the coaching component, some materials (such as a sample coaching agreement, a coaching log, visit forms, and participant journals) are available.
 - A local team of instructors must be approved by state EQ Initiative program staff to be able to offer the course.
 - The EQ Initiative has an online reporting system that local teams must use to submit information on training and coaching activities, including the number of hours of coaching received by each participant, on a quarterly basis.
 - Local changes to the course curriculum must be discussed in advance, documented, and approved by state EQ Initiative program staff. A collection of approved alternate activities for some components is currently being developed; these activities can be substituted locally without obtaining specific approval.
- 7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies**
- The EQIT course and EQ RELATE coaching model are implemented across Colorado by local Early Childhood Councils, who work with the training teams who are approved to offer the course.

B. Summary of existing research

The EQIT course and EQ RELATE coaching model were evaluated in a study (Moreno et al. 2015) that compared five groups of infant/toddler caregivers. The first three groups consisted of caregivers enrolled in the EQIT course who were randomly assigned to receive either no coaching, 5 hours of coaching, or 15 hours of coaching. Coaching began during the course and ended no more than two months after the course concluded. The other two groups consisted of caregivers enrolled in the standardized community college course on infant-toddler theory and practice required by Colorado for certain child care workers, and caregivers not enrolled in any course (the no-intervention group). The study selected sites where the EQIT course was perceived to be delivered with high fidelity; EQIT course and community college course enrollees in these sites were recruited to participate in the study during the first course meeting. The no-intervention group was formed by recruiting caregivers using lists of licensed centers and home-based providers from the state. Participants in the five groups were assessed on (1) teacher-child interactions using the infant and toddler Classroom Assessment Scoring System (CLASS; Hamre et al. 2011); (2) infant-toddler knowledge using a study-designed test (Green et al. 2011); and (3) attitudes and beliefs using an instrument of parenting self-efficacy (Bandura 1993) modified for the study for use with infant and toddler caregivers. Measures were collected at pretest (within two weeks of recruitment), posttest (four to six months after pretest, when the course and/or coaching were complete), and follow-up (four months after posttest). Table 1 provides an overview of the study. Below we discuss the findings from the study.

- Across all outcomes, the three EQIT groups and the community college group showed change that was positive and statistically significant in at least one outcome, whereas the no-intervention group tended to exhibit decreases over time for several outcomes. The 15-coaching-hour EQIT group displayed the strongest pattern of positive change over time.

- Using a construct of emotional-behavioral support created from specific dimensions of the infant CLASS and toddler CLASS, overall differences in the changes over time of scores for the five groups were close to but not statistically significant at the 0.05 level.
 - The community college and 15-coaching-hour EQIT groups showed consistent increases from pretest through follow-up; average effect sizes were about 0.33 and some were statistically significant.
 - The no-coaching EQIT group increased from pretest to posttest and decreased (by a smaller magnitude) from posttest to follow-up for an overall increase in score, whereas the no-intervention and five-coaching-hour EQIT groups decreased from pretest to posttest and increased (by a smaller magnitude) from posttest to follow-up for an overall decrease in score.
 - The 15-coaching-hour EQIT group experienced the largest improvement over time. The change from pretest to follow-up for this group was significantly greater compared to the change for the other four groups combined, for the no-intervention group, and for the five-coaching-hour EQIT group. However, the change for the 15-coaching-hour EQIT group was not significantly greater than the change for the community college group or for the no-coaching EQIT group. The 15-coaching-hour EQIT group also had the highest score at follow-up, although the significance of this score compared to the follow-up scores for the other groups was not tested.
- Infant CLASS and toddler CLASS dimensions were also used to create a construct for support for language and literacy. Here, the overall differences in the changes over time of scores for the five groups were statistically significant at the 0.01 level. The no-coaching and 15-coaching-hour EQIT groups exhibited consistent increases from pretest through follow-up that were generally statistically significant. The other three groups showed essentially no change in score from pretest to follow-up. Again, the 15-coaching-hour EQIT group experienced the largest improvement over time, one that was significantly greater compared to the change for the other four groups combined and for each individual group except the no-coaching EQIT group. The 15-coaching-hour EQIT group also had the highest score at follow-up, although the researchers did not examine whether this score was significantly different from the scores for the other groups.
- Using the scores on the test of infant-toddler knowledge, the differences in the changes over time of scores for the five groups were not statistically significant. The no-coaching and 15-coaching-hour EQIT groups showed statistically significant increases, with the latter group demonstrating the most positive effect.
- Differences in the changes over time on the measures of self-efficacy for the five groups were also not statistically significant. The community college, five-coaching-hour EQIT group, and 15-coaching-hour EQIT group had statistically significant increases from pretest to posttest. However, all five groups showed decreases from posttest to follow-up, resulting in scores similar to pretest levels.

C. For more information

Jo Koehn
EQ Program Director
Colorado Department of Education

201 E. Colfax Avenue, #105
Denver, CO 80203
303-866-6706
Email: koehn_j@cde.state.co.us
http://www.cde.state.co.us/early/eqinfant_toddler

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Table 1. Overview of existing research, EQIT & EQ RELATE

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Moreno et al. 2015	Comparison groups, with random assignment of coaching dosage within EQIT group	183 caregivers; 161 at posttest and 136 at follow-up; analysis of outcomes using data across all three time points had 120 caregivers (22 no intervention, 23 community college, 28 no-coaching EQIT, 26 5-coaching-hour EQIT; 21 15-coaching-hour EQIT)	Combined sample: mean age 33; 99 percent female; 74 percent white; 11 percent high school education or lower, 25 percent some college credit, 28 percent additional certificate or associate degree, and 35 percent bachelor's degree or higher; 11 percent Child Development Associate credential; mean years of experience with infants (4.8) and toddlers (6.3); mean salary \$18,000	CLASS (emotional-behavioral support and support for language and literacy) Study-designed test of knowledge Attitudes and beliefs regarding self-efficacy as a teacher	Observations conducted by research staff Study-administered questionnaire Surveys of participants

FIRST BEGINNINGS (PHILADELPHIA INCLUSION NETWORK)

A. Overview

1. Overview, model components, and content

First Beginnings is a professional development program for caregivers of infants and toddlers in out-of-home settings (centers and family child care homes) that features both training and on-site consultation designed to increase the quality of care children received. Along with similar programs for preschool educators and family care providers, the First Beginnings curriculum was developed and offered as part of the Philadelphia Inclusion Network (PIN). Specifically, First Beginnings consists of the following components:

- Participants take a group training class, which is delivered as a series of core modules and a selection of supplemental modules. Topics include caregiver-child relationships, strategies for promoting learning and development, inclusion and diversity, and working with families.
- Outside of class time, participants complete a project that involves reflecting on and writing about an infant or toddler in their care identified by them as having a special need.
- On-site observation visits are conducted before and after the program to collect measures of the quality of the participants' classroom environments and their interactions with the children in their care.
- Participants receive on-site consultation visits, which follow a specific protocol that includes a self-assessment, identification of areas for improvement, and a written follow-up plan. During the initial consultation visit, information from the first observation visit is provided to participants and used to help identify the areas for improvement. Consultation strategies include providing/reviewing resources or materials, brainstorming, modeling, and discussion.

First Beginnings and the other PIN professional development programs were developed by the Child and Family Studies Research Programs at Thomas Jefferson University. The program is not currently active, but its materials are available online.²⁵

2. Target population, including available languages

- PIN primarily serves caregivers of children from birth to age 5. The First Beginnings curriculum is specifically for caregivers of infants and toddlers (birth to age 3). In studies of the PIN curricula, participating caregivers tended to have extensive experience providing care, and most did not have a college degree.
- The PIN training curricula are designed to support caregivers working in child care settings in low-income urban areas.

²⁵ Since the completion of the PIN programs, the developers have also created training and materials for caregivers on creating adaptations for routines and activities for children in their care, including infants and toddlers (Campbell et al. 2012; Milbourne and Campbell 2007; Campbell and Milbourne 2014). The materials are based on lessons learned from the PIN program.

- PIN is designed to support caregivers in improving child care quality for all children, with an emphasis on the inclusion of children with disabilities or special needs.
- PIN curricula and services are conducted in English.

3. Targeted outcomes

- The PIN training program is designed to increase the quality of care provided to children.

4. Dosage and program length

- The modules in the First Beginnings group training class are offered over a three- to four-month period. Program materials mention that the training includes seven modules, but in one study of First Beginnings, five modules were taught. Each module is three hours. PIN materials mention that class sizes usually do not exceed 20 to 25 participants. In the study of First Beginnings, group sizes ranged from 25 to 30 participants.
- The on-site consultation takes place during the same three- to four-month period as the training; a total of three visits are conducted, timed to occur before or after a specific module. Each visit is one hour.

5. Staff requirements, including staff type, education, and experience

- PIN does not have specific requirements for the instructors teaching the training class other than prior experience providing training. Instructors include parents of children with special needs, early intervention staff, early childhood educators or staff, or consultants who specialize in providing training or technical assistance in a range of areas. Modules within a particular group training class can be taught by multiple instructors working together.
- Consultation visits are made by the training instructors, by others with early intervention or early childhood backgrounds, or by the staff coordinating the PIN training. In one study of First Beginnings, all eight consultants had at least three years of experience with child care, and half had master's degrees whereas the others had bachelor's degrees.

6. Supports for implementation

- PIN has an instructor guide, trainer guide, and consultation guide. The First Beginnings modules and other sessions have written materials for participants and instructors. Although the program is not currently active, these materials are available online to support replication.
- The staff coordinating the PIN training are responsible for ensuring continuity during the program, as sessions can be taught by different instructors. This could include orientation and review meetings for instructors, or mentoring and coaching the instructors on activities and teaching strategies. The PIN training coordinators also oversee the consultation (unless they provide it directly) and work with the consultants at the start of the program to go over how the consultation will be provided.
- In a study of First Beginnings, the consultants participated in a three-hour training session before the start of the program.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- When active, First Beginnings and the other PIN curricula were offered in the Philadelphia area by the program developer (the Child and Family Studies Research Programs at Thomas Jefferson University). The developer also disseminated the PIN materials to organizations interested in offering the program in other locations, including to early intervention consultants in Pennsylvania.

B. Summary of existing research

The First Beginnings program for infants and toddlers was evaluated in two studies, which are listed in Table 1. We summarize each study and its findings below.

In one study (Campbell and Milbourne 2005), participating caregivers received either the full First Beginnings curriculum including the on-site consultation, or the curriculum without the consultation component. Participants were recruited from child care programs in specific zip codes in Philadelphia; those who registered were placed in one of five training courses depending on their location. Participants in four of the five courses were offered consultation; the caregivers in these four groups who received consultation formed the consultation group, and the no-consultation group consisted of the caregivers in the fifth group as well as caregivers in the first four groups who did not actually receive consultation (primarily because their program directors refused). The Infant/Toddler Environment Rating Scale (ITERS; Harms et al. 1990) and Arnett Caregiver Interaction Scale (Arnett 1989) were used to assess the quality of caregivers' classroom environments and of their interactions with children before and after their participation in the program.

- The average of the overall mean score on the ITERS for consultation group classrooms increased from 3.20 before the program to 3.49 after, whereas the average of the overall mean score for no-consultation group rooms decreased from 3.43 before the program to 3.35 after. The difference between the pre-post changes for each group was statistically significant at the 0.01 level, although this could not be clearly attributed to participation in the consultation group.
- ITERS scores also provided quality ratings of inadequate (overall mean score below 3), adequate (3 to 4.99), or good (5 or above). The percentage of consultation group rooms rated adequate or good quality increased from 62 to 71 percent; for the no-consultation group, a decrease from 73 to 69 percent was found. Classrooms were also defined as experiencing observable change if their quality rating changed (or if their rating was good and they experienced a 1-point change in overall mean score). Twenty-one percent of the consultation group classrooms showed an observable change, compared with 8 percent of the classrooms in the no-consultation group.
- The consultation group's mean score became more favorable on three of the four factors in the Arnett Caregiver Interaction Scale from before the program to after, and less favorable on the fourth factor. The no-consultation group's mean score became more favorable on two of the four factors and less favorable on the other two factors over time. Differences in pre-post changes for each group were not statistically significant for any of the four factors.

A second study (Campbell et al. 2005) evaluated the overall First Beginnings program and the corresponding PIN curriculum for preschool-age children. This study was similar to the first study and the two had overlapping samples. Potential participants (which could include program directors and nonteaching staff in addition to caregivers) were recruited, and those who registered participated in one of eight training courses using the First Beginnings curriculum. The classroom quality of participating caregivers and their interactions with children were measured using the ITERS and Arnett Caregiver Interaction Scale. Unlike the first study, this research only compared pretest and posttest results for the overall group of participants. Without a comparison group, this study design offers no way to assess what participants' outcomes would have been in the absence of the training and consultation. Therefore, we cannot make causal inferences that the First Beginnings program *caused* the observed effect.

- The average of the overall mean score on the ITERS for First Beginnings participants' classrooms increased from 3.20 before the program to 3.48 after. This was statistically significant at the 0.001 level, with an effect size calculated as 0.52.
- The number of classrooms rated adequate or good increased from 62 percent before the training to 72 percent after. Twenty-two percent of classrooms experienced an observable change in quality.
- Mean scores on three of the four Arnett Caregiver Interaction Scale factors showed almost no change (0.05 points or less on a scale ranging from 1 to 4) after the program, whereas the fourth factor (permissiveness) became less favorable afterwards by 0.26 points.

C. For more information

Philippa Campbell, Ph.D.
Child and Family Studies Research Programs
Thomas Jefferson University
130 South 9th Street, Suite 600
Philadelphia, PA 19107
215-503-1602
Email: Philippa.campbell@jefferson.edu
<http://jeffline.tju.edu/cfsrp/childcare-early.html>

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Table 1. Overview of existing research, First Beginnings

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data Collection methods
Campbell and Milbourne 2005	Comparison group (not randomly assigned)	180 caregivers in 114 rooms in 60 programs; 123 caregivers in consultation group, 37 in no-consultation group, 20 caregivers with no posttest results	Consultation group vs. no-consultation group: mean age 41 vs. 38; 99 percent vs. 100 percent female; 91 percent vs. 85 percent African American; 79 percent vs. 71 percent high school education or lower and 18 percent vs. 26 percent associate degree or higher; 5 percent vs. 0 percent child development credential; 14 percent vs. 9 percent educational certificate; mean experience in child care 9.8 vs. 7.4 years	ITERS Arnett Caregiver Interaction Scale	Observations conducted by trained observer Observations conducted by trained observer
Campbell et al. 2005	Descriptive/pre-post	First Beginnings: 178 total participants; 154 participants in 70 rooms in 45 centers completed all requirements	First Beginnings: mean age 40; 98 percent female; 89 percent African American; 77 percent high school education or lower and 21 percent associate degree or higher; 4 percent Child Development Associate credential; 18 percent teacher certificate; mean experience in child care 9.6 years	ITERS Arnett Caregiver Interaction Scale	Observations conducted by trained observer Observations conducted by trained observer

INFANT CAREGIVER MENTORING PROJECT

A. Overview

1. Overview, model components, and content

The Infant Caregiver Mentoring Project is designed to improve the quality of infant and toddler child care programs through the use of mentoring. Participants in the project are paired with an experienced early childhood professional who serves as their mentor in a one-on-one relationship. The mentoring emphasizes a relationship-based, problem-solving approach. In the first part of the program, the mentor spends time getting to know the participant and observing him or her on site to develop a trusting relationship. After both parties feel comfortable, the mentor begins working more actively with the participant. Mentors focus on being open-minded, collaborative, and supportive of caregivers who are attempting new ideas and strategies. The mentoring program was developed by the Capital Area Early Childhood Training Institute (CAECTI) at The Pennsylvania State University (Penn State). This demonstration project is not currently active, although a manual is available online.

2. Target population, including available languages

- Mentoring participants are Pennsylvania caregivers from center-based child care programs serving children from birth to younger than age 3. All of the child care centers are licensed by the state.
- A majority of caregivers participating in a study of the program had no more than a high school education. These caregivers had an average of almost six years of experience in the early childhood field.
- The mentoring program is conducted in English.

3. Targeted outcomes

- The program focuses on improving the overall quality of the child care environment, especially the quality of caregiver–child interactions and the sensitivity of caregivers to the needs of their children.

4. Dosage and program length

- Mentoring occurs over a four-month period.
- Participants receive approximately 20 hours of mentoring per month for 4 months for a total of 80 hours.

5. Staff requirements, including staff type, education, and experience

- Mentors have a minimum of five to seven years of experience in the early childhood field as both a director and a teacher.

6. Supports for implementation

- The Infant Caregiver Mentoring Project has a manual that defines the program, its goals, and policies. It also has content and references for topics such as relationship building, adult learning, attachment, language development, play, and creating partnerships with parents.

Mentors also use a variety of tools and forms to guide their work with participants, such as a mentoring log, videotaped observations, participant self-assessments, individualized professional development plans, and charts documenting classroom routines and materials. Although the project is not currently active, the manual is available online to support replication.

- Mentors complete seven days of training before the program starts. The topics covered during the training include building relationships as a mentor, other skills to be effective as a mentor, and infant and toddler development.
 - Mentors and mentoring staff meet every two weeks to monitor the status of the overall program and ensure a consistent approach. Mentors also meet with the director of the mentoring program on a weekly basis to discuss their progress with each participant.
- 7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies**
- When active, the mentoring program was implemented by the developer (CAECTI at Penn State) at child care centers in south central Pennsylvania. The program did not include any family child care providers.

B. Summary of existing research

The Infant Caregiver Mentoring Project was a demonstration project developed and evaluated by CAECTI at Penn State (Fiene 2002). Caregivers were recruited to participate in the study and those who agreed to participate were randomly assigned to a group that received the mentoring intervention or to a comparison group. The evaluation compared results from four measures taken before and after the period during which the treatment group received the mentoring (the comparison group received the mentoring after data collection was complete). The Infant/Toddler Environment Rating Scale (ITERS; Harms et al. 1987) and Arnett Caregiver Interaction Scale (Arnett 1989) were used to observe caregivers on the overall quality of their classroom and interactions with children, and the Knowledge of Infant Development Inventory (KIDI; MacPhee 1981) and the Bloom Scales of Organizational Climate (Bloom 1989) were used to survey caregivers on their knowledge of infant development and perceptions of their center. Table 1 provides an overview of the study. Below we discuss the findings from the study.

- For both the mentoring and comparison groups, the pre-post differences on all four measures (the ITERS, Arnett scale, KIDI, and Bloom scale) were not statistically significant.
- The mentoring group experienced changes from pretest to posttest on two ITERS subscales, routines (average increase in total score = 5 points) and learning activities (average increase = 3 points), that were statistically significant at the 0.005 and 0.05 level, respectively. This group also experienced changes on two Arnett subscales, sensitivity (average increase in total score = 5 points) and appropriate discipline (average increase = 2 points) that were statistically significant at the 0.001 and 0.05 level, respectively. The comparison group experienced one statistically significant change from pretest to posttest, on the ITERS interactions subscale (average decrease = 2 points, significant at the 0.02 level).

C. For more information

Richard Fiene, Ph.D.

Bennett Pierce Prevention Research Center
Penn State University
314 Biobehavioral Health Building
University Park, PA 16802
Email: drfiene@gmail.com

Kathy Stennett
Director, Capital Area Early Childhood Training Institute
Penn State University–Harrisburg
2001 N. Front Street
Harrisburg, PA 17102
717-236-6108
Email: kes21@psu.edu
<http://harrisburg.psu.edu/capital-area-early-childhood-training-institute>

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Table 1. Overview of existing research, Infant Caregiver Mentoring Project

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Fiene 2002	Randomized controlled trial	52 caregivers	Mean age 36; 77 percent white; 57 percent high school education only, 16 percent some college credit, 21 percent Child Development Associate credential or associate degree, and 7 percent bachelor's degree or higher Mean experience as a caregiver = 6 years; average salary \$10,000 to \$15,000	ITERS Arnett Caregiver Interaction Scale KIDI Bloom Scales of Organizational Climate	Observations conducted by research staff Observations conducted by research staff Surveys of caregivers Surveys of caregivers

SEEDS TO SUCCESS

A. Overview

1. Overview, model components, and content

Seeds to Success is a coaching model for providing quality improvement services within a pilot child care quality rating and improvement system. It supports licensed family child care providers, center-based teachers, and child care center directors in improving: (1) the quality of early care and education and (2) staff access to professional development and training. The coaching model, the Consultative Coaching Program for Early Learning Professionals, was developed in 2008 by Thrive by Five Washington, Washington State's public-private partnership for early learning. The goal of the Consultative Coaching Program is to train coaches to develop a trusting relationship with early learning professionals and help them reflect on their practice (1) in the classroom or in their business and (2) during interactions with the other providers in that setting, with families, and with the children in their care. The Seeds to Success coaches aim to help the professionals stay motivated to attain their quality improvement goals and help establish skills and behaviors that support continuous quality improvement. Providers and coaches develop quality improvement plans that are used to guide the coaching sessions. The plans are based on results of a baseline observation of setting quality. Providers are also eligible to receive quality improvement grants and funds for professional development and to cover the costs of child care for providers' own children, release time, and books.

The Seeds to Success Modified Field Test was conducted in 2009 in two communities (Boller et al. 2010a, 2010b; Del Grosso et al. 2010). The demonstration project also expanded into three additional communities in 2009 (Joseph et al. 2010). After the demonstration period, the state Department of Early Learning assumed all administration of Seeds to Success and used it to develop the current iteration of Washington's quality rating and improvement system, which now operates throughout the state and is called Early Achievers. Coaching remains a hallmark of the program. The Early Achievers coaching model is described as practice-based coaching and has three main components, which are similar to the Seeds coaching model: (1) shared goals and quality improvement plans, (2) focused observations guided by the goals and quality improvement plans, and (3) reflecting and sharing feedback. Under Seeds, the coaching and quality improvement grants were provided to providers with all five quality ratings (levels 1 through 5). In Early Achievers, however, these supports are only provided to providers at levels 3 through 5. This reflects Early Achievers' revised structure for quality ratings, under which providers begin at level 1, complete designated activities to achieve a level 2 rating, and can then earn points through on-site evaluations in several standard areas to reach ratings between levels 3 and 5. Early Achievers also includes professional development, technical assistance, and other supports for providers. The focus of this profile is on the year 1 field test only.

2. Target population, including available languages

- The Seeds model targets licensed family child care providers, center-based teachers, and child care center directors caring for children birth to age 5.
- Coaching is offered in English and Spanish. Written materials are available in English only.

3. Targeted outcomes

- The Seeds model is intended to improve the quality of care provided by participating child care providers.

4. Dosage and program length

- The Seeds to Success Modified Field Test had a six-month implementation period.
- Center directors, classroom teaching staff, and family child care providers are eligible to receive up to eight hours of in-person coaching per month. Coaching hours for center classrooms are divided between lead teachers and assistants, with more hours intended for lead teachers.

5. Staff requirements, including staff type, education, and experience

- For the coaches, the implementing agencies seek individuals with experience and expertise in early childhood development, child care, culturally appropriate practice, and adult learning theories. In addition, the agencies seek bilingual individuals to work with the providers in their communities.

6. Supports for implementation

- In preparation for implementation, coaches participate in multiple training sessions, including trainings on coaching, the Environment Rating Scales (ERS),²⁶ and the administrative data system used to track the provision of coaching.
 - During the implementation period, coaches are supervised by the site coordinators at the implementing agencies during team and one-on-one meetings. During the field test, in one community, coaches' supervision was offered weekly. In the other community, supervision was offered monthly. Coaches also have the opportunity to meet with a mentor coach.
 - The implementing agencies use an administrative data system to track the provision of coaching, including the amount of coaching participants receive, the content of the coaching, and how the coaching aligns with stated goals in the participants' quality improvement plans.
7. Overview of the locations where model has been or is currently implemented, including types of implementing agencies
- For the field test, the Seeds model was implemented in two Washington State communities in family child care homes and child care centers.

B. Summary of existing research

An impact and implementation evaluation of the Seeds model was conducted in 2009 (Boller et al. 2010b). The impact evaluation was designed to determine whether the coaching model and financial incentives implemented as part of Seeds affected the quality of services provided by participating child care businesses (in both family home and center settings),

²⁶ The Environment Rating Scales include the Infant/Toddler Environment Rating Scale-Revised (ITERS-R; Harms et al. 2003), the Early Childhood Environment Rating Scale-Revised (Harms et al. 1998), and the Family Child Care Environment Rating Scale-Revised (Harms et al. 2007).

compared with those businesses that did not receive Seeds. Across two communities, 52 family child care providers and 14 centers that volunteered to participate were randomly assigned into treatment and control groups. The treatment group received the intervention described in this profile; the control group received funds only for professional development opportunities and supports. The goals of the implementation study were to determine whether Seeds met its goals of providing intensive, high quality coaching and other supports to participating providers and to capture the lessons learned about implementation during the field test.

Data sources for the Seeds impact study included classroom observations, self-administered questionnaires for center directors and educators (lead and assistant teachers), and interviews with family child care providers. Observations conducted at the start (baseline) and at the end (follow-up) of the field test included the ERS, the Arnett Caregiver Interaction Scale (Arnett 1989), and counts of children and adults to calculate child-adult ratios and group sizes. Data sources for the Seeds implementation study included (1) interviews and focus groups with site coordinators, coaches, and child care staff during site visits conducted by the evaluation team in June and November 2009; and (2) service use data collected by coaches and site coordinators from June through December 2009 and analyzed by the evaluator in winter 2010.

Table 1 provides an overview of the study. The main impact study findings include the following:

- Family child care providers in the treatment group were not more likely than providers in the control group to be enrolled in an education or training program. However, Seeds did improve center-based lead and assistant teacher enrollment in an education or training program, and significantly more lead teachers in the treatment group than in the control group attended college courses at least weekly.
- At follow-up, family child care providers and center-based lead and assistant teachers in the treatment group were significantly more likely than those in the control group to report visits from a coach at least weekly.
- At follow-up, there was no consistent pattern of positive impacts of Seeds on family child care providers' educational attainment. More center-based teachers in the treatment group than in the control group earned three credits in the past six months, but Seeds had no impact on completion of a postsecondary degree for center lead teachers and assistants.
- Lead teachers in the treatment group were significantly less likely than lead teachers in the control group to leave their centers during the study period (19 percent of treatment group lead teachers who completed baseline questionnaires left by follow-up, versus 45 percent in the control group).
- Child care businesses in the treatment group had significantly higher child care observed quality scores at follow-up than businesses in the control group. For both family child care providers and child care centers in the treatment group, the ERS total score and most of the ERS subscale scores were significantly higher than control group scores. Among infant and toddler center-based classrooms, the ITERS-R total scores for the treatment classrooms was significantly higher than for the comparison classrooms (4.65 versus 2.85, respectively).

The main implementation study findings include the following:

- The coaches and providers were able to implement the intensive coaching component of the Seeds model. On average, the amount of coaching providers received adhered to the Seeds model; however, participants had a range of experiences. On average, family child care providers, center directors, and lead teachers received 6 to 11 hours of coaching per month.
- Across all providers, quality improvement grants were most commonly used for supplies and materials. During focus groups, providers described using funds to pay for (1) materials, including books and art materials; (2) larger items, such as child-size tables and outdoor play equipment; and (3) safety improvements.
- According to administrative data, across communities, one-third to one-half of family child care providers and at least one staff person in each child care center received funding for professional development opportunities for their staff.
- During focus groups, providers described several barriers that deterred them from using the professional development opportunities, including (1) limited availability of trainings and classes, particularly near their places of employment or homes; (2) lack of trainings and classes that provided new or relevant information; and (3) low perceived “payoffs” to professional development, because salaries were unlikely to increase as a result of completion of professional development.

C. For more information

Juliet Morrison
Assistant Director for Quality Practice and Professional Growth
Washington State Department of Early Learning
P.O. Box 40970
Olympia, WA 98504-0970
360-725-4689
Email: Juliet.Morrison@del.wa.gov
<http://www.del.wa.gov/>

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Table 1. Overview of existing research, Seeds to Success

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Boller et al. 2010b	Randomized controlled trial; implementation study	52 family child care providers and 14 child care centers initially randomly assigned	<i>Family child care providers:</i> Average age 45; 57 percent Hispanic, 15 percent white non-Hispanic, and 26 percent other race or ethnicity; 45 percent less than a high school education and 14 percent associate degree, bachelor's degree, or completed graduate work; average years of experience in current job more than 6 years	Infant/Toddler Environment Rating Scale-Revised (Harms et al. 2003); the Early Childhood Environment Rating Scale-Revised (Harms et al. 1998); the Family Child Care Environment Rating Scale-Revised (Harms et al. 2007).	Observation
		49 family child care providers (26 treatment and 23 control) and 14 child care centers (7 treatment and 7 control) participated in study		Arnett Caregiver Interaction Scale (Arnett 1989)	Observation
			<i>Child care center staff:</i> Average age: center directors 43, lead teachers 35, assistant teachers 29; child care center staff most frequently white non-Hispanic; associate degree, bachelor's degree, or higher: center directors 56 percent, lead teachers 30 percent, assistant teachers 17 percent; average years of experience in current job: center directors 6 years, lead teachers 4 years, assistant teachers 3 years	Counts of the children and adults	Observation
				Center directors and educators (lead and assistant teachers): demographics and participation in training and education	Self-administered questionnaires
				Family child care providers: demographics and participation in training and education	Interviews
				Program implementation	Executive interviews and focus groups with site coordinators, coaches, and child care staff
				Service receipt	Service use data collected by coaches and site coordinators

SMART SUPPORT (EARLY CHILDHOOD MENTAL HEALTH CONSULTATION)

A. Overview

1. Overview, model components, and content

Smart Support is Arizona’s system of early childhood mental health consultation. It partners mental health consultants with early care and education providers to promote the social and emotional development of the children in their care, and to help them respond to children with behavioral challenges. A consultant first meets with a provider to explain the consultation services, confirm such services are appropriate for the provider’s needs, and verify that the provider remains interested in receiving these services. If so, the consultant works with the provider to develop an individualized plan that describes how services will be provided.

Three types of consultation can be provided in different combinations depending on provider needs and preferences: (1) program consultation focuses on the provider’s entire setting; (2) classroom consultation works with a teacher to improve his or her skills or outcomes in the classroom; and (3) child-centered consultation involves helping staff and parents develop a plan to support care for a child exhibiting difficult behaviors. Services provided by consultants may also include training as well as referrals to other services and resources. Regardless of the specific services offered, Smart Support uses several core components, tools, and techniques as its framework for consultation. These include the Teaching Pyramid Model from the Center on the Social and Emotional Foundations for Early Learning as well as the FAN approach developed by Dr. Linda Gilkerson at the Erikson Institute to guide interpersonal communication with caregivers.²⁷ Southwest Human Development, a nonprofit provider of early childhood services, designed and administers the program.

2. Target population, including available languages

- Smart Support works with child care providers for children from birth to age 5, including child care centers and preschools as well as family child care providers. To be eligible, a provider must be licensed or regulated by the appropriate Arizona state agency. Smart Support can also provide mental health consultation to home visiting and family, friend, and neighbor programs.
- Smart Support primarily offers services in English and has a limited capacity to provide services in Spanish.

3. Targeted outcomes

- Smart Support’s activities are intended to improve several short-term outcomes, including: the emotional climate in programs and classrooms; staff interactions with parents and other staff (this includes teachers and non-teaching staff such as administrators); teacher attitudes, beliefs, and knowledge; teacher–child relationships; child behavior; involvement with early intervention services; and reduced risk of expulsion.

²⁷ The term “FAN” is not an acronym but refers to the shape of the visual representation of the approach.

- The intended long-term outcome is an increased capacity of early childhood settings to meet children's social and emotional needs.

4. Dosage and program length

- The period of service is not set at the beginning of the program; rather, consultants encourage providers to work with them to set specific goals at the beginning of services, with the idea that the consultation will end after the consultant and provider agree that these goals have been met. The average length of participation is approximately one year, but this varies and can range from several months to much longer than one year.
- The primary component of consultation consists of in-person, on-site visits from the consultant, which are required to occur at a regular day and time. Visits usually occur weekly and last two to three hours. When appropriate, visits can be offered more or less frequently than weekly.

5. Staff requirements, including staff type, education, and experience

- Mental health consultants must have a master's-level degree in a mental health discipline. They must have experience working with young children and their families and caregivers.
- Supervisors of mental health consultants must have a license in a mental health field and at least five years of experience working with children, groups of children, or their families and caregivers. They must also have supervisory experience using reflective supervision or a similar approach.

6. Supports for implementation

- Smart Support has an implementation manual, a logic model, and a database with forms, data collection reports, and resources. The implementation manual describes in detail the step-by-step process for providing consultation, to ensure consistent service delivery and fidelity to the Smart Support model.
- New consultants go through a week-long orientation that includes 16 classroom hours, and shadow with experienced consultants. Their first year of employment serves as an extended orientation and includes the completion of a series of trainings on attachment, trauma, self-regulation, and other subjects as well as quarterly meetings that review key aspects of the consultation model. Other ongoing professional development activities for all consultants include a monthly book club, regular training opportunities (which may be required, or optional training that a consultant can request to attend), and weekly meetings with supervisors that use a reflective supervision approach.
- After completing the initial week-long Smart Support orientation, supervisors receive three hours of training per week for one month to support them in fully assuming their supervisory role. This training covers all aspects of the supervisory process. During this time, they also discuss topics in child development in small groups, shadow with experienced consultants to observe them in different stages of consultation, and sit in or participate in other meetings.
- Supervisors are responsible for ensuring fidelity to the Smart Support model. This primarily occurs through the weekly reflective supervision meetings with consultants that incorporate both case-based reflective discussion and administrative oversight to form a blended model of supervision.

- Supervisors also participate in their own weekly meetings with senior Smart Support leadership that use reflective supervision; they also have their own monthly book club.
- 7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies**
- Smart Support operates in Arizona in areas whose regional councils of First Things First (the state's early childhood development system) dedicate some of their funding for the program. These regions contain a large proportion of the state's population.
 - Mental health consultants are hired by Southwest Human Development or another agency, depending on the location in the state. Southwest Human Development supervises and trains all consultants and supervisors.

B. Summary of existing research

Smart Support's first year of implementation in 2010–2011 was the subject of an evaluation report (Shivers n.d.). This evaluation collected administrative data on program activities; information on the characteristics of the mental health consultants who provided services; surveys and self-assessments from teachers, child care program directors, and consultants; teacher-reported child data; and observations of classroom environments. Information collected from participating teachers and administrators was obtained at the beginning of the program and six months later, while they were still receiving services. The component of the study involving implementation is summarized in Table 1 and findings are discussed below. Only 21 percent of teachers in the first-year evaluation reported caring for infants and toddlers (birth to age 3).

- According to administrative data on services delivered, Smart Support mental health consultants visited teachers once per week on average, spending an average of 2.3 hours on site per week. Each consultant also facilitated an average of 6 training sessions and made an average of 21 referrals (which could be for children or families, or for directors, teachers, or child care programs). Consultants worked with teachers to create an average of 2.9 written action plans for specific children per teacher.
- Consultants' average age was 41, 94 percent were female, and all held a master's degree or higher. Consultants' primary field of expertise was either in mental health (49 percent), education (30 percent), or both (21 percent). Their average experience providing early childhood-related services was 11.1 years; average experience providing consultation, coaching, or training was 6.5 years; and average experience providing early childhood consultation was 5.4 years.
- Consultants were asked to self-rate their level of consulting knowledge and skills using a scale with five domains: basic knowledge, systems change, personal characteristics, communication, and collaborative problem solving (Buysse and Wesley 2005). On the scale of 1 (low) to 5 (high), consultants' average overall score was 4.32. The average score on each domain was greater than 4, with personal characteristics having the highest score and basic knowledge the lowest score.
- The report also included findings from the other sources, such as teacher-reported child data and observations of classroom environments. However, we did not review these findings because they are not disaggregated by child age and only 21 percent of participants cared for

infants and toddlers. In addition, several of the measures seem to only apply to preschool-age children and classrooms, which made them outside the scope of this report.

Smart Support has also released a one-page summary of evaluation findings of services provided from 2010 to 2014 (Southwest Human Development and Indigo Cultural Center 2015). Data involving 799 teachers and 1,028 children from 411 child care programs (94 percent of which were center-based providers) were collected at baseline and after 6 months and 12 months of Smart Support services. Positive, statistically significant results were found for several outcomes, including classroom emotional climate, teacher-child relationships, and children's self-regulation. However, an evaluation report containing these findings has not yet been produced.

C. For more information

Alison Steier, Ph.D.
Director, Smart Support
Southwest Human Development
2850 N. 24th Street
Phoenix, AZ 85008
602-200-0434
Email: asteier@swhd.org
<http://www.swhd.org/training/early-childhood-training/smart-support>

D. References

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Shivers, E.M. "Smart Support Year 1 Evaluation Report: 2010-2011." Phoenix, AZ: Indigo Cultural Center, Inc., Institute for Child Development Research & Social Change, n.d.

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Southwest Human Development and Indigo Cultural Center. "Summary of Smart Support Evaluation Findings 2010-2014." Phoenix, AZ: Southwest Human Development. Provided January 6, 2015.

Table 1. Overview of existing research, Smart Support

Study citation	Study design	Sample size/unit of analysis	Sample characteristics	Measures	Data collection methods
Shivers n.d.	Implementation; pre-post	47 consultants; 305 teachers at 199 child care centers and 14 family child care providers receiving services; 243 teachers at 147 child care centers and 5 family child care providers in evaluation	Centers/providers: mean of average daily attendance 55; 24 percent nationally accredited; 49 percent serving mostly low-income families and 29 percent serving mostly low- to mid-income families Teachers: mean age 36; 98 percent female; 53 percent white and 31 percent Latino; 52 percent high school education or lower, 21 percent Child Development Associate credential or relevant associate degree; 21 percent bachelor's degree or higher; mean experience as a caregiver 10 years	Program activities Consultant characteristics Consultant Knowledge and Skill Inventory (self-assessment)	Program administrative data Questionnaire completed by consultants Questionnaire completed by consultants

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CURRICULA MODELS

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ASSESSMENT, EVALUATION, AND PROGRAMMING SYSTEM (AEPS), SECOND EDITION, CURRICULUM FOR BIRTH TO THREE YEARS

A. Overview**1. Overview, model components, and content**

The *Assessment, Evaluation, and Programming System (AEPS), Second Edition, Curriculum for Birth to Three Years* provides activities that are arranged to meet the changing needs of children as they develop. The curriculum is designed to support caregivers in matching a child's goals and activities with activity-based intervention strategies based on the child's age and current level of development. These strategies involve working on goals and objectives within the children's routine (for example, mealtimes, bathing, and dressing), planned activities (for example, activities organized by an adult, such as painting), and spontaneous activities that capitalize on children's daily interactions with their social and physical environments to facilitate skill development. The curriculum is linked to the AEPS Test, an assessment designed to help teachers select and evaluate goals and objectives that are most appropriate for each individual child in key developmental areas. Overall, AEPS includes two sets of assessment and curriculum materials, one for children birth through age 3 and one for children age 3 through 6. The system is supported by a web-based data management system known as AEPSi, which caregivers can use to enter assessment information; link this information to goal development, intervention, and evaluation; and produce a variety of reports, including those that meet federal reporting requirements. AEPS was developed by Diane Bricker, Ph.D., and colleagues from the University of Oregon and is published by Brookes Publishing.

2. Target population, including available languages

- The curriculum is targeted to professionals (including early childhood educators in general, as well as special education teachers, early interventionists, family service coordinators, administrators, physical therapists, speech-language pathologists, and occupational therapists) working with children birth to age 3. AEPS was specifically developed for use with children who have disabilities or are at risk for developmental delays, but it can be used with all children.
- AEPS Curriculum for Birth to Three Years is only available in English.

3. Targeted outcomes

- AEPS Curriculum for Birth to Three Years targets outcomes in the following areas: fine motor, gross motor, adaptive, cognitive, social-communication, and social.²⁸

4. Dosage and program length

- Information about dosage and program length is not specified by the curriculum.

²⁸ The adaptive area consists of goals and objectives involving feeding, personal hygiene, and undressing.

5. Staff requirements, including staff type, education, and experience

- The curriculum is designed to be implemented by professionals, but education or experience requirements for staff are not specified on the AEPS website, and the developer did not clarify whether there are any requirements.

6. Supports for implementation

- AEPS Curriculum for Birth to Three Years includes an overview that provides background information about the curriculum and describes guidelines for using the curriculum.
- Trainers are available to conduct training seminars on the AEPS assessment and curriculum materials at implementing agencies. Training topics on the AEPS curriculum include the content and organization of the curriculum; how to link the AEPS assessment and curriculum; how to use the curriculum within an activities-based approach; individualizing instruction for young children using the curriculum; and working on goals and objectives within daily routines and planned intervention activities. Training topics can be modified to meet the needs of the participating professionals who will use AEPS.
- Fidelity guidelines and tools for monitoring fidelity of the AEPS Curriculum for Birth to Three Years are not specified on the AEPS website, and the developer did not clarify whether these are available.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- AEPS Curriculum for Birth to Three Years is implemented in early intervention/Individuals with Disabilities Education Act (IDEA) Part C programs, early child care programs, and Early Head Start programs.

B. Summary of existing research

We did not identify any research on the AEPS Curriculum for Birth to Three Years that fell within the scope of this report.²⁹

C. For more information

Brookes Publishing
800-638-3775

<http://www.brookespublishing.com>

Contact information for regional sales representatives is listed on the website:

<http://www.brookespublishing.com/customer-service/contact-us/>

²⁹ The existing research base includes studies of the psychometric properties of the AEPS assessment tools (inter-observer and test-retest reliability, internal consistency, and congruent validity); most studies focused specifically on children with disabilities.

D. References

Brookes Publishing Company. *The Assessment, Evaluation and Programming System (AEPS®), Second Edition, Curriculum for Birth to Three Years*. Available at: <http://products.brookespublishing.com/Assessment-Evaluation-and-Programming-System-for-Infants-and-Children-AEPS-Second-Edition-Curriculum-for-Birth-to-Three-Years-P474.aspx>. Accessed December 4, 2014.

THE CREATIVE CURRICULUM® FOR FAMILY CHILD CARE, SECOND EDITION

A. Overview**1. Overview, model components, and content**

The Creative Curriculum for Family Child Care, Second Edition, is a curriculum designed to help family child care providers: (1) set up the learning environment; (2) plan developmentally appropriate routines and activities for every day of the week; (3) promote children's learning and development in the areas of social-emotional, physical, language, cognitive, literacy, mathematics, science and technology, social studies, the arts, and English-language acquisition; and (4) build partnerships with parents. The curriculum includes two volumes. Volume 1: The Foundation covers the research that informed the development of the curriculum, how children develop and learn, organizing the home and daily schedule, caring and teaching, and building partnerships with families. Volume 2: Routines and Experiences discusses routines and experiences that promote development and learning of children birth to age 12 and describes strategies providers can use to implement these routines and experiences. The curriculum's learning objectives are intended for children birth through kindergarten, with the understanding that older children will have learning objectives from school. To make it easier for caregivers to implement activities, the curriculum also includes 68 Creative Curriculum LearningGames offering suggestions for helping families and caregivers interact with children, a list of necessary materials, and ways to adapt the activities to children's ability levels; a DVD about caregiving in the family child care setting and how children learn; and a CD-ROM with copies of forms and letters to parents. Versions of the curriculum for infant and toddler and preschool center-based classrooms are also available. The Creative Curriculum for Family Child Care was developed by Diane Trister Dodge, M.S., founder of Teaching Strategies, and colleagues Sherrie Rudick, M.S., and Laura J. Colker, Ed.D.

2. Target population, including available languages

- The curriculum is targeted to family child care providers caring for children birth to age 12.
- The 68 Creative Curriculum LearningGames are available in Spanish and English; the CD-ROM includes Spanish and English versions of forms and letters to parents.

3. Targeted outcomes

- The Creative Curriculum for Family Child Care targets learning and development in the areas of social-emotional, physical, language, cognitive, literacy, mathematics, science and technology, social studies, the arts, and English-language acquisition for children birth to age 12.

4. Dosage and program length

- Information about dosage and program length is not specified by the curriculum.

5. Staff requirements, including staff type, education, and experience

- No requirements for staff are specified on the Creative Curriculum website, and the developer did not clarify whether there are any requirements.

6. Supports for implementation

- The curriculum includes implementation guidelines and training sessions designed to help family child care providers foster development and learning objectives among the children in their care.
- Providers using the curriculum or overseeing settings using the curriculum are encouraged to familiarize themselves with the curriculum materials, including the two volumes and the LearningGames. The DVD on caregiving and learning also helps providers understand the purpose and use of the curriculum materials.
- Teaching Strategies offers a one- to two-day training for providers on The Creative Curriculum for Family Child Care. Trainings are offered on site in community locations.
- Tools for monitoring fidelity of The Creative Curriculum for Family Child Care are not specified on the Creative Curriculum website, and the developer did not clarify whether these tools are available. Teaching Strategies does offer coaching and fidelity resources for the preschool version of the Creative Curriculum and the preschool version of its comprehensive assessment, *Teaching Strategies GOLD*.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- The Creative Curriculum for Family Child Care may be used in a variety of settings, including rural and urban locations.
- The curriculum is intended for implementation by a variety of family child care providers, including daily or bi-weekly programs. Separate versions of the curriculum are available for center-based providers serving infants and toddlers and preschool-aged children. Family child care providers serving *only* infants and toddlers or *only* preschool-aged children may also use the versions of the curriculum developed specifically for those age groups, instead of The Creative Curriculum for Family Child Care.

B. Summary of existing research

We did not identify any research on The Creative Curriculum for Family Child Care.

C. For more information

Teaching Strategies

Email: info@teachingstrategies.com

<http://shop.teachingstrategies.com/page/71035-creative-curriculum-family-child-care.cfm>

Contact information for regional sales representatives is listed on the website:

<http://teachingstrategies.com/sales/regional-managers/>

D. References

Teaching Strategies. “The Creative Curriculum[®] for Family Child Care: Second Edition.”

Available at: <http://shop.teachingstrategies.com/page/71035-creative-curriculum-family-child-care.cfm>. Accessed December 4, 2014.

THE CREATIVE CURRICULUM® FOR INFANTS, TODDLERS & TWOS, THIRD EDITION

A. Overview

1. Overview, model components, and content

The Creative Curriculum for Infants, Toddlers & Twos, Third Edition is an early childhood education curriculum that is designed to help teachers (1) set up the learning environment; (2) plan developmentally appropriate routines and experiences for every day of the week; (3) promote children's social-emotional, language, cognitive, and physical development, as well as content area learning in literacy, mathematics, science and technology, social studies, and the arts; and (4) build partnerships with families. The curriculum comprises three foundational volumes and several additional resources, including Book Conversation Cards; Mighty Minutes for Infants, Toddlers & Twos; Intentional Teaching Cards; The Creative Curriculum LearningGames; and Highlights Hello magazines. Volume 1: The Foundation outlines the research that informed the development of the curriculum and discusses the five central components of nurturing care and teaching. Volume 2: Routines and Experiences discusses routines and experiences that promote development and learning of children birth to age 3 and explains how teachers can plan to implement these routines and experiences intentionally while maintaining the flexibility to respond to the changing interests and abilities of young children. Volume 3: Objectives for Development & Learning, Birth Through Third Grade describes skills, knowledge, and behaviors that promote the continuing development and learning of infants and toddlers and includes guidance to help teachers observe children effectively. It also describes (1) 38 objectives for development and learning, (2) two dedicated objectives for English-language acquisition for preschool- and elementary-aged children, (3) developmental progressions that show widely held expectations for children, and (4) research findings relating to each objective and strategies for teaching responsively. Related materials that are available separately from the curriculum include two training videos, Celebrating Language and Literacy for Infants, Toddlers & Twos, which explores the development of early literacy skills in the context of caring relationships with adults, and Strategies for Early Language and Literacy Development, which demonstrates how everyday routines, experiences, and environments support children's language development. Other materials include guides for families on ways they can extend classroom activities at home and Teaching Strategies GOLD, an observational assessment for children from birth through third grade. Versions of the curriculum for center-based preschool classrooms and family child care providers are also available. The Creative Curriculum for Infants, Toddlers & Twos was developed by Diane Trister Dodge, M.S., founder of Teaching Strategies, and colleagues Kai-leé Berke, M.S., Sherrie Rudick, M.S., and Heather Baker, M.L.S. The third edition of the curriculum was recently published; previously, the most recent version was the second edition, revised.

2. Target population, including available languages

- The curriculum is targeted to caregivers of children birth to age 3.
- The curriculum is available in English and Spanish.

3. Targeted outcomes

- The Creative Curriculum for Infants, Toddlers & Twos targets 38 objectives for development and learning, including those related to social-emotional, language, cognitive, and physical development, as well as content area learning in literacy, mathematics, science and technology, social studies, and the arts.

4. Dosage and program length

- Information about dosage and program length is not specified by the curriculum.

5. Staff requirements, including staff type, education, and experience

- No requirements for staff are specified on the Creative Curriculum website, and the developer did not clarify whether there are any requirements.

6. Supports for implementation

- The curriculum includes implementation guidelines and strategies designed to help teachers foster development and learning objectives among the infants and toddlers in their care. Training materials are available, including DVDs and a training guide.
- Staff using the curriculum or overseeing classrooms using the curriculum are encouraged to familiarize themselves with the curriculum materials. The Guide to The Creative Curriculum for Infants, Toddlers & Twos also helps providers understand the purpose and use of the curriculum materials. Online, self-guided tutorials are also available to help Teaching Strategies GOLD users explore the purpose and use of the curriculum's learning and development objectives.
- Teaching Strategies offers a variety of professional development opportunities on the curriculum for teachers and administrators. Sessions are generally available either at an implementing agency site or at Teaching Strategies' Professional Development Center.
 - Training topics for teachers on The Creative Curriculum for Infants, Toddlers & Twos include: how to observe and plan responsively and partner with families to inform teaching and caregiving; how to use the objectives for development and learning to plan a responsive and developmentally appropriate program; strategies based on trust and mutual respect for supporting families; how materials and experiences support young children's development of language and literacy skills; how to use the routines to build trusting relationships with children and promote development and learning; and how to observe and plan experiences to scaffold children's learning.
 - Training for administrators focuses on how to effectively build teams and support teachers in implementing the curriculum.
- Currently, Teaching Strategies offers coaching and fidelity resources only for the preschool version of the curriculum and the preschool version of its comprehensive assessment, *Teaching Strategies GOLD*. However, it plans to publish *Coaching to Fidelity, Infants, Toddlers & Twos Edition*, by the end of 2015.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- Information about the locations where the curriculum is implemented is not specified on the Creative Curriculum website, but it does note that it has been implemented across the country.
- The Creative Curriculum for Infants, Toddlers & Twos is used by center-based early childhood programs of various types, lengths, and settings. These include rural Migrant and Seasonal Head Start programs, urban Early Head Start programs, and other center-based Early Head Start programs. A separate version of the curriculum is available for family child care providers.

B. Summary of existing research

We did not identify any research on The Creative Curriculum for Infants, Toddlers & Twos.

C. For more information

Teaching Strategies

Email: info@teachingstrategies.com

<http://shop.teachingstrategies.com/page/76108-Creative-Curriculum-Infants-Toddlers-Twos.cfm>

Contact information for regional sales representatives is listed on the website:

<http://teachingstrategies.com/sales/regional-managers/>

D. References

Teaching Strategies. “The Creative Curriculum[®] for Infants, Toddlers & Twos: Second Edition, Revised.” Available at: <http://shop.teachingstrategies.com/page/76108-Creative-Curriculum-Infants-Toddlers-Twos.cfm>. Accessed December 4, 2014.

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HAWAII EARLY LEARNING PROFILE (HELP) 0-3

A. Overview

1. Overview, model components, and content

The Hawaii Early Learning Profile (HELP) 0-3 is a comprehensive, ongoing, curriculum-based assessment process for use by providers working with infants and toddlers and their families. The HELP 0-3 system includes: (1) the assessment; (2) a family interview designed to assess children's developmental skills and behaviors and identify family concerns, priorities and resources; (3) the HELP Activity Guide, a curricular resource that includes activities linked to each skill assessed by the HELP assessment, which caregivers can use with children; (4) HELP at Home, a curriculum designed for providers to individualize and give to families to use with their children; and (5) HELP When the Parent has Disabilities, an activity guide adapted to accommodate parents who have disabilities. The curriculum components can be used by families (guided by providers) or out-of-home caregivers. The HELP 0-3 system covers 685 developmental skills and behaviors across the following six domains: cognitive, language, gross motor, fine motor, social-emotional, and self-help. HELP 0-3 products are cross-referenced through skill identification numbers for easy linking between assessment and curriculum materials. Programs implementing HELP 0-3 can choose to use KinderCharts.net, an online system designed to measure children's developmental progress in essential domains. Although KinderCharts is a separate system, it is directly aligned with the HELP 0-3 assessments, so providers can enter assessment results and use KinderCharts to produce a variety of progress reports, including reports that meet Early Head Start requirements. Versions of the assessment and curriculum for children ages 3 to 6 are also available. The materials are published by the VORT Corporation.

2. Target population, including available languages

- HELP 0-3 is designed for use by parents and non-parental caregivers of children birth through age 3 as well as for use by Individuals with Disabilities Education Act (IDEA) Part C early intervention providers for infants and toddlers who have developmental concerns.
- The assessment and Activity Guide are available in English only; however, some supporting materials, such as HELP at Home, are available in Spanish.

3. Targeted outcomes

- HELP 0-3 targets outcomes in the following domains: cognitive, language, gross motor, fine motor, social-emotional, and self-help.

4. Dosage and program length

- HELP 0-3 provides materials relevant for a three-year period (from birth to age 3). The frequency of assessment and intervention is based on individual needs.

5. Staff requirements, including staff type, education, and experience

- There are no staff requirements, but if HELP 0-3 is being used for the Part C assessment process, staff should meet their state's definition of qualified personnel, which may include specific licenses or certifications. If HELP 0-3 is being used as a curricular program for

children who do not have significant developmental delays or disabilities, then any staff with experience and knowledge of infant-toddler development can implement the curriculum.

6. Supports for implementation

- Inside HELP is an administration and reference manual that provides assessment guidelines and procedures needed to implement all components of the HELP 0-3 system. Additional instructions are provided in each individual product.
- Onsite and online training opportunities on the HELP 0-3 system are available through VORT (see the website for more information).
- Fidelity guidelines and tools for monitoring fidelity of the HELP 0-3 system are not specified on the HELP website, and the developer did not clarify whether these are available.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- HELP 0-3 is being implemented throughout the United States.
- HELP 0-3 is implemented by a range of agencies including child care centers, Early Head Start programs, Part C providers, and hospitals. The HELP website does not specify whether the system is also intended for use by family child care providers, and the developer did not clarify whether this is the case.

B. Summary of existing research

We did not identify any research on the HELP 0-3 curriculum materials that fell within the scope of this report.³⁰

C. For more information

VORT Corporation
888-757-VORT (8678) (toll-free) or 650-322-8282
<http://www.vort.com>

D. References

VORT Corporation. “HELP: 0-3 years (Hawaii Early Learning Profile).” Available at: <http://www.vort.com/HELP-0-3-years-Hawaii-Early-Learning-Profile/>. Accessed December 3, 2014.

³⁰ The existing research base includes studies of the psychometric properties of the HELP assessment tools (interobserver and test-retest reliability, congruent validity and internal consistency); one study focused on using the HELP in home-based programs.

HIGHSCOPE INFANT-TODDLER CURRICULUM

A. Overview

1. Overview, model components, and content

The HighScope Infant-Toddler Curriculum uses a process of active learning—called active participatory learning—that consists of experiences and exploration with people, materials, events, and ideas. During active learning, caregivers scaffold (support and gently extend) infant and toddler learning by encouraging them to investigate the world around them. Learning and development are anchored by long-term, trusting relationships with caregivers. The curriculum is organized around six content areas and includes guidance for caregivers on teaching practices designed to support children’s growth and learning. The six content areas are: (1) approaches to learning; (2) social and emotional development; (3) physical development and health; (4) communication, language, and literacy; (5) cognitive development; and (6) creative arts. The teaching practices include adult–child interactions, arrangement of the physical environment, the use of daily schedules and routines, and observations and planning for children. The curriculum is linked to HighScope’s comprehensive online child assessment tool, called the Child Observation Record (COR) Advantage, which covers development from birth through kindergarten. Preschool and elementary school versions of the curriculum are available. The HighScope Educational Research Foundation developed the HighScope Infant-Toddler Curriculum.

2. Target population, including available languages

- The curriculum is targeted to children birth to age 3 and their out-of-home caregivers. Materials are also available to help families extend early learning from the classroom into the home.
- The curriculum manual, *Tender Care and Early Learning: Supporting Infants and Toddlers in Child Care Settings* (Post et al. 2011), is available in English and Spanish. COR Advantage is also available in English and Spanish, as are many of the support materials and resources (for example, DVDs).

3. Targeted outcomes

- The HighScope Infant-Toddler Curriculum targets 42 key developmental indicators across six content areas: (1) approaches to learning; (2) social and emotional development; (3) physical development and health; (4) communication, language, and literacy; (5) cognitive development; and (6) creative arts.

4. Dosage and program length

- The curriculum is appropriate for part-day and full-day programs.

5. Staff requirements, including staff type, education, and experience

- HighScope programs adhere to the staffing requirements of the appropriate licensing agency and/or program auspices (such as Early Head Start).
- HighScope offers a wide range of in-person and online staff development options. Caregivers who complete a rigorous 20-day training program can meet the requirements for

HighScope teacher certification, based on demonstrated curriculum knowledge and documented teaching practices.

- Programs in which all lead caregivers are certified and which have met additional standards for parent involvement, staff development, ongoing assessment, and management and operations can also earn HighScope program accreditation.

6. Supports for implementation

- The HighScope Infant-Toddler Curriculum manual (Post et al. 2011) includes implementation guidance, and accompanying teacher idea books and DVDs provide support for the implementation of key teaching practices. The manual is available in English and Spanish, and the DVDs are offered in English and include Spanish subtitles.
- HighScope offers a range of training options, including workshops, weeklong and multiweek trainings, and online offerings. The multiweek training course, required to become a HighScope certified teacher, is four weeks (20 days) spread across a 12-month calendar year and is offered onsite and at HighScope's headquarters. COR Advantage training is also available in-person and online.
- HighScope also offers customized on-site training and technical assistance for programs, as well as on-site observation and feedback, followed by mentoring and coaching.
- HighScope's Infant-Toddler Program Quality Assessment is designed to assess program quality and implementation of the HighScope Infant-Toddler Curriculum.

7. Overview of the locations where the model has been or is currently implemented, including types of implementing agencies

- The HighScope Infant-Toddler Curriculum is implemented in programs throughout the United States, as well as internationally.
- The HighScope Infant-Toddler Curriculum is used in a wide variety of program settings including public and private, and nonprofit and for-profit agencies. Settings include private child care centers, state-funded early childhood programs, and Early Head Start programs.

B. Summary of existing research

We did not identify any research on the HighScope Infant-Toddler Curriculum.

C. For more information

HighScope Educational Research Foundation

Email: info@highscope.org

<http://www.highscope.org/>

D. References

HighScope. "Infants and Toddlers." Available at

<http://www.highscope.org/Content.asp?ContentId=62>. Accessed November 22, 2014.

Post, J., M. Hohmann, and A.S. Epstein. Tender Care and Early Learning: Supporting Infants and Toddlers in Child Care Settings. Ypsilanti, MI: HighScope Press, 2011.

III. GAPS IN THE KNOWLEDGE BASE AND IMPLICATIONS FOR FUTURE RESEARCH

LITES identified 13 compelling models that are of interest to the ECE field for supporting infant and toddler early learning in out-of-home care settings. The models are in different stages of development, and most, but not all, have engaged in some implementation or descriptive outcomes research. Yet, all could benefit from further development and evaluation. Once the models are well developed and producing potentially positive child outcomes as demonstrated through descriptive research (such as pre-test post-test designs), they should then be rigorously tested to assess their effects on child outcomes.

As anticipated, because this component of LITES focused on identifying models that had not yet been rigorously evaluated to examine impacts on children's outcomes, we found primarily implementation and descriptive research on these models. As reported in the model summaries, eight of the models had research studies (Table III.1). Those with research often had only one study.³¹ The studies included implementation studies, descriptive outcome studies measuring interim and child outcomes, and, to a lesser extent, impact studies measuring interim outcomes. Two models had impact studies examining child outcomes that were underway at the time the scan was conducted.

None of the curricula models had research on implementation or outcomes. The preschool versions of HighScope and the Creative Curriculum have been rigorously evaluated, but not the infant and toddler curricula. Both AEPS and HELP had extensive research on the psychometric properties of the assessment tools that accompany the curriculum materials but not the curricula itself. Although the curricula had not been evaluated, the model developers note that the models were developed based on existing research evidence, including research on infant/toddler development, attachment, and brain development.

Despite the existence of some research on the compelling models, all could benefit from further development to specify how they should be implemented and how staff should be trained and supported to carry out these models with fidelity. Developing and testing the effectiveness of program models requires a range of research, including implementation, outcome, and impact studies. The type of research needed depends on the stage of each model's development. Implementation studies focus on assessing the feasibility of implementation and refining model specification, developing fidelity standards and measures, and assessing how the model may need to be adapted for different settings and target populations. Descriptive outcome studies can provide suggestive evidence about whether a model is producing expected outcomes and warrants more rigorous testing through an impact study.

³¹ We only report findings from studies that focused on infants and toddlers and their caregivers. Specifically, we report findings on children's outcomes for infants and toddlers, or interim outcomes for infant and toddler caregivers or settings where infants and toddlers received care. We include findings from implementation studies as long as they reported on care settings for infants and toddlers.

Rapid cycle evaluations can serve a cost-effective strategy for guiding decision making (Cody and Asher 2014; Metz et al. 2015). By leveraging data available in administrative records, model developers can test interventions more quickly than evaluations that require collecting data. Because the outcomes need to be observable in a short period of time, it is most useful in looking at outputs (such as the number of coaching sessions completed) and impacts on intermediate outcomes (such as caregiver knowledge). Rapid cycle evaluations can be particularly useful in testing potential solutions to implementation difficulties. For example, this type of evaluation could be used to test interventions for increasing ongoing attendance rates of informal caregivers participating in ELR (such as altering the time of day events are offered, offering transportation, or using text message reminders); ELR administrative data could serve as a data source for tracking whether the interventions led to increased attendance.

Finally, impact studies can provide evidence as to whether a given early learning model or intervention is responsible for changes seen in measured child outcomes. For a complete picture, researchers can couple impact studies with implementation studies that measure fidelity. Measuring fidelity helps researchers interpret the results of impact studies; for example, it can help them determine whether a model seems to be ineffective because it was not implemented correctly or, conversely, whether findings should be attributable to the model because it was implemented according to the developer's specifications (Knoche et al. 2010). Together, findings from across the spectrum of research can provide information about what was implemented and whether it worked.

Since the process of developing and testing models requires time and resources, several innovative strategies, including rapid cycle evaluations, should be considered for supporting model development. Model developers and other decision-makers may also be able to collaborate with networks of researchers to implement these types of evaluations. For example, the Network for Infant/Toddler Researchers (NITR) sponsored by OPRE, collaborative innovation and improvement networks (CoIINs), and Early Learning Labs could serve as forums for supporting development of ECE models for infants and toddlers. These networks bring together practitioners, researchers, and experts for mutual learning. Early Learning Labs aim to accelerate experimentation and development of scalable early learning interventions.

Table III.1. Overview of research on compelling models, by study type

Model	Implementation study	Descriptive study: child outcomes	Descriptive study: interim outcomes ^a	Impact study: interim outcomes	Impact study underway: child outcomes
Early Childhood Consultation Partnership (ECCP)	✓				✓ ^c
Early Learning Readiness (ELR) Program	✓		✓		
Educare		✓	✓		✓ ^c
Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching				✓ ^d	
First Beginnings ^e			✓		
Infant Caregiver Mentoring Project ^e				✓ ^f	
Seeds to Success ^e	✓			✓	
Smart Support	✓	✓ ^g	✓ ^g		

^aInterim outcomes are those *other than* child outcomes that are thought to be related to child development. For LITES, this included the following domains: global ECE quality, structural features of care, caregiver-child interaction, and caregiver knowledge of child development.

^bResults from a pilot impact evaluation of ECCP became publically available in December 2014, after analyses for the LITES systematic review and compelling models profiles were complete.

^cData collection is in progress for the first phase of an impact study on Educare, which follows children through age 3; the youngest children in the study turn 3 in September 2015.

^dThe study of EQIT included comparison groups of convenience. Within the EQIT intervention group, participants were randomly assigned to receive different amounts of coaching.

^eFirst Beginnings and the Infant Caregiver Mentoring Project are not currently active. After the Seeds to Success demonstration period concluded, it was used to develop a new system called Early Achievers, which is currently in operation.

^fThe study of the Infant Caregiver Mentoring Project used a randomized design, but reported analyses of pre-post differences within groups.

^gSmart Support presented study results in infographic provided by the developer rather than a research report.

A consideration about the implementation of the compelling models, particularly curriculum models, is that many out-of-home early learning settings rely on multiple models or select specific practices from models to meet program needs. In a survey of National Association for the Education of Young Children (NAEYC) members, 46 percent of respondents reported using various curriculum models but did not identify a principal model. Different models may serve different purposes in a setting. Practitioners may also rely on multiple models in an effort to innovate and improve services. In addition, the prevalence of reliance on multiple models may point to the need for more multicomponent models that provide all the components needed in an out-of-home early learning setting for infants and toddlers. As indicated by Epstein et al. (1996), practitioners may feel the need to combine models to provide a complete package of professional development support for staff, curricula, and other early learning supports for children and families. In contrast, multicomponent models include all of these program dimensions.

Our scan of the field yielded two compelling multicomponent models (Educare and the Early Learning Readiness Program for Informal Family, Friend, and Neighbor Caregivers [ELR]). The other models were professional development interventions or curricula. This finding may reflect a current policy trend toward supporting out-of-home care early learning initiatives focused on professional development or quality improvement in existing settings, such as through Quality Rating and Improvement Systems (QRIS), rather than multicomponent models. This investment may reflect the reality that, since welfare reform, most low-income infants and toddlers are already in out-of-home care while their parents work and current policies support low-income working parents by providing vouchers that they can use at any ECE setting (as opposed to directing families into specific ECE models). As a result, the field is focusing on improving the settings in which children already receive care. Moreover, developing and testing a multicomponent model is expensive; finding the resources to do so may not be feasible for most model developers. In the remainder of this chapter, we describe the spectrum of research needed to develop and test the models.

A. Model specification

Well-specified models have well-developed logic models in which services are closely linked with specific desired outcomes. They also have written materials and other supports available to guide implementation. The level of specification in the compelling models we profiled in this report varied, both across models and across implementation components (Table III.2). All models specified target outcomes and target populations. Most also had available implementation guides, training materials, and qualified trainers. Almost half of the models had specific training requirements for staff. For example, Smart Support has an implementation manual and a logic model. The implementation manual describes in detail the step-by-step process for providing consultation, to ensure consistent service delivery and fidelity to the Smart Support model. Smart Support consultants receive pre-service and in-service training, as well as ongoing supervision, to assist their work and fidelity to the model. In addition to these implementation supports, ECCP also uses a centralized information system for program operations, data collection, and reporting. The data from this system are used to create plans for delivering services, for quality assurance, and to promote fidelity to the model.

Even the models with written materials to support implementation could benefit from additional research to understand the mechanisms through which the models improve child or

caregiver outcomes, identify the components that require greater definition or structure to have a strong influence on participants, and identify different outcomes that might warrant further examination. This research could be used to develop detailed logic models before pilot tests or studies of models are launched, and to refine them as development proceeds.

Table III.2. Overview of documented implementation components

Implementation component	Number of compelling models
The model developer has specified the following:	
Target outcomes	13
Target population	13
Dosage of services	8
Program length	9
Staff education requirements	3
Staff training requirements	6
Supports for implementation	13
Implementation/operation manuals	11
Training materials	12
Qualified trainers	12
Fidelity standards	6
Systems for monitoring fidelity	6

B. Implementation research

Implementation studies are informative throughout the development of a model, but particularly so in the early stages. These studies explore the feasibility of implementing models and model components and how models are implemented in the field. For example, implementation studies can explore the use of multiple models simultaneously in ECE settings and differences in implementation of the same model depending on how they select and combine model components. In addition, implementation research can inform the development of fidelity standards and measures for assessing fidelity to track the degree to which components are implemented. To study implementation, researchers rely on various methodologies depending on the goals of the study, such as qualitative case studies to learn about how models are implemented; planned variation studies that examine how outcomes vary depending on the model components implemented; or rapid cycle evaluations that test the impacts of changes to implementation and that can inform continuous quality improvement.

Of the 13 compelling models profiled in this report, 4 had studies examining implementation (ECCP, ELR, Smart Support, and Seeds to Success; Table III.1). These studies reported on how services were implemented, teacher and caregiver satisfaction with the services, and barriers to implementation. Understanding the feasibility of implementation (including how services were implemented, the challenges of model implementation, and whether and how those challenges can be met) can help developers to better specify and refine model implementation. For example, a component of the Seeds to Success model includes funds for professional development. The study identified several barriers that made feasibly implementing this component difficult, including (1) limited availability of trainings and classes, particularly near their places of

employment or homes; (2) lack of trainings and classes that provided new or relevant information; and (3) low perceived “payoffs” to professional development, because salaries were unlikely to increase as a result of completion of professional development (Boller et al. 2010). Understanding these barriers can inform refinements to the model.

In addition, implementation research can inform the development of fidelity standards and test measures of fidelity that can be used for ongoing monitoring and program improvement. Measuring fidelity can also help researchers interpret the results of impact studies; for example, it can help them determine whether a model seems to be ineffective because it was not implemented correctly or, conversely, whether findings should be attributable to the model because it was implemented according to the developer’s specifications (Knoche et al. 2010). When models are specified and the content, intensity, duration, and approach to delivery of services have been defined, research is needed to develop standards for levels of fidelity that must be achieved to produce desired outcomes.³² For example, fidelity standards could include the minimum amount and quality of services needed to implement with fidelity, the time and training needed for out-of-home caregivers to achieve fidelity, and the support required to maintain it. About 40 percent of the compelling models specified fidelity standards or had systems for monitoring fidelity (see Table III.2). The studies of ELR and ECCP used administrative data to describe implementation fidelity; these studies did not, however, explore the levels of fidelity needed to produce desired outcomes (YMCA of the USA 2014; Fink and Wakai 2003).

C. Outcome and impact studies

Outcome studies can assess the degree to which a model seems on track to achieve its intended outcomes. Outcome study methods fall along a spectrum that can be thought of as progressing from descriptive, to suggestive, to conclusive in assessing the influence of the model on the desired outcomes. The methods are all useful but address different purposes and research questions. Because causal impact studies require substantial time and resources, it may be prudent to conduct descriptive outcome or correlational studies first. If results are potentially positive, an impact study may be warranted. Only an impact study can conclusively attribute positive findings to the program model.

Descriptive outcome studies. These studies examine the changes in outcomes only for participants in the model; there is no comparison group. Such studies are useful as performance measures for monitoring to ensure that a model is “on track” to achieve goals but do not allow researchers to make causal inferences that the program model *caused* the observed effect. Two of the compelling models had a descriptive study measuring children’s outcomes (Educare and Smart Support), and four models had descriptive studies of interim outcomes (ELR, Educare, First Beginnings, and Smart Support; see Table III.1).

³² Planned variation studies can provide useful information to inform the development of fidelity standards by testing which model components (or combinations of components) are most effective for delivering specific content or by testing the relative impact of different conditions within a model (such as levels of staff training or dosage). To test different components, caregivers could be randomly assigned to variations of a model with different levels of training or coaching for staff. Such a study could shed light on the qualifications or levels of training and support needed to achieve desired outcomes.

The descriptive studies of both Educare and Smart Support showed potentially positive findings on children's outcomes (Yazejian and Bryant 2012; Southwest Human Development and Indigo Cultural Center 2015). For example, the study of Educare found that more years of program attendance was associated with better school readiness and vocabulary skills. Similarly, the descriptive studies of interim outcomes pointed to the potential of the models to improve these outcomes. The studies of both ELR and Smart Support suggested the potential of the models to improve caregiver/consultant knowledge (YMCA of the USA 2014; Southwest Human Development and Indigo Cultural Center 2015). The study of Educare found higher levels of classroom quality as compared to national norms and the study of First Beginnings found improvements on pre- and post-measures of classroom quality (Yazejian and Bryant 2012; Campbell et al. 2005).

Causal impact studies. A conclusive test of effectiveness determines whether the model caused the differences between expected outcomes for the intervention and comparison group. Impact studies using well-executed designs such as RCTs, matched comparison group designs, regression discontinuity designs, and single case designs are needed to attribute findings to the model. To determine this causality, a study needs to examine the outcomes relative to what would have happened without the model. These studies rely on a comparison group that does not participate in the model but is otherwise similar to the group that does participate. When intervention and comparison groups are similar, the outcomes for both groups can be compared, and any differences can be attributed to the model.

Among the research on the compelling models, we identified three RCTs measuring interim outcomes (EQIT, Infant Caregiver Mentoring Project, and Seeds to Success). Across the studies, all three found higher observed quality in the intervention group versus the comparison group (Moreno et al. 2015; Fiene 2002; Boller et al. 2010). These findings indicate these caregiver professional development models are good candidates for impact studies examining whether the models can improve child outcomes. At the time this report was written, impact studies examining child outcomes were underway for two models: ECCP and Educare. Because the results were not yet available, however, these two models were not included in the LITES systematic review. The pilot study of ECCP, which was available after the completion of the LITES systematic review, found suggestive evidence of decreased hyperactivity for toddlers (Gilliam 2014). However, the small sample size may have impeded the authors' ability to detect a statistically significant impact. These findings warrant further investigation through rigorous research.

D. Conclusion

This report profiled 13 models that are viewed by the ECE field as having potential to promote infant and toddler early learning in out-of-home settings, but have not yet been rigorously evaluated. The models include two that provide direct early learning services to infants and toddlers; six focused primarily on working with caregivers through coaching, modeling, and/or collaborative consultation to help them support children's early learning; and an additional five models are curricula implemented in programs for infants and toddlers. Over half of the models are aimed at supporting children's development across domains, including language, cognition, or social emotional/behavioral development. The models tend to target children and caregivers in a range of out-of-home ECE settings including both center-based and

home-based settings. Eight of the 13 models had at least some research, usually a single implementation or descriptive study. None of the curricula models had existing research. The three models with impact studies of interim outcomes were all professional development models; the findings pointed to the potential of these models to improve observed quality and increase caregiver knowledge and skills.

Although many of the models have begun the process of building a research base, additional research on out-of-home ECE models for infants and toddlers is essential for moving the field forward. Two models—Educare and ECCP—are currently the focus of impact studies. As a follow-up to these studies, models can also be tested with different subgroups of caregivers (for example, family child care providers and center-based providers) or children (for example, dual language learners and monolingual English speakers) to identify the groups for which particular strategies are most effective. Additional compelling models that are well-specified and have some existing research evidence, such as EQIT, Infant Caregiver Mentoring Project, Smart Support, and Seeds to Success, might be ready for impact studies that examine their impact on children’s outcomes. Others, including the five curriculum models, might require a full spectrum of research to test the feasibility of staff training and implementation procedures, develop standards for high-fidelity implementation and measures to monitor fidelity, and assess whether the models show potential for producing intended outcomes.

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APPENDIX A

IDENTIFYING COMPELLING MODELS

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Table A.1. Electronic mailing lists for the LITES call for nominations

Group	Email or contact information
American Academy of Pediatrics	kidsdocs@aap.org
American Education Research Association	aeainfo@vanderbilt.edu
American Evaluation Association	info@eval.org
American Medical Association	mediarelations@jama-archives.org
American Professional Society on the Abuse of Children	apsac@apsac.org
American Psychiatric Nurses Association	tlantrip@apna.org
American Psychological Association	public.affairs@apa.org
American Public Health Association	comments@apha.org
American Sociological Association	publications@asanet.org
Association for Psychological Science	amikulak@psychologicalscience.org
Association for Public Policy Analysis and Management	appam-l@list.s-3.com
Association of Maternal and Child Health Programs	info@amchp.org
Center for Law and Social Policy	jrobinson@clasp.org
Child Care and Early Education Research Connections	contact@childcareresearch.org
Child Maltreatment Researchers Listserv	child-maltreatment-research-l@cornell.edu
Child Welfare Information Gateway	info@childwelfare.gov
Coalition for Evidence-Based Policy	danderson@coalition4evidence.org
Collaborative for Understanding the Pedagogy of Infant/Toddler Development	valotto@msu.edu
Early Head Start Research Consortium	ehs_research@listserve.icfi.com
Evidence Based Home Visitation Programs	ebhv@listserve.icfi.com
Federal Inter-Agency Workgroup on Child Abuse & Neglect	catherine.nolan@acf.hhs.gov
FRIENDS Listserv for Community Based Child Abuse Prevention Grantees and Interested Community Members	friendsnrc@lists.friendsnrc.org
Foundation for Child Development	info@fcd-us.org
Future of Children	foc@princeton.edu
Harvard's Center on the Developing Child	developingchild@harvard.edu
Health Resources and Services Administration Traumatic Brain Injury Technical Assistance Center Listserv	tbtiserv@list.nih.gov
Healthy Start Eval Listserv (NIH)	healthystarteval@list.nih.gov
International Society for the Prevention of Child Abuse and Neglect	ispcan@ispcan.org
The International Society on Infant Studies	lewkowic@fau.edu
Maternal and Child Health, Early Childhood Comprehensive Systems Listserv	eccs@lists.ucdenver.edu
Maternal and Child Health Training Listserv Members	mchtraining@list.nih.gov
National Association for the Education of Young Children	membership@naeyc.org
National Association for Welfare Research and Statistics	NAWRS2013@gmail.com
National Association of Social Workers	membership@naswdc.org
National Council on Family Relations	info@ncfr.org
Network of Infant/Toddler Researchers	nitr@lists.icfwebsservices.com
Partners in Maternal and Child Health Safety Net Listserv	Members contacted directly
Pew Charitable Trusts	info@pewtrusts.org
Prevent Child Abuse America	mailbox@preventchildabuse.org
Prevention Subcommittee Distribution List	Members contacted directly
Social Work Research Network (formerly called Institute for the Advancement of Social Work Research)	swrnet@bu.edu
Society for Prevention Research	info@preventionresearch.org
Society for the Psychological Study of Social Issues	spssi@spssi.org
Society for Research in Child Development	info@srcd.org
Society of Pediatric Nurses	spn@dancyamc.com
Zero to Three	0to3@presswarehouse.com

Table A.2. Models considered for inclusion

Model	Source	Reason for screening out
Screened in		
Assessment, Evaluation and Programming System	Data on curricula ^a	Screened in
Ball State University Child Study Center	Call for nominations	Screened in
Comprehensive Child Development, Inc.	ASPE recommendation	Screened in
The Creative Curriculum for Family Child Care	Data on curricula	Screened in
The Creative Curriculum for Infants, Toddlers & Twos	Data on curricula	Screened in
Cuyahoga County Early Childhood Initiative	Screened out of systematic review	Screened in
Early Childhood Consultation Partnership	Expert recommendation	Screened in
Early Learning Readiness Program for Informal Family, Friend, and Neighbor Caregivers	Call for nominations	Screened in
Educare	Expert recommendation	Screened in
Emotional Beginnings	Data on curricula	Screened in
Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching	Expert recommendation	Screened in
First Beginnings (Philadelphia Inclusion Network)	Expert recommendation	Screened in
Hawaii Early Learning Profile 0-3	Data on curricula	Screened in
HighScope Infant-Toddler Curriculum	Data on curricula	Screened in
Infant Caregiver Mentoring Project	Expert recommendation	Screened in
Piper Child Development Center for Family Studies and Child Development at Baylor University	Call for nominations	Screened in
Promethean Foundation (Pro-Kids)	Call for nominations	Screened in
Responsive Infant/Toddler Practice within a Suite of Inquiry	Call for nominations	Screened in
San Diego State University Children's Center	Call for nominations	Screened in
Seeds to Success	ASPE recommendation	Screened in
Smart Support	Expert recommendation	Screened in
Screened out		
The Anti-Bias Curriculum	Data on curricula	Did not meet 5 percent threshold ^b
AVANCE	ASPE recommendations	Primarily targets parents
Baby Signs	Expert recommendation	Targets parents
Beautiful Beginnings: A Developmental Curriculum for Infants and Toddlers	Data on curricula	Did not meet 5 percent threshold
Beyond the Delivery/Infant Massage	Call for nominations	Targets parents
Building Early Emotion Skills Curriculum	Call for nominations	Targets parents
Born to Learn/Parents as Teachers	Data on curricula	Home visiting curriculum
Celebrating Families! (0-3)	Call for nominations	Targets parents
Center for the Social and Emotional Foundations for Early Learning: Infant/Toddler Training Modules	Expert recommendation	Consists only of online trainings; lacking specific guidance on how materials should be implemented and/or support for implementation
Community Connections Preschool for All Program	Screened out of systematic review	Does not have an infant/toddler component; targets preschool children

Model	Source	Reason for screening out
Continuity of care	Call for nominations	Theoretical approach or general practice; not a replicable model without further specification
Developmental Learning Materials	Data on curricula	Infant/toddler curriculum not available; pre-K only
Domains Based Curriculum	Data on curricula	No information available
Early Childhood Research and Intervention Program	Screened out of systematic review	Targets children with medical and developmental disabilities
Early Learning Accomplishments Profile	Data on curricula	Assessment only
Games to Play with Babies	Data on curricula	Limited documentation available; handbook of activities only
Games to Play with Toddlers	Data on curricula	Limited documentation available; handbook of activities only
Growing Great Kids In Center-Based and Family Child Care Professional Development Program	Data on curricula	Consists only of online trainings; lacking specific guidance on how materials should be implemented and/or support for implementation
High Reach For Infants/High Reach For Toddlers and Twos	Data on curricula	Did not meet 5 percent threshold
Infant Toddler Project	Call for nominations	Draws largely on the Program for Infant/Toddler Care (see below)
Innovations	Data on curricula	Infant/toddler curriculum not available; preschool only
Just in Time Parenting	Call for nominations	Targets parents
Learning Activities for Infants	Data on curricula	No information available
LINKAGES: Building Strong Connections	Call for nominations	Targets parents
Montessori	Expert recommendation	Theoretical approach or general practice; not a replicable model without further specification
Ones and Twos	Data on curricula	No information available
Partners as Primary Caregivers	Data on curricula	No information available
Partners for a Healthy Baby (Florida State University)	Data on curricula	Home visiting curriculum
Partners in Learning	Data on curricula	No information available
Play and Learning Strategies curriculum	Expert recommendation	Parenting curriculum
Playgroup	Call for nominations	Targets parents
Playtime Learning Games for Young Children	Data on curricula	Limited documentation available; handbook of activities only
Program for Infant/Toddler Care	Data on curricula	Rigorous research examining children's outcomes exists, therefore included in systematic review
Reggio Emilia	Data on curricula	Theoretical approach or general practice; not a replicable model without further specification
Relaxation Techniques for Parents: Tools for Managing Stress	Call for nominations	Targets parents
Scholastic	Data on curricula	No information available
South Carolina Program for Infant/Toddler Care	Call for nominations	Draws largely on the Program for Infant/Toddler Care (see above)
Special Care Nursery	Call for nominations	Targets children with medical and developmental disabilities
Spilstead Model	Screened out of systematic review	Early intervention program, targets children with developmental needs
Talking to Your Baby	Data on curricula	Parenting curriculum
Tools of the Mind	Expert recommendation	Infant/toddler curriculum not available; preschool and older only

Model	Source	Reason for screening out
Toronto First Duty	Screened out of systematic review	Does not serve infants and toddlers, only older children
University-Housed Half Day Care Model	ASPE recommendations	Model no longer implemented and no information available

ASPE = Office of the Assistant Secretary for Planning and Evaluation.

^aTo identify commonly used curricula, we examined the Early Head Start Family and Child Experiences Survey (known as Baby FACES) and the Head Start Program Information Report (PIR).

^bUsing information from Baby FACES and the PIR, we screened out curricula used by less than 5 percent of Early Head Start programs.

APPENDIX B

OVERVIEW OF COMPELLING MODELS

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Table B.1. Overview of compelling models

Model name	Overview and key components	Targeted outcomes	Target population
Models that provide direct early learning services to children			
Early Learning Readiness (ELR) Program for Informal Family, Friend, and Neighbor Caregivers	ELR promotes early learning for children receiving care in informal child care settings, and supports their informal caregivers. These children and their caregivers participate together in the program through sessions that are facilitated and held in a group setting. A typical session consists of the following: (1) an opening circle time where the children and caregivers read stories and sing songs together; (2) time to explore a range of activities at 13 interest centers; and (3) a closing circle to review the day's learning. During the sessions, facilitators talk with caregivers about the interest centers, how the activities encourage learning in children, and the role caregivers can play in promoting learning and development using the activities. In addition, activities at each center include written guidance for caregivers that list learning concepts, vocabulary words, and questions caregivers can ask the children. Session content features monthly, culturally sensitive themes and is designed to align with local standards for school readiness.	Child development and school readiness, both directly with children and by increasing the skills and knowledge of their caregivers	Low-income children from birth to age 5 who receive informal care from family members, friends, and neighbors, as well as their informal caregivers
Educare	The Educare Learning Network is a national network of schools that provide full-day, full-year early care and education to low-income children from birth to age 5. The Educare model contains several core features, which are grouped into four domains: (1) data utilization, (2) high quality teaching practices, (3) embedded professional development, and (4) intensive family engagement. Under a system of continuity of care, children stay with the same teaching team and cohort of children from program entry until age 3, and then stay with a second team until they transition out of Educare and into elementary school at age 5. Within each teaching team, every child has a primary caregiver, and each classroom has three adults with eight infants and toddlers. Groups of staff from up to four classrooms are supervised by master teachers who provide mentoring, coaching, and support to classroom teachers. Local Educare sites choose their own curriculum, which must be research-based and focus on pre-literacy, early math, and social-emotional skills, and integrate development of these skills with arts activities. Educare schools also offer on-site family engagement services, provided by full-time family support supervisors and specialists, to promote parent involvement. These staff also coordinate referrals for parents to other services.	Language and literacy, social-emotional development, early math concepts, problem-solving, and motor development for children; parents' abilities to support their child's learning and promote family well-being after they leave Educare	At-risk children from birth to age 5 and their families; families must meet Head Start income requirements to qualify
Models that primarily focus on professional development for caregivers			
Early Childhood Consultation Partnership (ECCP)	ECCP is an early childhood mental health consultation program that operates statewide in Connecticut. The program is designed to build the capacity of caregivers (primarily non-parental caregivers such as center-based educators and family child care providers, but in some cases parental caregivers as well) by offering support, education, and on-site consultation to help them meet the social-emotional needs of children in their care. It is designed to address a continuum of care that includes promotion, prevention, and early intervention.	Outcomes for children, including social, emotional, and mental wellness, and preventing at-risk children from developing mental health disorders or being	Children from birth to age 5 and their non-parental caregivers in early care and education settings, which include both center-based care and family child care homes; in some cases,

Model name	Overview and key components	Targeted outcomes	Target population
	Services provided by ECCP consultants range in scope and can consist of (1) child-specific services, which help non-parental caregivers and family members meet the needs of a particular child; (2) core classroom services, which help a teacher or caregiver meet the needs of their classroom (and include some child-specific services); or (3) intensive center services, which help center staff build capacity to address the needs of the full center (and may include child-specific and classroom services).	suspended or expelled	children's families, including services within children's homes; ECCP aims to support children who are at risk of developing a mental health disorder or of being suspended or expelled
Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching	The EQIT course provides training for caregivers of infants and toddlers to improve their knowledge and skills. Course content covers the importance of brain development in the first three years of life; the social-emotional, cognitive, language, and physical development of infants and toddlers; relationship-based care and relationship-based approaches to guiding children's behavior; partnerships with families; quality curriculum and environments; and health, safety, and nutrition. Completion of the course meets some state licensing requirements, and, when possible, partnerships with local community colleges allow for course participation to result in college credit. These partnerships are also used to encourage participants to consider additional formal coursework. Class sizes are intended to be 20 or fewer caregivers. An orientation may be held before the course begins to introduce instructors, provide an overview of the course, set course expectations, and provide additional information. Participants are also offered the option of receiving on-site coaching through the EQ RELATE coaching model to supplement the course. The coaching supports participants in reflecting on the skills and knowledge learned in the course and integrating this information into the care they provide to their infants and toddlers.	Knowledge and skills of caregivers in multiple areas, including supporting children's social-emotional, cognitive, and physical development	Colorado caregivers or other individuals who work with infants and toddlers in group settings, whether in center-based care, family child care, or another setting
First Beginnings	First Beginnings is a professional development program for caregivers of infants and toddlers in out-of-home settings (centers and family child care homes) that features both training and on-site consultation designed to increase the quality of care children received. First Beginnings consists of four components: 1. Participants take a group training class. Topics include caregiver-child relationships, strategies for promoting learning and development, inclusion and diversity, and working with families. 2. Outside of class time, participants complete a project that involves reflecting on and writing about an infant or toddler in their care identified by them as having a special need. 3. On-site observation visits are conducted before and after the program to collect measures of the quality of the participants' classroom environments and their interactions with the children in their care. 4. Participants receive on-site consultation visits. Consultation strategies include providing/reviewing resources or materials, brainstorming, modeling, and discussion.	Program quality	Caregivers of infants and toddlers (birth to age 3) in centers and family child care homes
Infant Caregiver Mentoring Project	The Infant Caregiver Mentoring Project is designed to improve the quality of infant and toddler child care programs through the use of mentoring. Participants in the project are paired with an experienced early childhood professional who	Overall quality of the child care environment, especially the quality of	Pennsylvania caregivers from center-based child care programs serving

Model name	Overview and key components	Targeted outcomes	Target population
	serves as their mentor in a one-on-one relationship. The mentoring emphasizes a relationship-based, problem-solving approach. In the first part of the program, the mentor spends time getting to know the participant and observing him or her on-site to develop a trusting relationship. When both parties feel comfortable, the mentor begins working more actively with the participant. Mentors focus on being open-minded, collaborative, and supportive of caregivers who are attempting new ideas and strategies.	caregiver–child interactions and the sensitivity of caregivers to the needs of their children	children from birth to younger than age 3
Seeds to Success	Seeds to Success is a coaching model for providing quality improvement services within a pilot child care quality rating and improvement system. It supports licensed family child care providers, center-based teachers, and child care center directors in improving: (1) the quality of early care and education and (2) staff access to professional development and training. The coaching model, the Consultative Coaching Program for Early Learning Professionals, was developed in 2008 by Thrive by Five Washington, Washington State's public-private partnership for early learning. The goal of the Consultative Coaching Program is to train coaches to develop a trusting relationship with early learning professionals so that they can help early learning professionals reflect on their practice (1) in the classroom or in their business and (2) during interactions with the other providers in that setting, with families, and with the children in their care. The Seeds to Success coaches aim to help the professionals stay motivated to attain their quality improvement goals and help establish skills and behaviors that support continuous quality improvement. Providers and coaches develop quality improvement plans that are used to guide the coaching sessions. The plans are based on results of a baseline observation of setting quality.	Overall quality of care	Family child care providers, center-based teachers, and child care center directors caring for children birth to age 5
Smart Support	Smart Support is Arizona's system of early childhood mental health consultation. It partners mental health consultants with early care and education providers to promote the social and emotional development of the children in their care, and to help them respond to children with behavioral challenges. A consultant first meets with a provider to explain the consultation services, confirm these are appropriate for the provider's needs, and verify that the provider remains interested in receiving these services. If so, the consultant works with the provider to develop an individualized plan that describes how services will be provided. Three types of consultation can be provided in different combinations depending on provider needs and preferences: (1) program consultation focuses on the provider's entire setting; (2) classroom consultation works with a teacher to improve his or her skills or outcomes in the classroom; and (3) child-centered consultation involves helping staff and parents develop a plan to support care for a child exhibiting difficult behaviors. Services provided by consultants may also include training as well as referrals to other services and resources.	Emotional climate in programs and classrooms; staff interactions with parents and other staff; teacher attitudes, beliefs, and knowledge; teacher–child relationships; child behavior; involvement with early intervention services; and reduced risk of expulsion; capacity of programs to meet children's social and emotional needs	Child care providers caring for children from birth to age 5, including child care centers and preschools as well as family child care providers; consultation can also be provided to home visiting and family, friend, and neighbor programs
Curricula models			
Assessment, Evaluation, and Programming	AEPS is designed to support caregivers in matching a child's goals and activities with activity-based intervention strategies based on the child's age and current level of development. These strategies involve working on goals and objectives	Fine motor, gross motor, adaptive, cognitive, social-communication, and social	Professionals (including early childhood educators in general, as well as special education teachers,

Model name	Overview and key components	Targeted outcomes	Target population
System (AEPS), Second Edition, Curriculum for Birth to Three Years	within the children's routine (for example, mealtimes, bathing, and dressing), planned activities (for example, activities organized by an adult, such as painting), and spontaneous activities that capitalize on children's daily interactions with their social and physical environments to facilitate skill development. The curriculum is linked to the AEPS Test, an assessment designed to help teachers select and evaluate goals and objectives that are most appropriate for each individual child in key developmental areas. Overall, AEPS includes two sets of assessment and curriculum materials, one for children birth through age 3 and one for children age 3 through 6. The system is supported by a web-based data management system known as AEPSi.		early interventionists, family service coordinators, administrators, physical therapists, speech-language pathologists, and occupational therapists) working with children birth to age 3. Specifically developed for use with children who have disabilities or are at risk for developmental delays, but can be used with all children.
The Creative Curriculum for Family Child Care, Second Edition	The Creative Curriculum for Family Child Care, Second Edition, is a curriculum designed to help family child care providers: (1) set up the learning environment; (2) plan developmentally appropriate routines and activities for every day of the week; (3) promote children's learning and development in the areas of social-emotional, physical, language, cognitive, literacy, mathematics, science and technology, social studies, the arts, and English-language acquisition; and (4) build partnerships with parents. To make it easier for caregivers to implement activities, the curriculum also includes 68 Creative Curriculum LearningGames offering suggestions for helping families and caregivers interact with children, a list of necessary materials, and ways to adapt the activities to children's ability levels; a DVD about caregiving in the family child care setting and how children learn; and a CD-ROM with copies of forms and letters to parents. Versions of the curriculum for infant and toddler and preschool classrooms are also available.	Social-emotional, physical, language, cognitive, literacy, mathematics, science and technology, social studies, the arts, and English-language acquisition	Family child care providers caring for children birth to age 12
The Creative Curriculum for Infants, Toddlers & Twos, Third Edition	The Creative Curriculum for Infants, Toddlers & Twos, Third Edition, is an early childhood education curriculum that is designed to help teachers (1) set up the learning environment; (2) plan developmentally appropriate routines and experiences for every day of the week; (3) promote children's social-emotional, language, cognitive, and physical development, as well as content area learning in literacy, mathematics, science and technology, social studies, and the arts; and (4) build partnerships with families. The curriculum comprises three foundational volumes and several additional resources, including Book Conversation Cards; Mighty Minutes for Infants, Toddlers & Twos; Intentional Teaching Cards; The Creative Curriculum LearningGames; and Highlights Hello magazines. Related materials available separately from the curriculum include two training videos on early language and literacy development; guides for families on ways they can extend classroom activities at home; and Teaching Strategies GOLD, an observational assessment for children from birth through third grade. Versions of the curriculum for center-based preschool classrooms and family child care providers are also available.	Social-emotional, language, cognitive, and physical development, as well as content area learning in literacy, mathematics, science and technology, social studies, and the arts	Caregivers of children birth to age 3
Hawaii Early	HELP 0-3 is a comprehensive, ongoing, curriculum-based assessment process	Cognitive, language,	Parents and non-parental

Model name	Overview and key components	Targeted outcomes	Target population
Learning Profile (HELP): 0-3	for use by providers working with infants and toddlers and their families. The HELP 0-3 system includes (1) the assessment; (2) a family interview designed to assess children's developmental skills and behaviors and identify family concerns, priorities and resources; (3) the HELP Activity Guide, a curricular resource that includes activities linked to each skill assessed by the HELP assessment, which caregivers can use with children; (4) HELP at Home, a curriculum designed for providers to individualize and give to families to use with their children; and (5) HELP When the Parent has Disabilities, an activity guide adapted to accommodate parents who have disabilities. The HELP 0-3 system covers 685 developmental skills and behaviors across the following six domains: cognitive, language, gross motor, fine motor, social-emotional, and self-help. HELP 0-3 products are cross-referenced through skill identification numbers for easy linking between assessment and curriculum materials. Programs implementing HELP 0-3 can use KinderCharts.net, an online system designed to measure children's developmental progress in essential domains that is directly aligned with the HELP 0-3 assessments. Versions of the assessment and curriculum for children ages 3 to 6 are also available.	gross motor, fine motor, social-emotional, and self-help	caregivers of children birth through age 3 as well as Part C early intervention providers for infants and toddlers who have developmental concerns
HighScope Infant-Toddler Curriculum	The HighScope Infant-Toddler Curriculum uses a process of active learning—called active participatory learning—that consists of experiences and exploration with people, materials, events, and ideas. During active learning, caregivers scaffold (support and gently extend) infant and toddler learning by encouraging them to investigate the world around them. Learning and development are anchored by long-term, trusting relationships with caregivers. The curriculum is organized around six content areas and includes guidance for caregivers on teaching practices designed to support children's growth and learning. The six content areas are: (1) approaches to learning; (2) social and emotional development; (3) physical development and health; (4) communication, language, and literacy; (5) cognitive development; and (6) creative arts. The teaching practices include adult-child interactions, arrangement of the physical environment, the use of daily schedules and routines, and observations and planning for children. The curriculum is linked to HighScope's comprehensive online child assessment tool, called the Child Observation Record Advantage, which covers development from birth through kindergarten. Preschool and elementary school versions of the curriculum are available.	Approaches to learning; social and emotional development; physical development and health; communication, language, and literacy; cognitive development; and creative arts	Out-of-home caregivers of children birth to age 3

Table B.2. Overview of compelling model implementation guidelines

Model name	Dosage	Program length	Staff education requirements	Staff training requirements	Supports for implementation
Models that provide direct early learning services to children					
Early Learning Readiness (ELR) Program for Informal Family, Friend, and Neighbor Caregivers	Twice per week; each session is 2 hours	38 to 42 weeks per year	Not specified, although a background in early childhood, education, or social work is recommended for local supervisors and facilitators	The program has a training plan for newly hired local staff that includes in-person training sessions, online modules on broader topics such as development and achievement gaps, and webinars on specific program components.	Training materials Qualified trainers Fidelity tools Systems for monitoring fidelity
Educare	Full-day (locally determined but minimum of 6 hours per day), full-year services	Up to 5 years (from age 6 weeks to kindergarten entry)	Each classroom has a lead teacher with a minimum of a bachelor's degree in early childhood education; an assistant teacher with a minimum of an associate degree in early childhood education; and a teacher aide with a high school diploma/GED and a credential in child development or training in infant and toddler development. Master teachers have master's degrees in early childhood education; for birth-to-age-3 classrooms, they have special training in infant and toddler development. Family support supervisors have	Not specified	Operation/ implementation manuals Training materials Qualified trainers Fidelity tools Systems for monitoring fidelity

Model name	Dosage	Program length	Staff education requirements	Staff training requirements	Supports for implementation
			master's degrees in social work or a related field, and family support specialists have bachelor's or master's degrees in social work, health, or a related field.		
Models that primarily focus on professional development for caregivers					
Early Childhood Consultation Partnership (ECCP)	Weekly, 1.5 to 3 hours depending on visit type	6 weeks for child services; 12 to 14 weeks for classroom services; 9 months for center services	ECCP consultants must have a master's-level degree in a human services field, such as social work, counseling, or child development, and preferably are licensed mental health providers.	ECCP consultants receive orientation and an initial series of trainings in early childhood mental health consultation during their first six months. After this initial phase, consultants are provided additional trainings as continuing education and receive regular supervision from the ECCP leadership team that has clinical, reflective, and administrative components.	Operation/ implementation manuals Training materials Qualified trainers Fidelity tools Systems for monitoring fidelity
Expanding Quality in Infant Toddler Care (EQIT) course and EQ RELATE Model of Coaching	The EQIT course is typically offered biweekly for 6 hours per class. Total direct class time is 48 hours. The number of hours of coaching offered to each participant is determined on an individual basis and may depend on the availability of funding	The EQIT course is typically offered over a 16-week period Coaching is offered during the course, and for course graduates, for up to one year following completion of the course.	Not specified	Course instructors must complete an 80-hour train-the-trainer course, which includes additional written work, and have previously completed the EQIT course or a similar infant-toddler course. They must obtain approval to be an intermediate-level trainer from Colorado's trainer approval system.	Operation/ implementation manuals Training materials Qualified trainers

Model name	Dosage	Program length	Staff education requirements	Staff training requirements	Supports for implementation
				Coaches must complete an additional two days of training on the EQ RELATE coaching model and tools before offering any coaching. Instructors are expected to continue their professional development by annually participating in a minimum of 6 hours of training seminars and other learning opportunities offered by the EQ initiative.	
First Beginnings	Each training module is 3 hours; some classes include five or seven modules. On-site consultation consists of three 1-hour visits.	3 to 4 months	There are no requirements for instructors or consultants, although in one study of the program, consultants all held master's or bachelor's degrees.	There are no requirements for instructors or consultants, although in one study of the program, the consultants participated in a 3-hour training session before the program started.	Operation/ implementation manuals Training materials
Infant Caregiver Mentoring Project	Approximately 20 hours of mentoring per month; total of 80 hours	4 months	Not specified	Mentors complete seven days of training before the program starts. The topics covered during the training include building relationships as a mentor, other skills to be effective as a mentor, and infant and toddler development.	Operation/ implementation manuals Training materials Qualified trainers
Seeds to Success	Up to 8 hours of coaching per month	6 months	Not specified, although the implementing	In preparation for implementation,	Training materials Qualified trainers

Model name	Dosage	Program length	Staff education requirements	Staff training requirements	Supports for implementation
			agencies seek individuals with expertise in early childhood development, child care, culturally appropriate practice, and adult learning theories.	coaches participate in multiple training sessions, including trainings on coaching, the Environment Rating Scales, and the administrative data system used to track the provision of coaching. During the implementation period, coaches are supervised by the site coordinators at the implementing agencies during team and one-on-one meetings. During the field test, in one community, coaches' supervision was offered weekly. In the other community, supervision was offered monthly. Coaches also have the opportunity to meet with a mentor coach.	Fidelity tools Systems for monitoring fidelity
Smart Support	Weekly for 2 to 3 hours per visit	The average length of participation is approximately 1 year, but varies and can range from several months to much longer than 1 year	Mental health consultants must have a master's-level degree in a mental health discipline. Supervisors of mental health consultants must have a license in a mental health field.	New consultants go through a week-long orientation that includes 16 classroom hours, shadow with experienced consultants, and are expected to complete trainings on attachment, trauma, self-regulation, and other subjects as well as attend quarterly meetings that review key aspects of the	Operation/ implementation manuals Training materials Qualified trainers Fidelity tools Systems for monitoring fidelity

Model name	Dosage	Program length	Staff education requirements	Staff training requirements	Supports for implementation
				model over a 12-month period. Other ongoing professional development activities for all consultants include a monthly book club, regular training opportunities (which may be required, or optional training that a consultant can request to attend), and weekly meetings with supervisors that use a reflective supervision approach.	
Curricula Models					
Assessment, Evaluation, and Programming System (AEPS), Second Edition, Curriculum for Birth to Three Years	Not specified	Not specified	Not specified, although designed to be implemented by professionals	Not specified	Operation/ implementation manuals Qualified trainers
The Creative Curriculum for Family Child Care, Second Edition	Not specified	Not specified	Not specified	Not specified	Operation/ implementation manuals Training materials Qualified trainers
The Creative Curriculum for Infants, Toddlers & Twos, Third Edition	Not specified	Not specified	Not specified	Not specified	Operation/ implementation manuals Training materials Qualified trainers ^a
Hawaii Early Learning Profile (HELP): 0-3	Not specified	HELP 0-3 provides materials relevant for a three-year period (from birth to age 3)	There are no requirements, but staff using HELP for the Part C assessment process should meet their state's definition of qualified personnel. Any staff with knowledge of	Not specified	Operation/ implementation manuals Training materials Qualified trainers

Model name	Dosage	Program length	Staff education requirements	Staff training requirements	Supports for implementation
			infant-toddler development can use HELP as a curricular program.		
HighScope Infant-Toddler Curriculum	Not specified	Not specified	There are no requirements for the curriculum, but HighScope adheres to the staffing requirements of the agency or program using the curriculum	None specified, although caregivers who complete a rigorous 20-day training program can meet requirements for HighScope teacher certification	Operation/ implementation manuals Training materials Qualified trainers Fidelity tools Systems for monitoring fidelity

^a Currently, fidelity tools are not available for The Creative Curriculum for Infants, Toddlers & Twos, but the developer plans to publish them by the end of 2015.

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APPENDIX C

LITERATURE SEARCH METHODS AND RESULTS

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Our literature search was designed to locate published research on the 13 compelling models that we identified. In this appendix, we describe the methods we used to carry out the literature search, the screening procedures we used to identify relevant literature, and the results of the literature search.

A. Targeted search for relevant literature

We searched for all relevant literature on the 13 compelling models. To maximize our search results, we implemented the following search techniques.

Step 1. Develop focused search terms. Building off the search terms used for the LITES systematic review, we worked closely with our librarians to develop search terms that captured the range of relevant literature on the compelling models (Table C.1). We included the model names as key search terms.

Table C.1. Search terms used for the LITES compelling models literature search

Category	ID	Search term
Search	--	Studies published in English only
Restrictions		Studies published during or after 1960
Model name	S1	Each model was searched individually
Activity	S2	[(early near educat*) or preschool or “pre-school” or childcare or “child care” or daycare or “day care” or “nursery school*” or “early learn*” or “nonparental care” or “non-parental care” or “early care” or “center based” or “center-based” or “infant care” or “toddler care” or “early childhood” or “child develop*] And (program* or intervention* or service* or model*)
Target group	S3	“birth to three” or “zero to three” or baby or babies or infan* or newborn* or toddler* or (birth near “36 mo”) or (prenatal near “36 mo”) or “birth to 3” or zero to 3” or “0 to 3”
Document type	S4	(stud* or studies* or evaluat* or research or trial or experiment* or “clinical trial” or “controlled clinical trial” or “controlled study” or “randomized control trial” or longitudinal stud* or “program evaluation” “quasi-experimental” “matched group comparison design” or “pre post” or “correlational” or “descriptive” or “implementation” or “case study”) and (effect* or efficac* or impact* or outcome* or evidence or implement* or fidelity or cost* or replic* or finding* or result*)
Combine terms	S5	S1 AND S2 AND S3 AND S4

Notes: When performing proximity searches (for instance, quality near child care), we recommend using a parameter that defines *near* as *within five words of* to optimize our ability to find relevant literature without capturing a large volume of irrelevant literature. Searches look back to 1960 only if a given database has literature of that age; otherwise, we begin the search at the earliest available date.

Step 2. Database search. Using the focused search terms, the Mathematica library staff initiated a search of titles, abstracts, subjects, and key words within numerous databases. Table C.2 lists each of the databases searched.³³ Mathematica librarians used advanced searching

³³ All databases were searched for all models with one exception. The search for Educare in Child Care and Early Education Research Connections resulted in an extremely high number of citations. As a result, we conducted a separate and more targeted screening process of these citations. The citations, with the exception of one citation that screened in, were not included in RefWorks and therefore are not included in the results listed in Table B.3.

techniques—such as proximity searches—to optimize our ability to find relevant literature (for example, requiring the words *early*, *childhood*, and *education* to be within five words of one another). Databases differ in how they organize content; therefore, the librarians tailored the search methods to the databases and checked the project search terms against keyword and subject terms for each database when possible to ensure we did not overlook relevant citations. The librarians saved literature search results in a designated project account created in RefWorks, an online (but private and password-protected) bibliographic management system that enables storing, scanning, and sorting a customized list of study citations and abstracts.

Table C.2. Databases searched for the LITES compelling models literature search

Academic Search Premier	Campbell Collaboration
Child Care and Early Education Research Connections	CINAHL with Full Text
Cochrane Central Register of Controlled Trials	Cochrane Database of Systematic Reviews
Cochrane Methodology Register	Database of Abstracts of Reviews of Effects
EconLit	Education Research Complete
E-Journals	ERIC
MedLine	PsycINFO
ProQuest Dissertations & Theses	SAGE Journals
SocINDEX with Full Text	Scopus

B. Screening procedures

After we completed the search, trained staff conducted a multistep screening procedure to identify the most relevant citations. All screening was conducted in RefWorks. Citations screened out were assigned a disposition code describing the reason for their exclusion.

Step 1. Preliminary screening. In this step, we removed citations from our list that were not useful to the review.

- **Deduplication of citations.** When using the search terms across multiple databases, searches sometimes identified the same citation in more than one database. We retained only one copy of each citation, deleting the others from RefWorks.
- **Exclude publications that are not studies.** Screeners next eliminated any irrelevant non-study citations the search terms yielded (for example, letters to the editor, book reviews, or press releases). These were not considered further but remained in RefWorks labeled as *nonstudies*.
- **Not a model.** Screeners also eliminated studies that did not focus on one of the 13 named compelling models. These were not considered further but remained in RefWorks labeled as *not a named model*.

Step 2. Screening. After the removal of non-studies and studies that did not examine a named model, additional screening for relevance was necessary using the study abstracts and, if needed, the full text of the citation. For instance, some studies focused on a named model but the target population for the study was preschool-age children rather than infants and toddlers. We screened out studies for the following reasons:

- **Not policy relevant.** We excluded studies of early care and education (ECE) models delivered in a developing-world context.
- **Not a primary study.** We excluded summaries of studies reported elsewhere (for example, literature reviews or meta-analyses).
- **Target population out of range.** We excluded studies in which the children or families were not enrolled in the ECE services before the child reached age 36 months.

C. Literature search results

Our search yielded 253 unduplicated studies. Of these, 7 studies screened in. The primary reason studies screened out was because they were not focused on a named model. In addition, we excluded 41 citations that were not studies. Table C.3 provides detailed information about the search and screening results.

Table C.3. Literature search and screening results

	Total
Total number of unduplicated studies	253
Screened in	7
Step 1: Screened out	
Not a study	41
Not a named model	176
Step 2: Screened out	
Not policy relevant	17
Not a primary study	3
Target population out of range	9

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VALIDATION OF QUALITY RATING AND IMPROVEMENT SYSTEMS FOR EARLY CARE AND EDUCATION AND SCHOOL-AGE CARE



Research-to-Policy, Research-to-Practice Brief OPRE2012-29
April 2012



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ACKNOWLEDGMENTS

The authors would like to thank Ivelisse Martinez-Beck and Naomi Goldstein at the Office of Planning, Research and Evaluation, Kathryn Tout at Child Trends, and Laura Hamilton at RAND for their guidance and feedback on this paper.

Validation of Quality Rating and Improvement Systems for Early Care and Education and School-age Care

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April 2012

Submitted to:

Ivelisse Martinez-Beck, PhD., Project Officer
Office of Planning, Research and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services

Submitted by:

Gail L. Zellman, RAND Corporation
Richard Fiene, Pennsylvania State University

Contract Number: GS10F0030R

Project Director: Kathryn Tout
Child Trends
4301 Connecticut Ave NW
Washington DC, 20008

Suggested Citation:

Zellman, G. L. & Fiene, R. (2012). *Validation of Quality Rating and Improvement Systems for Early Care and Education and School-Age Care*, Research-to-Policy, Research-to-Practice Brief OPRE 2012-29. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

This Brief was developed by members of the Quality Initiatives Research and Evaluation Consortium (INQUIRE) which is designed to facilitate the identification of issues and the development and exchange of information and resources related to research and evaluation of quality rating and improvement systems (QRIS) and other quality initiatives. INQUIRE is funded by the Office of Planning, Research and Evaluation through the Child Care and Early Education Policy and Research Analysis and Technical Expertise contract with Child Trends.



Validation of Quality Rating and Improvement Systems for Early Care and Education and School-age Care

Quality Rating and Improvement Systems (QRIS) for early care and education and school age care programs are designed to collect information about quality and to use that information to produce program-level ratings, which are the foundation of a QRIS. The ratings are intended to make program quality transparent for parents and other stakeholders and to encourage the selection of higher-quality programs. The ratings also provide benchmarks that can support efforts to help programs improve their quality. **Validation of a QRIS is a multi-step process that assesses the degree to which design decisions about program quality standards and measurement strategies are resulting in accurate and meaningful ratings.** Validation of a QRIS provides designers, administrators and stakeholders with crucial data about how well the architecture of the system is functioning. A carefully designed plan for ongoing validation creates a climate that supports continuous quality improvement at both the program and system level.

To date, QRIS validation efforts have been limited. One reason may be that validation is a complex endeavor that involves a range of activities. In addition, there has been little guidance available that clarifies the purpose of QRIS validation or identifies the activities that comprise validation. At the same time, there is growing pressure to validate these systems as stakeholders seek evidence that QRIS are functioning as intended. The federal government has elevated QRIS validation by including it as a central component of the 2011 Race to the Top Early Learning Challenge and requiring state applicants to develop QRIS validation plans as part of their submissions.

The purpose of this Brief is to help QRIS stakeholders better understand validation and to outline a set of complementary validation activities. The Brief defines validation, describes different types of validation studies, and provides guidance on developing a validation plan, including tools to determine the appropriate scope and timing of validation activities. It also lists references and resources for those who wish to learn more. This Brief is aimed at readers in positions to authorize, finance, design, and refine QRISs and other quality improvement efforts, including state child care administrators, early education policy and program specialists, legislators, and other potential funders.



QRIS Validation and Its Role in Continuous System Improvement

*Validation is a multi-step process that assesses the degree to which design decisions about QRIS program quality standards and measurement strategies are resulting in accurate and meaningful program ratings.*¹

Validation is particularly important for QRISs because these systems at their core rely on ratings of program quality. They are built on the assumption that the quality of early childhood and school-age programs can be reliably measured and that differences in quality across these programs can be identified through the use of a set of quality indicators. Validity data can support conclusions about whether such quality indicators measure quality well and whether the strategies used to combine measures and develop ratings are working as intended (Cizek, 2007).² Valid ratings are critical to QRISs because parents and other stakeholders use these ratings to select the highest-quality care that they can afford. The overall quality rating also carries increasingly high stakes for programs. Indeed, the theory underlying QRISs intentionally creates those stakes to motivate both provider and parent behaviors in support of increased quality (e.g., Zellman et al., 2008; Zellman et al., 2011). In addition to attracting more children, programs that score well may receive higher subsidies for subsidy-eligible children, and may qualify for grants, incentives, and tax credits.

Why QRIS validation is important. A QRIS is a primary strategy states employ to improve early childhood education and school-age care (ECE-SAC) program quality. Because ratings are a central element of a QRIS, it is important to collect data to establish that these ratings are accurate and meaningful indicators of quality. Validation studies can lend credibility to a QRIS, identify needed changes, and support continuous improvement of a QRIS.

Validity is not determined by a single study; instead, validation should be viewed as a continuous process with multiple goals: refining the ratings, improving system functioning, and increasing the credibility and value of rating outcomes and of the QRIS system as a whole. A carefully designed validation plan will promote the accumulation of evidence over time that will provide a sound theoretical and empirical basis for the QRIS (AERA, APA, & NCME, 1999; Kane, 2001). Ongoing validation activities that are carried out in tandem with QRIS monitoring activities (that aim to examine ongoing implementation of the QRIS) and evaluation activities (that examine the outcomes of QRIS) can help a QRIS improve its measures and effectiveness throughout its development and implementation (see Lugo-Gil et al., 2011 and Zellman et al., 2011 for guidance on developing a comprehensive QRIS evaluation).

¹ The definition of validation has changed over time. Rather than identifying separate types of validity (construct, predictive, face, concurrent and content), the current notion is that construct validity includes all evidence for validity, including content and criterion evidence, reliability, and the wide range of methods associated with theory testing (Messick, 1975, 1980; Tenopir, 1977; Guion, 1977; Embretson, 1983; Anastasi, 1986). As a consequence, we do not differentiate types of validity in this brief.

² Reliability represents the ability of a measure to assess its target behaviors or characteristics consistently. In the case of QRISs, reliability refers to the extent to which independent raters produce similar ratings on individual QRIS elements and on the summary rating (inter-rater reliability) as well as the degree to which raters are consistent over time in their ratings (intra-rater reliability). Such consistency is a prerequisite for validity of any measure.

QRIS validation activities may produce three important benefits. First, validation evidence can promote increased support for the system among parents, ECE-SAC providers and other key stakeholders. Ratings that match the experiences of parents and providers can build trust in the ratings and increase the overall credibility of the system. Second, a system that is measuring quality accurately is better able to target limited quality improvement supports to those programs and program elements most in need of improvement. Third, validation evidence can be used to improve the efficiency of the rating process. If a QRIS is expending resources to measure a component of quality that is not making a unique contribution to a summary quality rating or that is not measuring quality accurately, it can be removed or revised. For example, measures that vary little if at all across providers whose quality varies substantially in other ways make little or no contribution to quality ratings. Measures of family engagement that include parent ratings are particularly prone to this problem, as parents who have chosen to use and continue to rely on a given provider are highly likely to see the care as good and to rate it according to their views (Zellman and Perlman, 2006; McGrath, 2007; Keyes, 2002; Kontos et al., 1987; Shimon, 1992). If all or almost all programs receive high ratings on the family engagement measure, then that component of the rating may not be working to distinguish between lower-quality and higher-quality programs. It may be considered important to collect measures of family engagement to ensure that providers continue to focus on it. But knowing that a given measure is not contributing to an overall program quality rating may motivate program developers to consider another way to measure the concept, which might both increase the value of the measure and reduce measurement costs. Indeed, understanding the relationships among rating elements through validation studies can save substantial time and effort.

Despite the importance of validation activities to strengthen QRIS, support for these activities may be impeded by limited resources and concern about the value of validation activities. In states with more mature QRISs, there may be reluctance among stakeholders to assess an established system. In newer systems, policymakers may question the need for validation given the arguments recently offered in support of establishing the system. Validation plans can address each of these concerns by providing evidence to help the system run more efficiently and to establish a climate of continuous improvement. A validation plan will clarify that the system is open to change, intent on improvement, and dedicated to increasing the odds of reaching its goals.

Designing and Implementing Validation Efforts

A comprehensive validation plan includes multiple studies that rely on different sources of information and ask different but related questions. These can be understood and organized around four complementary and interrelated approaches to validation. In this section we provide details of the four approaches. Summaries of these details are provided in two tables. Table 1 presents an overview of the four approaches including the purpose of each approach, the activities that might be undertaken, the questions that are asked and the limitations of each approach. Table 2 presents the data needed, data sources, and analysis methods for selected studies within each approach.³

³ The four basic approaches described in the table are very similar to and compatible with those used in the QRIS Evaluation Toolkit (Lugo-Gil et al., 2011).

When reviewing the tables and the remainder of the Brief, it is helpful to be familiar with how three key QRIS terms – component, standard and indicator – are defined. The term quality **component** refers to the broad quality categories used in QRIS (such as staff qualifications, family engagement, and the learning environment). A quality **standard** is defined as a specific feature of quality such as specialized curriculum and assessment training in the staff qualifications component; a set of quality standards comprise each quality component. Quality **indicators** are metrics that can be measured or verified for each of the quality standards. A given quality standard could have one or multiple quality indicators that represent it in a QRIS. For example, in the category of staff qualifications, a standard may be “Teaching staff have specialized training in curriculum and assessment.” An indicator related to this standard may be “At least 50% of teaching staff have completed the two-course statewide curriculum training session on curriculum and assessment.”

Table 1. Four Related Approaches to Validating a QRIS

Approach	Activities and Purpose	Typical Questions Approach Addresses	Issues and Limitations
1. Examine the validity of key underlying concepts	Assess whether basic QRIS quality components and standards are the “right” ones by examining levels of empirical and expert support.	Do the quality components capture the key elements of quality? Is there sufficient empirical and expert support for including each standard?	Different QRISs may use different decision rules about what standards to include in the system.
2. Examine the measurement strategy and the psychometric properties of the measures used to assess quality	Examine whether the process used to document and verify each indicator is yielding accurate results. Examine properties of key quality measures, e.g., inter-rater reliability on observational measures, scoring of documentation, and inter-item correlations to determine if measures are psychometrically sound. Examine the relationships among the component measures to assess whether they are functioning as expected. Examine cut scores and combining rules to determine the most appropriate ways to combine measures of quality standards into summary ratings.	What is the reliability and accuracy of indicators assessed through program administrator self-report or by document review? What is the reliability and accuracy of indicators assessed through observation? Do quality measures perform as expected? (e.g., do subscales emerge as intended by the authors of the measures?) Do measures of similar standards relate more closely to each other than to other measures? Do measures relate to each other in ways consistent with theory? Do different cut scores produce better rating distributions (e.g., programs across all levels rather than programs at only one or two levels) or more meaningful distinctions among programs?	This validation activity is especially important given that some component measures were likely developed in low-stakes settings and have not been examined in the context of QRIS. ¹

Approach	Activities and Purpose	Typical Questions Approach Addresses	Issues and Limitations
3. Assess the outputs of the rating process	Examine variation and patterns of program-level ratings within and across program types to ensure that the ratings are functioning as intended. Examine relationship of program-level ratings to other quality indicators to determine if ratings are assessing quality in expected ways. Examine alternate cut points and rules to determine how well the ratings distinguish different levels of quality.	Do programs with different program-level ratings differ in meaningful ways on alternative quality measures? Do rating distributions vary by program type, e.g., ratings of center-based programs compared to ratings of home-based programs? Are current cut scores and combining rules producing appropriate distributions across rating levels?	These validation activities depend on a reasonable level of confidence about the quality components, standards and indicators as well as the process used to designate ratings.
4. Examine how ratings are associated with children's outcomes.	Examine the relationship between program-level ratings and selected child outcomes to determine whether higher program ratings are associated with better child outcomes.	Do children who attend higher-rated programs have greater gains in skills than children who attend lower-quality programs?	Appropriate demographic and program level control variables must be included in analyses to account for selection factors. Studies could be done on child and program samples to save resources. Findings do not permit attribution of causality about QRIS participation but inferences can be made about how quality influences children's outcomes.

Table 2. Data Needs, Data Sources and Analysis Methods for Selected Studies

Approach	Data needed	Data sources	Analysis methods
1. Examine the validity of key underlying concepts	Evidence about the relationship between key quality standards and desired outcomes. Expert opinions about proposed quality standards and indicators.	Empirical literature on how proposed components contribute to high quality care and improved child outcomes. Experts in early childhood education who can provide input on the quality standards and indicators.	Synthesis of available data relating to each component; Analysis of degree to which evidence meets criteria for relatedness; Consensus process; Decision rules that specify the value of components without an established evidence base. ⁱⁱ
2. Examine the measurement strategies and psychometric properties of the measures used to assess quality.	Rating data from participating programs. Data from additional quality measures.	Most such data are collected as part of program ratings. Additional quality measures may be collected to allow comparisons with measures being used in the QRIS.	Distribution of provider scores on a given component; Correlations among components; Correlations of selected components with other measures.
3. Assess the outputs of the rating process	Program-level ratings from participating programs. Raw scores from measures of quality that are included in the rating. Data from additional quality measures that are not included in the rating.	Most of the necessary data are collected as part of program ratings. Another measure of quality may be administered to allow comparisons with program ratings.	Examination of rating distributions by program type; Correlations of program ratings with other measures; Changes in rating distributions using different cut scores.
4. Relate ratings to expected child outcomes.	Program rating data from participating programs. Assessments of child functioning.	Program rating data are collected as part of program ratings. Trained, reliable independent assessors collect data from individual children (may be a designated sample). Teacher reports on individual children.	Estimate the relationship between program ratings and child outcomes. ⁱⁱⁱ

Approach 1: Examine the validity of key underlying concepts. This approach involves examination of the elements or concepts that are to be included in program ratings. It is an important validation activity because it provides the foundation for the quality components, standards and indicators that together will produce program-level ratings and that will be the focus of quality improvement activities. Together, the components included in ratings, (e.g., staff qualifications, learning environment, family engagement) define quality for the QRIS. This validation activity provides justification and support for the elements of the QRIS. If the examination includes stakeholders, the process can also promote buy-in for the QRIS.

This validation approach asks whether quality components, standards and indicators included in a QRIS are the “right” ones, and is similar to what is proposed in the Toolkit, under *Validating Quality Standards* (Lugo-Gil et al., 2011). Because this effort addresses the cornerstone concepts and measures of the QRIS, it ideally would be conducted prior to the implementation of the QRIS.

For QRISs, the key concept is quality of care. The quality of care in early childhood education and school-aged care (ECE-SAC) programs is a complex, multi-dimensional construct; this complexity is amplified in centers by the fact that programs are comprised of multiple classrooms staffed by multiple individuals. Quality can be operationalized using a number of specific quality components. However, most QRISs have adopted similar ones. The QRIS Compendium found that six quality components were included in the majority of the 26 QRIS that were examined (Tout et al., 2010). These categories include licensing compliance (26 QRISs), classroom environment (24 QRISs), staff qualifications (26 QRISs), family partnership (24 QRISs), administration and management (23 QRISs) and accreditation (21 QRISs). Three categories—curriculum (14 QRISs), ratios and group size (13 QRISs), and child assessment (11 QRISs)—are included in half or just under half of the QRISs assessed. However, while similarities exist in the general quality components included in QRISs, the way in which each of these components of quality is measured varies substantially.

One activity that can help to validate a QRIS’ underlying concepts involves assessing the degree to which the quality components in the QRIS rating include standards and indicators that have an empirical base linking them to key program, family and child outcomes. This assessment might include an examination of the degree to which each element as operationalized in the QRIS is viewed by experts as a valid measure of the component. A number of states (including Delaware, Rhode Island, Minnesota and Virginia) have used a systematic expert review process to help identify which quality components (and the standards and indicators that comprise each component) to include in their QRIS. Attention might also be paid to the views of programs and parents about the degree to which selected components reflect their priorities. For example, focus groups with parents were conducted in Minnesota to inform the development of the final rating tool used in the QRIS pilot (Minnesota Department of Education and Minnesota Department of Human Services, 2007)

Another activity which is part of this approach involves examining the research literature to determine the level of empirical support for each proposed component. This review would examine the research base on the proposed standards and indicators selected to represent program quality. The review would weigh the existing evidence and provide arguments for why a particular quality component should be included or excluded from the QRIS.

Purdue University’s scientific review of the quality standards contained in Paths to Quality, Indiana’s QRIS, demonstrates this approach. The overall goal of the review was to conduct an “external evaluation of the scientific validity” of the Paths to Quality standards (Elicker et al., 2007). The study included review of available evidence for the importance of each of the four quality components--Health and Safety, Learning Environment, Planned Curriculum, and National Accreditation-- and the relationship of the standards and indicators of each component to other measures of quality and to children’s development and well-being. The review used standards of evidence to classify each proposed indicator. For example, one or two well-designed studies that supported the indicator was classified as “some evidence;” “substantial evidence” required more than five such studies. For three-quarters of the indicators, researchers found “substantial evidence” that they supported children’s development.

Like many validation activities, such reviews ideally would be updated from time to time to determine if revisions to the QRIS would be advisable in light of new research findings. Such a review might utilize such tools as the *QRS Compendium* (Tout et al., 2010) or *Caring for Our Children* (AAP/APHA/NRC, 2011) as well as other recently published findings.

Approach 2: Examine the measurement strategies and the psychometric properties of the measures used to assess quality. A second type of validation effort focuses on the attributes of the individual measures in the QRIS as well as on the way in which the measures are combined to produce the summary rating of program quality. This approach is similar to what is discussed in the QRIS Evaluation Toolkit under *Validating the Construction of Quality Levels* (Lugo-Gil et al., 2011). This approach addresses how well the measures are working in the context of the QRIS. These efforts ask questions such as, “is there evidence that a given indicator measures what it purports to measure?” “If it claims to have a specific number of dimensions, do we find those dimensions in our data?” “Is there sufficient variance in scores on this indicator to justify its inclusion in the QRIS?” “Do scores on the indicator covary in expected ways with other measures of quality?”

Efforts to address these issues might involve an assessment of the distribution of participating provider scores on a given rating element. For example, in Zellman et al.’s (2008) evaluation of Colorado’s QRIS, initial work revealed that the measure of family engagement then in use produced very little variation across programs; all programs achieved the highest score possible on this measure. This meant that the QRIS was expending substantial resources to collect data on a measure that did not differentiate among programs. Another validation activity might involve an assessment of the relationship of a given indicator to other indicators of quality, both those included in the QRIS and others. In such studies, it is important to look at the degree of correlation found: ideally, measures would be moderately correlated so that each measure provides some non-redundant program quality information (see Zellman et al., 2008 for an example). Correlation patterns also should make sense. For example, two measures of interaction quality should be more closely related to each other than to a measure of ratios. If such studies reveal for example that the correlation between ratios and interaction processes is very high, this result might argue for eliminating one or the other indicator from the QRIS, as they may not be providing additional information (although some QRISs include certain elements to ensure that they are paid attention to, even if their psychometric properties are not ideal).

The research literature provides limited guidance concerning the most appropriate ways to combine measures of quality elements into summary ratings (Lugo-Gil et al., 2011; Tout et al., 2009; Zellman et al., 2008). Yet this process is crucial to producing meaningful program quality ratings, which are the key output of the rating process. States that are collecting and combining data could use these data to conduct studies that examine the effects of altering cut scores or combination rules, much as Karoly and Zellman (2012) have done in a “virtual pilot” for California’s QRIS, using data collected for another purpose, or as was done in studies in Minnesota (Tout et al., 2011) and Kentucky (Isner et al., 2012). These efforts will help QRIS designers and policy makers consider how well indicators are working, which indicators appear to be picking up variations in quality, and how closely different indicators relate to each other.

A number of other existing studies examine the properties of proposed QRIS indicators and can provide guidance to QRIS validation efforts (Scarr, Eisenberg, & Deater-Decker, 1994; Zellman & Perlman, 2008; Tout et al, 2011; McWayne & Melzi, 2011). Additionally, tools exist to help QRIS stakeholders review the options for QRIS measures and to support decision-making about the inclusion of new measures. For example, a Quality Measures Compendium is available and updated on a regular basis (Halle, Vick-Whittaker, & Anderson, 2010). If promising new measures are developed, it might be worthwhile to examine the performance of a new measure against the measure in current use.

Approach 3: Assess the outputs of the rating process. A third validation approach focuses on assessing the *outputs* of the rating system: the scores and levels that are assigned to providers who undergo a rating. Studies conducted under this approach examine the degree to which the quality levels in the QRIS are meaningfully distinct from each other. The results of these studies may indicate that measures, cut scores, or rules for combining measures need changing in order to distinguish quality levels effectively. Because these studies can result in proposals for significant changes to the composition of QRIS levels, it is helpful for these studies to occur prior to studies that examine associations between quality levels and children’s development.

Output studies may focus on individual indicator scores, such as how providers score on an environmental rating, as well as on the program-level score that is the final output of the rating process. Studies conducted as part of this approach ask questions like, “are providers that received four stars actually providing higher quality care than those that earned three stars?” Studies using this approach may also address questions about cut scores, e.g., “do different cut scores produce dramatically different program-level ratings, and if so, which cut scores produce distributions that most closely relate to other measures of quality?” These studies typically rely on a measure of quality not included in the QRIS to make this assessment, and examine whether assessments on both measures vary in predictable ways.

The University of Southern Maine is conducting a validation study of Maine’s QRIS to assess similarities and differences across program ratings; the study is also examining what if any differences exist between similar types of programs at different step levels (see Lahti et al., forthcoming, for further details on this study and several others.) For example, researchers in Maine administer the Environment Rating Scales (ERS; Harms & Clifford, 1989; Harms, Clifford & Cryer, 2005; Harms, Cryer & Clifford, 2006; Harms, Cryer & Clifford, 2007), which are not used to establish a rating in Maine’s QRIS, and examine whether there are statistically significant differences in ERS scores between programs at different rating levels. These findings help program designers determine if the quality levels determined by QRIS ratings relate in expected ways to an external measure of global quality.

As a second example of validation studies using this approach, Karoly and Zellman (2012) used data collected for another purpose to model some of the features of a newly-designed California QRIS. The data come from a 2007 survey of center-based providers that is representative of the state. Observations were conducted in 251 centers serving children birth to 5. The purpose of this “virtual pilot” study was to determine the likely distribution of programs across QRIS tiers using specified cut points, examine the association among quality components, and to identify “outlier” quality elements on which otherwise well-rated programs tend to score poorly. This information is very valuable at the design phase; data on “outlier” elements is particularly helpful in understanding what it will take for programs to improve their rating in a QRIS that uses a block design to designate ratings (in which all indicators at one level must be met before a rating at the next level is possible). By examining such things as the relationship between scores on the Classroom Assessment Scoring System (CLASS; Pianta, La Paro & Hamre, 2008) and the Early Childhood Environment Rating Scale - Revised (ECERS-R; Harms, Clifford & Cryer, 2005), and the relationship between staff education and training and other measures of quality, the work can help policymakers assess the value of different measures of quality, provide input into establishing cut scores, and suggest targets for technical assistance efforts.

Other states also have conducted validation studies that focus closely on differences in QRIS levels. For example, Pennsylvania has studied programs participating in the Keystone STARS QRIS (Fiene, Greenberg, Bergsten, Fegley, Carl, & Gibbons, 2002; Barnard, Smith, Fiene, & Swanson, 2006; OCDEL (Office of Child Development and Early Learning), 2010; Manlove, Benson, Strickland, & Fiene, 2011) to determine if their program ratings were indicative of quality differentials across program types and services. Similarly, recent work in Indiana (Elicker, Langill, Ruprecht, Lewsader & Anderson, 2011) found that ERS scores varied with program-level ratings, while research in Minnesota found significantly higher scores on the ERS and CLASS only between the highest level (4-star) of the QRIS and the other rating levels (2- and 3-stars) (Tout et al., 2011). These findings are being used by program developers to make needed adjustments to quality indicators, metrics and cut scores.

Approach 4: Relate ratings to children's development. A fourth approach to validation focuses on children's development. It is similar to the Toolkit's *Linkages between quality levels and desired outcomes*, although it focuses more narrowly on child outcomes. For QRISs, the logic model asserts that higher quality care will be associated with better child outcomes. Therefore, one important piece of validation evidence concerns whether children make greater developmental gains in programs with higher program-level ratings than in programs with lower ratings.

Studies using this approach do not attempt to identify causal linkages between *QRIS participation* and children's outcomes. Instead, they examine whether the QRIS ratings and quality components that comprise the ratings are related in expected ways to measures of children's development. Appropriate designs and controls could allow causal inferences to be made about how *quality* (as measured and rated by the QRIS) influences children's outcomes.

To date, few QRIS validation studies have incorporated children's outcomes as they are costly and difficult to conduct. As Elicker and Thornburg (2011) note, results from such studies are mixed, at least in part because of the challenges of conducting them. A primary challenge is the inability to control for all the factors that may vary between children whose families have selected different programs. Additional challenges include recruitment of programs and children across all quality levels; availability of appropriate outcome measures for children of diverse ages, abilities, cultures and linguistic backgrounds; and, lack of variation in the quality of participating QRIS programs.

In Missouri, children who participated in programs with higher quality ratings showed significantly greater gains on measures of social-emotional development compared to children in programs with lower ratings (Thornburg et al., 2009). These effects were even more pronounced for low-income children. However, in an evaluation of Colorado's QRIS, linkages between the ratings and children's outcomes were not found (Zellman et al., 2008). Recent reports from Indiana (Elicker, Langill, Ruprecht, Lewsader, & Anderson, 2011) and Minnesota (Tout et al., 2011) found no consistent relationships between program ratings and measures of child outcomes. A number of possible explanations were offered for the lack of expected linkages, including overall low levels of quality in participating QRIS programs (perhaps not meeting a threshold of quality necessary to detect linkages with child outcomes; see Zaslow et al., 2010 for further discussion of quality thresholds) and a lack of variation among participating programs and families. Yet, even with these limitations, program administrators in both Indiana and Minnesota have used the findings to recommend changes to the structure and content of the QRIS.

Developing a Validation Plan

Given the complexity of validation, it is advisable to develop a plan for system validation as early as possible in the QRIS design process. Ideally, the validation plan will be part of a larger evaluation plan designed to address a wider range of important questions the answers to which will guide refinement of the QRIS and its implementation. The plan should include the key questions that will be addressed and the methods to be used to address each one. One advantage of developing a plan early is that it may highlight opportunities to conduct a number of the proposed efforts as part of the implementation of the QRIS itself or as part of planned evaluation activities. A comprehensive approach to validating a QRIS ideally will include studies under each of the four approaches described above. Table 3 outlines issues in the timing of validation studies, discusses their relative cost, and suggests strategies for addressing validation questions if resources do not permit the implementation of validation studies.

Table 3. Considerations in Developing a Validation Plan

Approach	Timing and Duration	Cost considerations	Options to consider ^{IV}
1. Examine the validity of key underlying concepts	Ideally conducted prior to QRIS implementation. Study should be able to be completed within 3-6 months.	Relatively inexpensive. This work can be contracted to a local university, consultant or research firm.	Many states are using similar concepts and measures; their efforts will provide useful information. ^V
2. Examine the measurement strategies and psychometric properties of the measures used to assess quality	Must wait until ratings are implemented, although individual measures themselves might be available from other sources and could be examined earlier. ^{VI}	Depends on data quality and amount of analysis. Additional measures will increase costs, particularly if the measure is observational.	Can rely to some extent on existing research on each of the components. Consider using available data for a “virtual pilot.” ^{VII}
3. Assess the outputs of the rating process	Must wait until ratings are implemented. Once data are available, several studies could be conducted using the same data set.	Depends on data quality and amount of analysis. Additional measures will increase costs, particularly if the measure is observational.	This work is state system-dependent so is not readily borrowed, though lessons learned about structure and cut-points can be shared across QRISs.
4. Relate ratings to children’s development	Best to launch these studies when the QRIS rating process is stable and adequate numbers of programs have been rated.	Costs for the collection of child data are very high. Study could be done just with one cohort of children and two rounds of data collection (fall and spring) to assess developmental gains.	Requires significant funds, a powerful research design, and research expertise. Sampling children and programs will substantially reduce costs.

Summary and Conclusions

Validation is a complex, ongoing, iterative process. The objective of validation activities is to understand whether the rating process is able to distinguish among programs of different quality levels and whether program ratings are associated in meaningful ways to children's outcomes.

Validation activities help to determine whether key design decisions are working well in practice. States and localities that have implemented QRISs are expending substantial resources to train raters, fund ratings, support various forms of technical assistance, and provide a range of improvement incentives. All of these efforts assume that the ratings are accurate and the system is performing as intended. QRIS design decisions often rely heavily on the judgments of experts and on colleagues in other states, because there is limited empirical data on which to base them. For this reason, it is critical for states to set in place a process for assessing how well the design decisions underlying the system are working. Validation activities do this.

Ideally, validation is an ongoing process based on a carefully designed validation plan. The plan should include all four validation approaches, although resource constraints may limit these efforts, and may particularly limit studies that include child outcomes. A good validation plan, thoughtfully developed and implemented, can provide information critical to improving the system at many points in the process, and increase the odds of its ultimate success. Validation is unquestionably challenging, but no more so than the launch and operation of a QRIS or its evaluation. The networks and references in the next section can help states develop a deeper understanding of validation approaches and help them construct and implement validation plans that address stakeholder and system needs and produce timely and valuable information.

Resources and References

Resources

INQUIRE – Quality Initiatives Research and Evaluation Consortium

http://www.acf.hhs.gov/programs/opre/cc/childcare_technical/index.html

The purpose of INQUIRE is to support high quality, policy-relevant research and evaluation on Quality Rating and Improvement Systems and other quality initiatives by providing a learning community and resources to support researchers and evaluators. INQUIRE also provides input and information to state administrators and other policymakers and practitioners on evaluation strategies, new research, interpretation of research results, and implications of research for practice. Research briefs are available on topics related to QRIS evaluation issues and strategies.

CCEERC – Child Care and Early Education Resource Connections

<http://www.childcarereseach.org/> search under Quality Rating and Improvement Systems.

This site has many additional reports and resources, such as:

Quality Rating Systems: A Key Topic Resource List. New York: Child Care & Early Education Research Connections.

<http://www.researchconnections.org/files/childcare/keytopcis/QualityRatingSystems.pdf>

This resource list is an annotated bibliography of selected research focused on the design, implementation, and evaluation of Quality Rating Systems and Quality Rating and Improvement Systems in early childhood and after school settings.

The Child Care Quality Rating System (QRS) Assessment

Tout, K., Starr, R., Soli, M., Moodie, S., Kirby, G. & Boller, K. (2010). ***The Child Care Quality Rating System (QRS) Assessment: Compendium of Quality Rating Systems and Evaluations, OPRE Report.*** Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

http://www.acf.hhs.gov/programs/opre/cc/childcare_quality/compendium_qrs/qrs_compendium_final.pdf

Describing 26 Quality Rating Systems nationwide (19 statewide and 7 local or pilot), the Compendium presents comprehensive information through cross-QRS matrices and individual QRS profiles.

Lugo-Gil, J., Sattar, S., Boss, C., Boller, K. Tout, K., & Kirby, G. (2011). ***The Quality Rating and Improvement System (QRIS) Evaluation Toolkit. OPRE Report #2011-31.*** Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

http://www.acf.hhs.gov/programs/opre/cc/childcare_quality/qrisc_toolkit/qrisc_toolkit.pdf

The QRS Assessment Toolkit will provide guidance, recommendations and evaluation support on a range of topics including: development of a logic model and research questions, evaluation design and methods, and selection of measures.

QRIS National Learning Network

<http://qriscnetwork.org/>

The Network provides information, learning opportunities, and direct technical assistance to states that have a QRIS or that are interested in developing one. Its National Resource Library assists states in learning more about QRIS and their elements and in QRIS planning. The library contains, toolkits, handouts and published documents on a variety of searchable topic areas.

The Networks' State Resource Library contains detailed QRIS implementation information, including training guides, forms, and technical assistance materials that individual states have developed for their QRIS.

State QRIS Contacts who have agreed to serve as peer resources for one another are listed, as are Technical Assistance Providers.

Additional Resources

Lahti, M., Langill, C., Sabol, T., Starr, R., & Tout, K., (in progress). ***Validating Standards in Child Care Quality Rating and Improvement Systems: Exploring Validation Activities in Four States, OPRE Report.*** Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

This report will provide case studies of four states that have undertaken validation studies in their respective states. This report provides validation and evaluation approaches, identification of similar QRIS standards amongst the four states, description of cross case analysis QRIS validity issues and the results of the validation conceptual model from this brief examining the following: concepts of quality, measures used to assess quality, outputs or scores of the rating process, and if ratings are related to expected outcomes. It is the companion document to supplement this guide in which four states validation experiences are highlighted.

Halle, T., Vick Whittaker, J. E., & Anderson, R. (2010). ***Quality in Early Childhood Care and Education Settings: A Compendium of Measures, Second Edition***. Washington, DC: Child Trends. Prepared by Child Trends for the Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

http://www.acf.hhs.gov/programs/opre/cc/childcare_technical/reports/complete_compendium_full.pdf

The Quality in Early Childhood Care and Education Settings: A Compendium of Measures, Second Edition was compiled by Child Trends for the Office of Planning, Research and Evaluation of the Administration for Children and Families, U.S. Department of Health and Human Services, to provide a consistent framework with which to review the existing measures of the quality of early care and education settings. The aim is to provide uniform information about quality measures. It is hoped that such information will be useful to researchers and practitioners, and help to inform the measurement of quality for policy-related purposes.

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Endnotes

ⁱ Validity is not attached to a measure, but to a measure used for a particular purpose in a particular context. This means that measures which may be valid for one use must be validated again for use in a different context (AERA, APA, & NCME, 1999). Measures developed in low-stakes contexts, e.g., for use in research or program self-assessments, must be validated again in high-stakes contexts because those being assessed may react in high-stakes contexts in ways that could undermine the meaningfulness of interpretations derived from those measures (AERA, APA, & NCME, 1999).

ⁱⁱ Some components such as parent involvement have been included in QRISs even when strong empirical support of the ability of measures to distinguish among programs of different quality was lacking because designers believed that if they were not, programs would ignore these components in favor of measured ones.

ⁱⁱⁱ Random assignment of children to programs with different quality ratings is not possible in QRIS. Alternative analytic approaches must be used that employ adequate controls for selection bias. See Zellman and Karoly (2012) for further discussion of this approach.

^{iv} This column recognizes that state budgets are limited and validation is rarely seen as the highest priority. Ideally, states might combine data and efforts to conduct some of these studies.

^v Ideally, states might combine data and efforts to conduct some of these studies.

^{vi} However, as noted above, measures collected in low-stakes and high-stakes settings cannot be assumed to be comparable.

^{vii} It may be possible to use existing data to test assumptions and measures. See, for example, Karoly and Zellman (2012), for a description of such work in California.