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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Contents

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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) Settings[1]	
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 *au pair*, 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 guidance[3] 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 USA[4] 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 QRIS[5]. 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

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[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 OIG[10] 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, Crowley[11] 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

10US 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 required[14] 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, Dreby[16] 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 2011[20], 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 value[21]," 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.

DECAL's Mission and Vision Statements

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

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 Aware[31] 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's[32] 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 NACCRRA). (2012). Leaving Children to Chance: NACCRRA'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 children[33]. 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 Grant[40] 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 Reseach (NIER). 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) announced[42] 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 instructions[45] 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 colleagues[49] 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. Whitebook[52] 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. Apple[53] 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 Jones[54] 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 s 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/qris

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 Stoney[59] 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 guidance[63] 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.

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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 Insitute 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] Keenan[77] 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.

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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 accrditation 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:

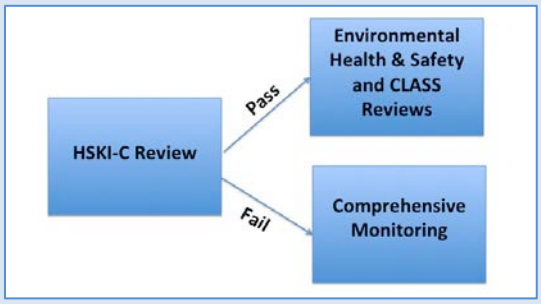
- No findings on the previous review cycle,
- No fiscal findings in the past two review cycles,
- No findings in the annual audits,
- No Designation Renewal System (DRS) criteria met,
- No significant program changes (e.g., changes in program leadership), and
- No concerns identified through input from 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://rikinstitute.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 safety[82]

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 (CCEEPRA) 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 bi-partisan 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.