National Child Care Benchmarks – Research to Public Policy

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January 2011

Introduction

The concept of having national child care standards/benchmarks has a controversial and long history. For some, it is a major problem because we are the only major industrialized country that does not have national child care standards; for others, they don't want to have the federal government being part of establishing national child care regulations for young children. The premise of this paper is that by default because of the tremendous advocacy work done by the National Association of Child Care Resource and Referral Agencies (NACCRRA) we have evolved to the point through a voluntary approach where we do have national child care benchmarks in place.

This discussion begins back in the 1960's when the federal government started to get into the child care business in a big way. As with any new endeavor that governmental agencies are part of, regulations and standards are not far behind. So in 1968 the **FIDCR – Federal Interagency Day Care Requirements** - were promulgated. These new federal requirements were used to govern all federal child care as these programs started to grow into a national program. In the late 1970's a large federal study was undertaken to look at the appropriateness of the FIDCR. This study looked at not only the FIDCR's content but also its monitoring capability. How would the federal government monitor and enforce the FIDCR in all child care programs that were now growing to be a very large national program. There needed to be a more efficient/effective approach to monitoring and enforcement. In their search for such an approach, two researchers in Pennsylvania, Susan Aronson, a pediatrician with a strong interest in child care, and Richard Fiene, a child psychologist with a strong interest in child care public policy research had developed an innovative **Child Development Program Evaluation (CDPE)** (Aronson, Fiene, & Douglas, 1977) system that looked like a promising monitoring and enforcement system.

The only problem with the new CDPE system was that it was very labor intensive and time consuming to administer. In discussions between Aronson & Fiene and the Federal HEW Children's Bureau, a proposal was made that a **key indicator approach might be a useful methodology.** An analogy would be similar to the 1040 IRS form and the 1040EZ form where the 1040EZ form used a key indicator approach. The team of Aronson & Fiene developed such a system in 1979 and presented it to the Children's Bureau, which was excited about piloting it

nationally. Unfortunately, in 1980, a moratorium was placed on the FIDCR and over the next several years the focus of regulations moved from the national/federal level to the individual state levels.

Methodology

The federal government started to support state agencies in helping them to improve their respective child care monitoring systems and a group of five states, Pennsylvania (as lead), California, West Virginia, Michigan, and New York received a grant to develop this system. The group of five states called themselves the **Children's Services Monitoring Transfer Consortium (CSMTC)** and started to look at Pennsylvania's CDPE system. The focus of the CSMTC was to take the CDPE system and make it a more generic system that could be used by all 5 states and the remaining 45 states in monitoring their child care systems. The result was two systems called the **Instrument Based Program Monitoring System (IPM**) (Fiene & Nixon, 1981) **and the Indicator Checklist System (ICS) (**Fiene & Nixon, 1983). The IPM/ICS systems were pilot tested in the five states and the results compared to see if there were similarities in the results obtained. There were similarities and a combined data base was begun of the five states and a **Generic Child Care Indicator Checklist** was developed (Fiene & Nixon, 1985). Based upon these findings and publications, other states began to use the IPM and ICS systems in their respective states and by 1989 approximately 30 states were using the methodology/tools/systems (GAO, 1989). What was appealing to states was the simple and straightforward approach of the IPM and ICS systems. Also, what was occurring were the identification of a small group of key licensing child care indicators that could be used by all states as they developed their respective child care regulatory systems.

In 1987, a study was conducted in Pennsylvania utilizing the CDPE (IPM) (Fiene, 1984a), CDPE-ICS (Fiene, 1984b), ECERS – Early Childhood Environment Rating Scale (Harms & Clifford, 1980) and looked at **child development outcomes** in a small group of child care programs mainly in the Northeastern part of the state. Based upon this study, a clear relationship was developed between scores on the **CDPE-ICS** (Fiene, 1984b) and how well children were doing in the respective programs (Kontos & Fiene, 1987). This study showed that by utilizing the ICS approach it could pay huge dividends for states in how they monitored their child care delivery systems. Here was a cost effective and efficient methodology that produced positive outcomes for children.

By the early 1990's a federal grant obtained by **Zero to Three** and three states, Utah, Florida and Illinois was to take the **IPM/ICS methodologies** and to expand them into a **comprehensive child care program quality model** involving training, technical assistance, monitoring, program evaluation, resource and referral, and parent education (Griffin & Fiene, 1995). This new comprehensive child care program quality model became the **precursor to the development of Quality Rating Systems** that are very popular with states today.

Two other developments during the 1990's involved the use of the ICS methodology. The first involved the National Child Care Association, which was beginning **a new accreditation system based upon the ICS approach.** This new system was studied extensively between 1991-1994 and the results of this study were published by NAEYC in a monograph on child care accreditation (Fiene, 1996). The second involved the American Academy of Pediatrics (AAP) and the American Public Health Associate (APHA), when they jointly published a voluntary set of health and safety guidelines, ***Caring for Our Children*** (AAP/APHA, 1992). Because of their comprehensive nature and the great length of the standards, a shorter version utilizing the ICS methodology was proposed and created called ***Stepping Stones*** (AAP/APHA, 1995) to assist states as they revised their child care regulations.

Results

In the late 1990's/early 2000's, the National Center for Health and Safety in Child Care (NCHSCC) and the Assistant Secretary's Office for Program Evaluation (ASPE) were interested in documenting the research behind the key indicators that formed the basis of *Stepping Stones*. In **2002, the publication, *13 Indicators of Child Care Quality, A Research Update*** (Fiene, 2002) was published by ASPE/NCHSCC. This comprehensive publication documented all the research to support the ICS key indicator approach in child care. It depicted how the 13 indicators were supported by the past 20 years of child care research that had been taking place in the field. A parent guide quickly followed.

After publication of the *13 Indicators of Child Care Quality*, the National Association for Child Care Resource and Referral (NACCRRA) adopted this research publication and parent guide as their default research standards when publishing their various guides and reports. NACCRRA published their own parents' guide based on the 13 indicators and then in **2007 and 2009 published a very influential *Report Card on Child Care Quality - We Can Do Better: NACCRRA's Ranking of State Child Care Center Standards and Oversight* at the state level.** NACCRRA has also produced a companion Report Card for family child care as well, *Leaving Children to Chance: NACCRRA's Ranking of State Standards and Oversight in Small Family Child Care Homes* (2008).

The 13 indicators are the following: prevention of child abuse, immunizations, staff child ratio, group size, staff qualifications and training, supervision/discipline, fire drills, medication administration, emergency plan/contact, outdoor playground, inaccessibility of toxic substances, and proper hand washing/diapering (Fiene, 2002, 2003).

Conclusion

These 13 indicators have become by default national child care benchmarks because of the advocacy and research work of NACCRRA. By publishing these two **Child Care Report Cards in 2007 and 2009 NACCRRA** has helped states to focus on the key regulatory items that

should be in place in their respective child care delivery systems. NACCRRA plans on publishing their 2011 update in March 2011.

Because of NACCRRA groundbreaking work, we are at a tipping point in which national child care benchmarks are a reality for states. It is not intended to become a heavy handed approach established by the federal government but rather as guidance for states as they further develop their individual state child care standards as outlined in the NACCRRA Report Card Reports for child care centers and family child care homes. The 13 indicators are not perfect, but they are based upon empirical evidence over a 30-year period that provides us in the child care field with a beginning point. The 13 indicators are readily measureable, and easily explainable to parents on why they are important to ensure the health and safety of their children while in out of home child care.

As NACCRRA has suggested in their Report Card Reports, let us move from an overly burdensome, complicated, confusing system to one that embraces a simple first step to establishing a baseline to program quality through these 13 key child care indicators. When I originally designed the licensing indicator methodology in 1979 the purpose was to streamline a cumbersome, complicated, difficult child care licensing and monitoring process to a more simple, efficient and effective system. One in which there was a balance between child care licensing and program quality indicators. I never intended that it be the end all to improving quality, but a **first step for the federal government and state governments to begin the quest for child care improvement**.

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