



We Can Do Better:

NACCRRRA'S Ranking of State Child
Care Center Standards and Oversight

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About NACCRRA

NACCRRA, the National Association of Child Care Resource and Referral Agencies, is our nation's leading voice for child care. We work with more than 800 state and local Child Care Resource and Referral agencies to ensure that families in every local community have access to high-quality, affordable child care. To achieve our mission, we lead projects that increase the quality and availability of child care, offer comprehensive training to child care professionals, undertake groundbreaking research, and advocate child care policies that positively impact the lives of children and families. To learn more about NACCRRA, and how you can join us in ensuring access to high-quality child care for all families, visit us at www.naccrra.org.

About the Report

The National Association of Child Care Resource & Referral Agencies (NACCRRA) and individual state and local Child Care Resource & Referral (CCR&R) agencies work within every state to help ensure that families have access to affordable high-quality child care. CCR&Rs are uniquely positioned within communities to not only work with parents, but also with child care providers and state and local government to strengthen the quality of child care. Because the requirements for health, safety, and child development vary greatly from state to state, the quality of child care across states also varies greatly.

About \$11 billion in federal funds is used annually by the states for child care. For the most part, funding for child care comes from the Child Care and Development Block Grant (CCDBG), the Temporary Assistance for Needy Families (TANF) program, the Social Services Block Grant (also referred to as SSBG or Title XX), and state funds required to draw down a portion of CCDBG that requires a match. Since the nature of these funds is a block grant, states have wide discretion about how to spend this money. CCDBG is the primary federal program allocating funds for child care, but health and safety requirements in the law are broad. As a result, each state crafts its own standards and oversight policies.

In 2006, the National Association for Regulatory Administration (NARA) and the National Child Care Information and Technical Assistance Center (NCCIC) released the findings of their research on child care center regulations for each of the 50 states and the District of Columbia. This information provides a rich review of the basic standards and oversight in place for child care centers.

NACCRRA wanted to know “How are we doing?” We know from research (ours and others) that there is much that can be done to improve the quality of child care.

As we reviewed the possible criteria for state rankings and put the scores together, we were shocked to see in real detail how low the bar is set for the quality of care that 12 million children under age five spend significant parts of their time in each week.

The total possible score for each state is 150 points. The Department of Defense (DoD) child care model had the highest score (for both standards and oversight of child care centers). Other than DoD, the top-ranked states are Illinois and New York – with 90 points. The average score is 70.2.

How are we doing? We can do better.

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Introduction



Child care has become part of the daily routine for millions of American families. Almost 12 million children under age 5 (63 percent) are in non-parental care each week. This includes the children of working mothers who spend about 36 hours every week in some type of child care (U.S. Census Bureau, 2005). With the increasing participation of women in the workforce, many parents now use child care from their child's infancy through kindergarten.

As a result, the quality of these settings where children spend a large part of their time is a matter for public concern. The quality of the environment in which children receive care is important for several reasons. Young children are extremely vulnerable to illness and injury and their health and safety must be protected. In addition, the early years of life are critical for

children's development, specifically in the areas of intellectual, social, emotional, linguistic, physical and cultural development. In fact, research on the brain shows that 80 percent of the brain develops by the age of three, and 90 percent by the age of five.

Parents use a variety of child care settings, including care provided in child care centers and regulated family child care homes, as well as in informal settings such as with relatives, in-home nannies and other unregulated settings. Child care centers are by far the most common arrangement for children in non-relative care, with almost two-thirds of these children under age 5 in center-based care (U.S. Census Bureau, 2005). This report, which focuses on state standards and oversight for child care centers, shows that even high-ranking states do not have

sufficient standards and oversight in place to ensure that children in child care centers are healthy, safe, and learning.

Responsibility for the safety and well-being of children while they are in child care settings is shared by parents, caregivers, and state governments and agencies, who set the standards and provide the oversight. Unfortunately, in the United States, most states are not living up to this responsibility, because they have either weak standards or poor oversight.

In order to bring attention to this situation, NACCRRRA ranked the 50 states, the District of Columbia and the U.S. Department of Defense (DoD) on their current child care center standards and oversight system.¹ In the future, a set of benchmarks on state family child care home standards will be added. The information used to score each state was obtained from the recent *2005 Child Care Licensing Study: Final Report*² and the National Child Care Information and Technical Assistance Center (NCCIC) database on child care systems and regulations. For a few states, some of the information was updated based on more recent changes in regulations. NACCRRRA, however, recognizes that the ranking is only as current as the date on which the information used was supplied to NARA/NCCIC by each regulatory office. Information on the DoD programs was taken from DoD Instruction 6060.2 and other relevant DoD policy documents.³

States have wide latitude to craft and implement child care policies. The primary federal program through which funds are allocated to the states to be used for child care is the Child Care and Development Block Grant (CCDBG). To receive funds from CCDBG, states must have policies in place “designed to protect the health and safety of children that are applicable to child care providers”⁴ in the following areas:

- The prevention and control of infectious diseases (including immunization);
- Building and physical premise safety; and
- Minimum health and safety training appropriate to the provider setting.

Based on actual policies that states have in place, NACCRRRA scored the states on several key components of their licensing standards and oversight system, including health and safety policies and other key features of a quality child care system. These benchmarks were developed based on the available research in the field and in consultation with key researchers. The next section describes these benchmarks in detail. As the report reveals, most states fall far short of meeting these benchmarks.

¹ The 50 states, the District of Columbia and the U.S. Department of Defense (DoD) are hereafter referred to as states. NACCRRRA included the DoD in the scoring, because it has its own set of licensing standards and oversight system.

² This study, which included a survey of state child care administrators and a review of state licensing regulations was conducted by the National Association for Regulatory Administration and the National Child Care Information and Technical Assistance Center in 2005. The results were published in December 2006 and are available at www.nara-licensing.org.

³ Department of Defense Instruction 6060.2, Child Development Programs. Department of Defense, 1993.

⁴ Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110, Stat. 2278.

NACCRRRA Scoring System

for Ranking State Child Care Center Standards and Oversight Systems

To rank the states, NACCRRRA scored the states on the following aspects of their minimum standards for child care centers:

- a. staff:child ratios
 - b. group size requirements
 - c. educational qualifications for center directors
 - d. educational qualifications for teachers
 - e. pre-service training requirements for teachers
 - f. annual training requirements for teachers
 - g. criminal background check requirements
 - h. developmental domains programs must address
 - i. health and safety requirements: immunizations, guidance and discipline, Sudden Infant Death Syndrome (SIDS) prevention by requiring placing infants on their backs to sleep, fire drills, medication administration, incident reporting, hand washing and diapering, hazardous materials, playground surfaces, and emergency preparedness
 - j. parent involvement, communication, and parental access
- d. the educational qualifications required of licensing staff
 - e. whether or not licensing inspection reports and complaints are available online for parents and the public

States could receive a maximum of 10 points for each item, if they met the benchmark fully. States that are making progress toward these benchmarks received partial credit on those items. NACCRRRA scored states on 10 aspects of child care center standards for a total of 100 points, and 5 aspects of child care center oversight for a total of 50 points. The overall score is a combination of the two and is based on 150 points. States were then ranked on the overall score and the individual standards and oversight scores.

NACCRRRA Benchmarks on Standards

States must establish basic health and safety standards to promote the well-being of children. They should also have regulations in place that will promote the intellectual, emotional and physical development of children, and ensure that they enter school ready to learn. Guided by these principles, NACCRRRA developed the following 10 benchmarks on standards child care centers should be required to meet.

I. Staff:Child Ratios

A review of the research in child care clearly demonstrates the importance of maintaining appropriate staff:child ratios (Fiene, 2002). The staff:child ratios that programs are required

In addition, the states were also scored on the following elements of their oversight system:

- a. whether both child care centers and family child care homes are licensed
- b. how frequently inspections of child care centers are conducted
- c. the number of child care programs for which an individual licensing staff member is responsible



to follow are among the best indicators of the quality of a child care program, and impact many other areas including health and safety and adult-child interactions. There is considerable variation among the states on the staff:child ratios required for the different age groups in care. Staff:child ratios by age group are part of the requirements for accreditation by the National Association for the Education of Young Children (NAEYC), and these ratios are generally accepted by experts in child care.

NACCRRRA Benchmark: Staff:child ratios are in compliance with NAEYC Accreditation requirements.

NAEYC Staff:Child Ratio Requirements:

Birth to 15 months - 1:3-1:4
12 to 28 months - 1:3-1:4
21 to 36 months - 1:4-1:6
2 to 3 years - 1:6-1:9
4 years - 1:8-1:10
5 years - 1:8-1:10

II. Group Size

In child care programs, children are divided into groups, usually by age, so that the environment and program of activities can be tailored to their needs. In high-quality child care programs the number of children in a group is limited based on the age of the children. Because they require more help with their physical needs, smaller groups are better for younger children. As with staff:child ratios, group size impacts the quality of child care offered and specifically caregivers' ability to protect children's health and safety. There is considerable variation among the states on the group sizes allowed. Some states do not regulate group size. Specific group sizes by age are required for accreditation by NAEYC, and these group sizes, are generally accepted by experts in child care.

NACCRRA Benchmark: Group size requirements are in compliance with NAEYC Accreditation requirements.

NAEYC Group Size Requirements:

Birth to 15 months - 6-8 children
12 to 28 months - 6-8 children
21 to 36 months - 8-12 children
2 to 3 years - 12-18 children
4 years - 16-20 children
5 years - 16-20 children

III. Director Qualifications

Typically, child care programs are headed by a director employed by the sponsoring organization to manage and lead the program. In some cases, the director is also the person who owns the program. Most directors have many responsibilities, including oversight of the program's curriculum, fiscal management, personnel management, facility management, and working with parents. The leadership provided by the director is critical because many of the individuals who work in child care have no prior experience, training, or education to prepare them for their responsibilities. Directors who have education and experience

in child development or a related field are better prepared to provide staff with the supervision and training they need. Increasingly, child care programs are being looked to as a means of preparing children for school readiness and success. Requiring directors to have a Bachelor's degree places their qualifications on the same level as elementary school teachers who are responsible for only one age group of children. In fact, a director's role is similar to that of a school principal.

NACCRRA Benchmark: Center directors have a Bachelor's degree or higher.

IV. Teacher Qualifications

The quality of the child care that children receive depends in great part on the knowledge and skills of the people who care for and teach them (Fiene, 2002). Several studies have reported that child care teachers holding the Child Development Associate (CDA) credential (a competency-based credential that can be earned while working) or having an Associate's degree in early childhood education or a related field provide higher quality child care (Howes, 1997).

NACCRRA Benchmark: Center teachers have a CDA credential or Associate's degree in early childhood education or a related field.

V. Orientation and Pre-Service Training

Young children are vulnerable to illness and injury; those caring for them must know how to protect them from harm and promote their growth and development. If states require new child care employees to receive orientation training, the basics of healthy and safe care for young children can be addressed. Critical areas for orientation training include disease control, first aid, CPR, fire evacuation, preventing Sudden Infant Death Syndrome, and positive discipline. Orientation training is critical in reducing diseases, injuries and fatalities in child care programs and protecting children from child abuse and neglect (American Academy of Pediatrics [AAP]/American Public Health Association [APHA] & National Resource

Center for Health and Safety in Child Care[NRCHSCC], 2002). In fact 95 percent of parents with children under age six support pre-service training for all unrelated caregivers (NACCRRRA, 2006).

NACCRRRA Benchmark: Orientation training for center staff includes first aid certification, CPR training, fire safety training, and other critical health and safety issues.

VI. Annual Training for Teachers

Almost half of caregivers in regulated child care settings enter the profession with no more than a high school education – 20 percent of child care center teachers, 43 percent of center assistants, and 44 percent of family child care providers have a high school education or less (Burton and others, 2002). As a result, they must be trained while in their positions. Few programs can afford to offer training in all of the required subjects during orientation training alone. Training is more effective if it is cumulative and provided over time within the context of the individual's job responsibilities. Annual training of teachers helps increase their knowledge and skills and reinforces prior instruction. It also provides an opportunity to update first aid and CPR



certifications and convey new information on critical health issues such as SIDS. In order to advance competencies and accomplish certification requirements, at least 24 hours of annual training is recommended (AAP/APHA/NRCHSCC, 2002). In fact, 93 percent of parents with children under age six support ongoing annual training for all unrelated caregivers (NACCRRRA, 2006).

NACCRRRA Benchmark: All center teachers have at least 24 hours of annual training.

VII. Criminal History Background Checks of Staff

A major concern of parents who use child care is whether or not their child will be safe while in child care. Although the research on child abuse indicates that fewer instances of child abuse occur in child care programs than in homes (Finkelhor & Williams, 1988), the few instances that do occur can be devastating to children and families. One way to reduce the risk of child abuse is to ensure that those hired to work in centers do not have a history of child abuse and neglect. Finding out if a person has such a history should be accomplished by checking multiple sources and using fingerprints to check for previous criminal activities. Most parents (67 percent) think that states conduct background checks on caregivers (NACCRRRA, 2006), when the reality is that 21 states do not conduct fingerprint checks, which make a background check complete.

NACCRRRA Benchmark: Center staff are required to undergo a criminal history background check, a check of child abuse and neglect registries, a state fingerprint check, a federal fingerprint check, and a check of sex offender registries.

VIII. Program of Activities Addresses Six Child Developmental Domains

During their earliest years, children are growing and developing in many ways – socially, emotionally, intellectually, and physically. In addition, they are acquiring language and literacy skills and learning about cultural

and social expectations. Child care programs promote school readiness and physical and emotional well-being when they offer a balanced program of activities which addresses all areas of development (AAP/APHA/NRCHSCC, 2002).

NACCRRA Benchmark: Center programs are required to address six areas of child development: social, physical, language/literacy, cognitive/intellectual, emotional, and cultural.

IX. Health and Safety Requirements

A. Guidance and Discipline/Corporal Punishment – Physical and other excessive punishment are forms of child abuse and can damage children emotionally, socially, and physically. Some states allow corporal punishment (hitting, spanking, beating, shaking, pinching, and other measures) or fail to specifically prohibit it.

B. Immunizations – Immunizations help protect children not just during childhood but for the rest of their lives. Immunizations are one of the most effective means for controlling the spread of infectious diseases in child care (Fiene, 2002). Young children in child care face a greater risk of acquiring infectious diseases as compared to older children (Brady, 2005).

C. Sudden Infant Death Syndrome (SIDS) – Sudden Infant Death Syndrome (SIDS) is responsible for more infant deaths in the United States than any other cause of death during infancy beyond the neonatal period. The original 1992 sleeping-position recommendation from the American Academy of Pediatrics (AAP) identified any nonprone position (i.e., side or supine) as being optimum for reducing SIDS risk. In 2000, on the basis of new evidence, the AAP advised that placing infants on their backs confers the lowest risk and is the preferred position (AAP, 2005).



D. Fire Evacuation – Children under the age of 5 are 2.5 times more likely to die from fire than any other childhood age group (Fiene, 2002). Child care programs must be able to evacuate groups of children in the event of a fire in order to prevent injury and death.

E. Administration of Medication – Failure to administer medications correctly or failure to administer needed medications can have serious effects on a child's health. Medicines should be stored where children cannot access them.

F. Incident Reporting – Parents have the right to know if their child has been injured or harmed in some way while in a child care program. They also need to know if their child has been exposed to an illness or been the victim of child abuse. Health departments should be notified when one or more cases of some communicable diseases occur in child care programs.

G. Handwashing/Diapering – Handwashing is the single most effective way to interrupt the transmission of infectious diseases that are spread through fecal-oral route (diarrheal diseases and Hepatitis A) and through contact with infected urine and saliva

(CMV) (Fiene, 2002). Proper diapering procedures can reduce the spread of disease in child care settings (AAP/APHA & NRCHSCC, 2002).

- H. Hazardous Materials – Many of the cleaning and other products that can be found in child care programs (centers and homes) are poisonous and, if ingested by children, can cause illness, injury, and death. Children’s eyes, skin, and limbs can be damaged by sharp objects and moving parts. The child care environment must be kept free of these and other hazardous materials.
- I. Surfaces Under Playground Equipment – Falls are the leading cause of injury among children on playgrounds. If the area around playground equipment is a hard surface (soil, grass, asphalt, cement, or other hard surfaces) children are more likely to be seriously injured when they play on playground equipment. Playground equipment should be surrounded by a resilient material of an acceptable depth.
- J. Emergency Preparedness – As recent events have demonstrated, serious injuries and loss of life can occur as the result of natural, man-made, and technological disasters. Child care programs must be

prepared to evacuate children or take shelter-in-place to protect children from harm when disasters occur.

NACCRRRA Benchmark: Center procedures address all of the above 10 topics and explicitly prohibit corporal punishment.

X. Parent Involvement

Continuity in the care of the child occurs when parents are involved in the program’s activities and the program staff communicates with parents on a regular basis. Ensuring parents have access to the program at all times may be the single most important method of preventing the abuse of children in child care settings (AAP/APHA & NRCHSCC, 2002).

NACCRRRA Benchmark: Centers are required to involve and communicate with parents, and allow parental visits.

NACCRRRA Benchmarks on Oversight

States should not only establish standards for the care of children, but also monitor the extent to which programs are meeting these standards. NACCRRRA has established benchmarks for five aspects of state licensing systems.

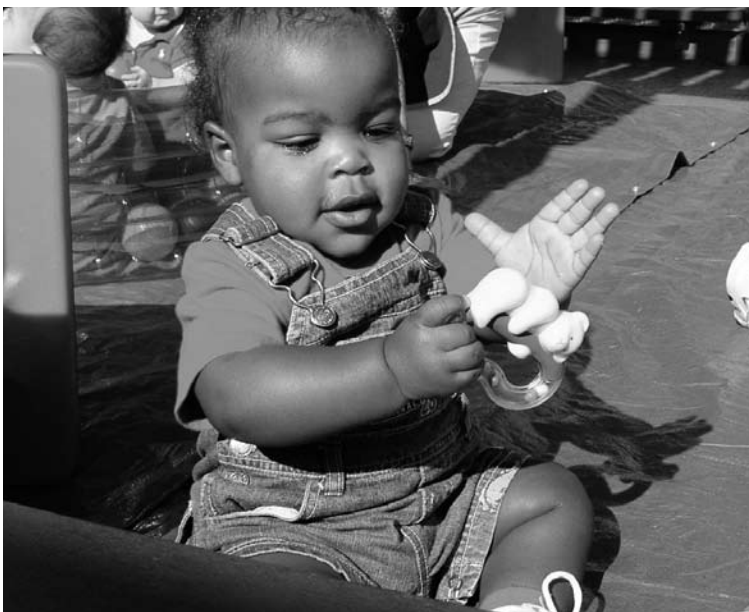
I. License All Programs

Licensing means that children are cared for by providers who meet minimum state standards. States should license all facilities that provide services for a fee, including all centers, large family or group child care homes, and small family child care homes caring for any unrelated children.

NACCRRRA Benchmark: Both child care centers and all family child care homes caring for even one unrelated child on a regular basis for a fee are required to be licensed.

II. Frequency of Inspections

Child care centers are more likely to adhere to required standards when more frequently inspected (Gormley, 1995). Without a strong



system of enforcement visits, state regulations may have little impact on the quality of care children receive (Morgan & Azer, 2000). Congress directed the DoD to conduct quarterly inspections of military child care centers. According to Campbell and others (2000) critical features of the system that led to military centers being designated by Congress as a “model for the nation” were the inspection and sanction requirements.

NACCRRRA Benchmark: Child care centers are inspected at least four times a year.

III. Licensing Staff Caseload

Licensing agencies should have sufficient staff and resources to effectively implement the regulatory process. The staff members responsible for inspection visits often have other responsibilities, including licensing and training. On average, licensing staff should be responsible for no more than 50 child care programs (NAEYC, 2006).

NACCRRRA Benchmark: Licensing staff are responsible for monitoring no more than 50 child care programs per person.

IV. Qualifications of Inspectors

In order for child care regulation to be effective, licensing inspectors must be capable of fairly and effectively applying and enforcing state regulations (AAP/APHA/NRCHSCC, 2002). They should have education and training on the type of child care they are inspecting. Licensing staff need to be knowledgeable about early childhood education or a closely related field, as well as the principles of regulatory administration (Gazan, 1998).

NACCRRRA Benchmark: Licensing staff have a Bachelor’s degree or higher in early childhood education, child development, or a related field.

V. Inspection Reports/Complaints

Available to Parents

The primary responsibility for selecting child care rests with parents. However, it is difficult in most states for parents to get detailed information about the quality of the programs in their area. Due to the difficulty of accessing inspection and complaint reports in most states, parents and the public have made limited use of these reports to assess the quality of their child care choices. Witte & Querait (2004) found that having inspection and complaint reports available online helped improve the inspection process and strengthen classroom environments.

NACCRRRA Benchmark: Both licensing reports and complaint reports are available online for parents and the public.

Based on these 10 standards and 5 oversight criteria, NACCRRRA scored and ranked the states. The next section shows how each state scored and their ranks. For greater detail about each individual state’s score, see the Appendix.

