Quality in Early Care and Education


California Childcare Health Program
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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To describe the critical components of quality in early care and education (ECE) programs.

To identify possible barriers to quality improvement.

To describe how to enhance quality through three commonly occurring routines in ECE programs.

To identify funding opportunities for quality improvement.

To utilize health and safety assessment tools in ECE programs.

RATIONALE

Quality in ECE has many dimensions and is supported by an environment that allows children to grow and thrive developmentally, socially, cognitively, physically and emotionally. The Child Care Health Advocate (CCHA) plays a significant role in influencing quality in ECE programs as well as in helping children to enter school ready to learn.
WHAT A CCHA NEEDS TO KNOW

According to research based on the National Survey of America’s Families, 73% of all children younger than 5 years old spend time regularly in nonparental care (Capizzano & Adams, 2004). In California, it is estimated that 1.5 million of the 3 million children from birth to 5 years have working parents (see Handout: The 2005 California Child Care Portfolio; California Child Care Resource and Referral Network, 2005). Eighty-three percent of children with working parents in California spend an average of 35 hours per week in nonparental child care (Public Policy Institute of California, 2003). With so many young children spending time in nonparental care, attention has been drawn to the quality of available child care and the effects of quality care on children’s health and well-being.

What Are the Types of ECE Programs?

There are many different types of nonparental care in the United States (see Handout: Types of Out-of-Home Child Care Facilities). The types of care can be defined by these three dimensions:

- **The child’s relation to the ECE provider.** Is this ECE provider a relative or not a relative?
- **The environment in which the care is provided.** Is the care provided in the child’s home, the provider’s home or a center-based facility?
- **The formality of the arrangement.** Informal care is not regulated by the state or federal agencies. Formal care is regulated and required to meet certain health and safety standards.

How Quality ECE Programs Influence Children’s Development

High-quality programs have a positive influence on the social, emotional and cognitive development of children (Vandell, 1996). The positive effects of quality ECE programs on every part of children’s development are some of the most consistent findings in developmental science. Study after study has shown that high-quality care positively affects children’s development across every ethnic, cultural and language group (Shonkoff & Phillips, 2000). A child’s ability to be ready for school is also linked to quality in preschool. The child’s readiness for school depends on several factors, including the child’s physical well-being and motor development; social and emotional development; approaches to learning; language development; and cognition and general knowledge. Delays or challenges in any of these areas will affect the child’s ability to succeed in school.

Research suggests that high-quality care, especially when provided in center-based programs, is especially beneficial for low-income families (Burchinal, Landesman-Ramey, Reid & Jaccard, 1995). Children at risk of failing school benefit even more from quality child care (Cost, Quality & Child Outcomes Study Team, 1995). Children in good to excellent ECE programs score higher than children in mediocre to poor programs in cooperation, compliance and behavior; relations with peers; and cognitive and language development (Cost, Quality & Child Outcomes Study Team, 1995).

Research has shown that the quality of ECE programs in the United States is usually mediocre. The National Institute of Child Health and Human Development Study of Early Child Care (1999) reported that most ECE programs did not meet the American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) standards for quality. The Cost, Quality and Child Outcomes Study (1995) of more than 400 center-based ECE programs in four states found that 86% of these programs provided mediocre or poor-quality care. Therefore, 80% of children spend their days—up to 50 hours per week—in poor or mediocre ECE settings (Cost, Quality & Child Outcomes Study Team, 1995). Infant and toddler care is especially poor, with 40% of the programs studied rated as low quality (Helburn & Howes, 1996). In a study of quality in family child care and “relative” care, only 9% of family child care homes and relative care in three states were rated as good, 56% of the homes were rated as adequate and as many as 35% of the homes in the study were rated as inadequate (Galinsky, Howes, Kontos & Shinn, 1994).
**Relationships**

The single most important factor in quality is the relationship between the child and ECE provider. Children who receive warm and sensitive care are more likely to trust others, to enter school ready and eager to learn, and to get along well with other children (Carnegie Task Force on Meeting the Needs of Young Children, 1994). High-quality ECE programs create environments that promote warm and positive relationships between children and staff. Children whose caregivers provide plenty of social and cognitive stimulation and individual care do better on tests that measure cognitive, language and social development (Howes, Hamilton & Philipsen, 1998; Peisner-Feinberg et al., 1999). Stability in caregiving is also essential for the development of positive relationships (Raikes, 1993; Whitebook, Howes & Phillips, 1990). Children who do not have consistent care tend to be more aggressive, less socially competent with peers and have smaller vocabularies (Howes et al., 1998; Whitebook et al., 1990).

**Routines**

Routines and predictable, structured activities are also important for quality care. Routines such as feeding, napping and toileting are opportunities to spend individual and responsive one-on-one time with children. Infants, toddlers and young children feel safe and secure in familiar routines. Routines provide the foundation for exploring the social, emotional, cognitive, language and physical skills they need. The absence of routines or poorly managed routines can be stressful and may negatively affect children's development. However, there can also be many opportunities for injury, spread of infection and power struggles during routines. For example, if young children are expected to wait in long lines to wash hands, keeping children busy during these waiting periods could be difficult.

For ECE professionals to set up appropriate routines, develop positive relationships with and between children, and nurture early learning, they must be educated about and understand developmental processes in young children. Although having enough education and understanding is essential, it is also important to have a way to get that education, the desire to use the skills that are learned and an ECE program that has the appropriate structure for putting those skills into practice (Phillipsen, Burchinal, Howes & Cryer, 1997; Vandell, 1996).

**ECE provider qualifications**

ECE programs that are of a higher quality have teachers with more specialized training and education in early childhood than lower-quality ECE programs (Whitebook, 1995). ECE providers with degrees or special training in ECE are better able to help young children learn; educated and trained ECE providers are more likely to promote the physical and mental health, safety and cognitive development of the children in their care (Fiene, 2002). In addition, getting continuing education through workshops and courses is important to help ECE providers keep up-to-date on developments in the ECE field.

**Adult-to-child ratio and group size**

The fewer the children for each adult, the better the quality of the ECE program and the more attention each child will receive (Fiene, 2002). Staff-to-child ratios and group sizes are two of the best signs for determining the quality of an ECE program, and they influence many other health and safety issues. ECE programs with smaller group sizes have less risk of infection than ECE programs with larger group sizes (Fiene, 2002). States regulate the ratio that is acceptable for licensing. For younger children (under 1 year of age), the ratios are generally lower (e.g., one adult to three to four infants) than for older children. Cost, Quality and Child Outcomes in Child Care Centers (1995) found that centers with low staff-to-child ratios were seen as providing higher-quality care. Research suggests that children in groups of 12 to 14 with two caregivers are more cooperative and compliant, and show more creative play than children in groups of 24 to 28 with four caregivers. Children in smaller groups also have better social skills than children in larger groups (Clarke-Stewart, Gruber & Fitzgerald, 1994). Children become securely attached to individuals whom they trust to care for them in a responsive and sensitive manner. ECE providers with small groups are more actively involved and spend more time playing with children; they are more responsive, more socially stimulating and less restrictive than caregivers in larger groups (Vandell, 1996).

According to the Community Care Licensing division, the adult-to-child ratio for California in child care centers is 1:4 for infants, 1:6 for toddlers and 1:12 for preschoolers (State of California, 2002; Reg 101216.3, 101216.4, 101416.5). These regulations vary.
for family child care homes. For more information on Community Care Licensing regulations, see the following Web site for highlights: http://www.cclld.ca.gov/res/pdf/CCCRegulationHighlights.pdf.

Turnover

When choosing an ECE program, parents should ask about how long ECE providers have been at the center or have provided care in their homes. It is best if children stay with the same ECE provider for at least 1 year. Staff turnover is a sign of how stable the ECE program is, how the staff are treated and of overall quality. In ECE programs with high staff turnover, children may have a difficult time getting adjusted. Getting used to new ECE providers takes time and energy that could instead be spent on learning new things. Comprehensive Approaches to Raising Educational Standards (CARES) is a program that promotes, rewards and encourages education among ECE professionals in California. The goal of the program is to reduce turnover and enhance educational opportunities. For more information on county programs, contact the local Child Care Planning Council. CARES applicants may qualify for stipends based on their level of education and their professional experience in ECE programs.

Barriers to Quality in ECE Programs

Barriers to quality ECE programs can be linked to high staff turnover rates, high staff-to-child ratios and not enough training for ECE providers. Staff turnover is quite high in the ECE field due to the low salary, inadequate benefits and limited growth opportunities. Turnover rates range from 25-50% of staff per year (Howes, Phillips & Whitebook, 1992). New staff may not be as well trained or as experienced as those who leave. High staff turnover rates require continuous training to provide needed services that ensure the well-being of young children and the quality of the program.

Staff turnover disrupts the consistency and familiarity of the environment and, as a result, may decrease the quality of care. Turnover also disrupts the close, caring relationships that children have established with ECE providers and other children.

ECE staff may not match the language, class or culture of the children enrolled. This can make it difficult to provide the type of care children receive at home and for programs to communicate effectively with families.

Health and Safety Practices for Three Routine Activities in ECE Programs

Across all types of ECE programs, whether in a center or family child care home, there are three commonly occurring routines that define how a large part of the day is spent. These activities are toileting/diapering, napping and feeding. All children in ECE programs need attention in these areas. How the routines are handled and how safety and health procedures are followed during these routines are important in determining quality of care. ECE providers can improve quality of care through these routine activities.

Toileting/Diapering

- An area with a disposable surface should be set aside for diapering. Diapering that happens on the floor increases the chances for the spread of infectious disease. Diapering on the floor may be allowed if it does not place the child at risk of being stepped on and if it is done on a disposable surface. If the remaining, nondisposable surface can be disinfected and the ECE provider does not risk injuring the back by kneeling on the floor, then it may be possible, but not preferable, to diaper children on the floor.
- Even with good diapering surfaces and areas, the diaper table may cause injury or lead to the spread of infection. Older children should climb up to the surface of the table so the provider does not need to lift them. Supplies should be readily at hand, but not within the child’s reach. The height of the table should be comfortable for the provider and the sink should be close enough to prevent other surfaces from being contaminated. Children old enough to wash their own hands should be close enough to be supervised.
- If cloth diapers are used, soiled diapers should be removed in one piece along with the protective covering to cut down on contact with stool. To the dismay of some parents, diapers should not be rinsed by providers, but emptied and tied
securely in plastic bags and sent home. Diaper creams are considered medication and require parents to complete a medication form. Creams should be kept in children’s personal containers, marked clearly with their name and stored with their diapering supplies. Some diaper ointments contain lead, and parents need to be told about this risk. Bloody diaper rashes will require the use of latex gloves (or the equivalent) by the ECE provider. To avoid contaminating the ointment container, ECE providers can dispense the amount of ointment needed for the diaper change onto a paper towel before beginning the procedure.

- Gloves are not required by either the California Community Care licensing regulations or the recommended National Health and Safety Performance Standards unless there is blood (AAP, APHA & National Resource Center for Health and Safety in Child Care, 2002; State of California, 2002). Using gloves inappropriately sometimes occurs in ECE programs. CCHAs should observe gloving procedures for many diaper changes with different ECE providers to get a sense of whether the recommended procedure is being followed. If a program chooses to use gloves for diaper changes when there is no blood, vinyl is recommended. Vinyl is better than latex because vinyl gloves are more likely to be removed right after each diaper change because they are not as comfortable as latex gloves, thus reducing the spread of germs. In addition, some individuals are allergic to latex. See Handout: Health and Safety Notes: Latex Allergy and Sensitivity in the Child Care Setting for more information. Observe when and how ECE providers remove their gloves; encourage them to remove their gloves between each diaper change and to wash their hands after each diaper change.

- Hand washing, while one of the most basic and frequently covered training issues in ECE, is still rarely done correctly or often enough. ECE providers and children must wash their hands after every diapering/toileting episode. There are many debates over liquid versus bar soap. The use of antibacterial soap is almost universal in ECE programs, and the use of waterless hand sanitizers has recently caught on. Observe when and how such products are used and encourage plain liquid soap and water unless it is absolutely not an option. You might observe that some ECE providers skip hand washing when gloves are used, and they need to be instructed that gloves do not replace hand washing. The California Childcare Health Program (CCHP) has produced miniposters and other materials on hand washing, gloving and other procedures. Visit the CCHP Web site at http://www.ucsfchildcare-health.org for free downloadable PDF copies.

- Some programs require children to be toilet trained in order to enroll or to move up to the next older age grouping. The National Health and Safety Performance Standards (AAP et al., 2002) recognizes that toilet training, or more appropriately toilet learning, is a developmental milestone that may not correspond to chronological age. Programs that require toilet learning conflict with the Americans with Disabilities Act (ADA) because some children may never be toilet trained or may progress at a much slower pace. Programs that tailor their care to each child can accommodate children in diapers at any age as long as they have the facilities to diaper safely and appropriately.

- It may be difficult to supervise children when they are able to use the toilet without help. The goal is to staff and arrange the environment in such a way that children can be supervised while they independently and privately use the toilet and wash their hands.

- Toilet training can be an area of conflict for ECE providers and parents. Culture, parenting styles and economics can influence the decision to start toilet learning before the child is ready. Generally, developmental guidelines will indicate when a child is ready to switch from diapers to pants.

**Sleeping/Napping**

- ECE programs are now expected to follow sleeping recommendations by the AAP to reduce the risk of Sudden Infant Death Syndrome (SIDS). *It is necessary to put all infants to sleep on their backs.* Policies and procedures for sleep position, crib specifications and bedding should be in place and communicated to parents upon enrollment in the ECE program. Recent research has shown that the rate of SIDS is higher in ECE programs than in infants’ homes, especially when infants are placed to sleep on their stomach in ECE programs and on their back at home (AAP Task Force on Infant Sleep Position and SIDS, 2000).
• Napping is a sensitive topic in ECE programs. Many programs have a set time for napping and expect all children to participate. Programs often rely on this time to schedule staff breaks, do paperwork and prepare for the next activity. However, the sleeping schedule and the amount of sleep needed vary with each child and do not lend themselves easily to a set schedule. Licensing regulations (Section 101230) require that “all children shall be given the opportunity to nap or rest without distraction or disturbance from other activities at the center” (State of California, 2002). Children who need to sleep longer or more often must be allowed to do so, and the environment and schedule of the ECE program should make this possible. For children who do not nap or who wake up early, programs must find ways to prevent them from disturbing children who are sleeping or resting. The availability of space and activities for quiet play and development are essential.

• Having enough space for napping can be difficult in some programs. Cot storage and bedding must not provide an opportunity for the spread of infection.

• To prevent baby bottle tooth decay and to reduce the risk of ear infections, children should not be placed to sleep with bottles. If a parent insists and the child will not rest without a bottle, programs may choose to agree to bottles containing a small amount of water for the child.

Feeding

Guidance on general nutrition and food sanitation will be covered in a separate module (see Nutrition and Physical Activity module). We will focus here on only the main health and safety issues.

• The safe preparation of bottles for infant formula requires hygienic practices outlined in the licensing regulations (State of California, 2002, Section 101427) and the National standards (AAP et al., 2002). Staff and parents may disagree about the disposal of unfinished bottles. Compromises can be reached by preparing more bottles with fewer ounces of formula to reduce waste. Bottles of formula can rapidly grow bacteria and must not be refrigerated for feeding at a later time.

• Breastfeeding is encouraged whenever possible and is appropriate for the infant and mother (see Handout: Health and Safety Notes: Supporting Breastfeeding Families). With more young infants in ECE programs, it has proven a challenge for some programs to create “breastfeeding friendly” environments. Handling of breast milk is outlined in the National Health and Safety Performance Standards (AAP et al., 2002, Standard 4.015). Programs can help mothers breastfeed by timing bottle feedings so that the infant will nurse when the mother picks up the child at the end of the day or as arranged. Having a comfortable place in which to nurse will also encourage breastfeeding. Since breast milk is a body fluid, it is essential that bottles of breast milk not be shared with other children. This can be assured by holding all infants when they are fed and not allowing children to walk around with bottles. Holding infants during bottle feeding is also the best way to nurture and become attuned to the child’s signals.

• Infants should never be given honey until 1 year of age because of the risk of botulism.

• To prevent baby bottle tooth decay, it is recommended that infants be introduced to a cup by about 6 months of age and weaned from the bottle at around 1 year of age. Parent preferences may require careful exploration and negotiation by ECE providers.

• Solid food is generally recommended at about 4 to 6 months of age, and the recommended sequence for introducing foods is listed in the licensing regulations (State of California, 2002, Section 101427). ECE providers should not add solid food such as cereal to an infant’s bottle even if the practice is common at home. Learning to feed oneself is messy business and can take a very long time. Reading children’s signals and going at their pace helps ECE providers be responsive and helps children gain a sense of mastery. If parents and ECE providers do not agree on how to introduce solid foods, they may need to discuss different options to meet the child’s needs.

• It is important to eliminate choking risks in ECE programs. Hot dogs, raw carrots cut into rounds and whole grapes should not be served to children younger than 4 years of age. Foods do not need to be eliminated, but must be changed by cooking or cutting them differently so they can be served safely.

• Food allergies are very common in young children and must be treated as a serious health
threat. Special care plans must be on file for all children with food allergies and updated at least every 6 months. Staff who serve snacks or meals, or who use food products in craft activities must be aware of allergies and emergency procedures in case the child is exposed. Epinephrine (EpiPen Jr®) injecting devices should be obtained by parents from their health care provider and given to the ECE program. Staff should be trained to use the device and to know when to use it. Research has shown that many parents do not know how to properly give epinephrine to their child, do not carry the medicine with them at all times or carry expired medicine. By requiring parents to complete the special care plan with their medical provider, ECE programs may be saving a child’s life by making sure the parent is adequately trained and that medication is current.

- Children with special health and developmental needs may also have special feeding needs. ECE programs can encourage parents to schedule occupational therapy services in the ECE setting to help ECE providers better meet the feeding needs of the child.
- Programs need to consider the ethnic and cultural food preferences of families when planning menus for children.

What Resources Are Available for Improving Quality?

There are many federal, state and local agencies that have money to help fund ECE programs to improve quality of care.

Support Available from Regulatory Agencies

Although the law requires that ECE programs follow state licensing regulations (State of California, 2002), these regulations are not always enforced. In addition, following National standards (AAP et al., 2002) is more difficult than following state regulations and sometimes can be costly. Studies show that better monitoring of ECE programs increases their compliance with health and safety standards (Koch, 1994). For this reason, better support and education about quality and compliance with National standards is needed in ECE.

California Department of Social Services, Community Care Licensing Title 22 regulations. California’s center-based regulations and ratio regulations are above the national median. However, stricter educational and training requirements, higher health and safety standards, and broader enforcement and adequate monitoring of compliance could improve quality.

California Department of Education, Child Development Division (CDD). Desired Results for Children and Families is a system that includes Program Performance Standards, which are required to fund center-based programs and family child care home networks that contract with CDD. These standards support the achievement of “desired results” for children from birth to 14 years and their families. Key aspects of desired results include the following: developmental and programmatic assessments, accountability, teaching and learning opportunities, staffing and professional growth, parent and community involvement, and decision making and administration. Best practices have been defined for child care centers, family child care homes, and resource and referral agencies. All programs supported by CDD are required to complete developmental profiles on each child (including cognitive, social-emotional, language and physical development). All programs supported by CDD also need to do a self-study each year to make sure they are following Program Performance Standards.

Local First 5 County Commissions. Local First 5 County Commissions offer many resources for quality improvement, including grants to improve facilities and to train staff. Incentives are also offered to ECE providers to increase their knowledge, skills and retention in the field.

Local Child Care Planning Councils. Every county in California has a local child care planning council. Child care planning councils are a resource for ECE programs. Planning councils decide what the needs are for the county in terms of child care—whether more ECE programs are needed in the area or not. They will have a list of available funds ECE programs can apply for to help with the costs of improving quality and safety in the programs. They also help with accessing and giving out resources for quality improvement.
Training Opportunities

California Department of Social Services, Community Care Licensing Division provides training for new and prospective family child care providers.

California Department of Education CDD funds many training activities, including the following:

- **The Child Care Initiative Project**, which directs grants to local child care resource and referral agencies to train family child care providers and to improve the quality and supply of child care in California.
- **The Program for Infant/Toddler Caregivers**, an integrated system for providing training and technical assistance to early childhood professionals working with children from birth to 3 years.
- **The Child Development Training Consortium and Early Childhood Mentor Program** address the serious shortage of qualified staff in ECE programs by supporting the professional growth and development of those already working in the field.

CARES is a program that promotes, rewards and encourages education among ECE professionals in California. For more information on county programs, contact the local Child Care Planning Council. CARES applicants may qualify for stipends based on their level of education and professional experience in ECE programs.

Accreditation Opportunities

Fewer than 15% of ECE centers and family child care homes are accredited. Funding to increase accreditation is available through many local child care resource and referral agencies and First 5 programs. Professional organizations such as the National Association for the Education of Young Children (NAEYC) and the National Association of Family Child Care Providers (NAFCCP) provide accreditation criteria, training and support for ECE programs.

Funding Opportunities

Programs that seek outside sources of funding tend to be of higher quality than programs that do not (Howes & Brown, 2000). Federal funding guidelines from the Child Care and Development Block Grant require that at least 4% of funding be used for quality improvement activities in each state. In California, an estimated $101 million is spent on quality improvement activities annually, including the Family Child Care Training Project and playground safety grants, as well as the following infant and toddler care programs:

- The Program for Infant/Toddler Caregivers
- infant/toddler specialist for the CCHP Healthline
- inclusion of infants and toddlers with disabilities
- infant and toddler early development and learning guidelines

The U.S. Department of Health and Human Services and the Administration for Children and Families also federally fund Head Start and Early Head Start.

Resource and referral agencies are located in every California county. These agencies address local and statewide child care needs, support recruitment and training efforts for ECE providers, and advocate for quality, accessible and affordable ECE programs.

Local grants or loans can also help improve quality. They can come from local ECE programs and development planning councils. Funds may be given for the renovation of facilities, repairs and instructional materials.

Early Childhood Mentor Programs and child care salary and retention incentive programs provide funding to pay ECE providers.

Assessing Programs for Quality

The Early Childhood Environment Rating Scales are used to assess the quality of an early childhood or school age care setting. There are three environmental rating scales, each designed for different types of ECE programs. Additional training is required to use these tools.

Early Childhood Environment Rating Scale-Revised Edition (ECERS-R)

The most widely used tool to assess the quality of center-based ECE programs is the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R; Harms, Clifford & Cryer, 2004). The ECERS-R may be used by staff for periodic self-assessment, as well as by outside reviewers. It can help to identify
ways to improve the quality of the program and to measure change. The ECERS-R is a 43-item observational measure to assess ECE center-based programs serving children 2 1/2 through 5 years of age. The ECERS-R includes the following seven subscales:

1. Space and Furnishings
2. Personal Care Routines
3. Language-Reasoning
4. Activities
5. Interaction
6. Program Structure
7. Parents and Staff

Each item on the ECERS-R is ranked on a scale from 1 to 7, with 1 being inadequate to 7 being excellent. For a single item, scoring must start at 1, inadequate, and progress upward until the correct score is reached (Harms, Cryer & Clifford, 2004).

Infant/Toddler Environment Rating Scale-Revised Edition (ITERS-R)

The Infant/Toddler Environment Rating Scale-Revised Edition (ITERS-R) is a 35-item observational measure used to assess the quality of center-based ECE programs serving children up to 30 months of age (Harms, Clifford & Cryer, 2002). The items are organized into the following seven subscales:

1. Furnishings and Display for Children
2. Personal Care Routines
3. Listening and Talking
4. Learning Activities
5. Interaction
6. Program Structure
7. Adult Needs

Family Day Care Rating Scale (FDCRS)

The Family Day Care Rating Scale (FDCRS) is designed to assess family child care programs located in a provider’s home (Harms & Clifford, 1989). The scale consists of 40 items, including eight additional items for programs enrolling children with disabilities. The items are organized into the following seven subscales:

1. Space and Furnishings for Care and Learning
2. Basic Care
3. Language and Reasoning
4. Learning Activities
5. Social Development
6. Adult Needs
7. Provisions for Exceptional Children

The ITERS-R (Harms, Cryer & Clifford, 2002) and FDCRS (Harms & Clifford, 1989) use the same scoring method as the ECERS-R (Harms et al., 2004).

Assessing Programs for Health and Safety

Health and safety is an essential part of quality ECE programs. Healthy and safe environments encourage and support learning opportunities for young children. Health services that focus on prevention and education are needed to improve quality of care in ECE programs (Alkon & Boyce, 1999). It is highly recommended that a standardized tool be used to assess whether health and safety regulations and standards are being met. CCHP has developed a health and safety checklist, which is described below.

CCHP Health and Safety Checklist-Revised (CCHP H & S Checklist-R)

The original CCHP Health and Safety Checklist (CCHP H & S Checklist) was based on the Child Care Evaluation Summary (Quality Enhancement Project for Infants and Toddlers, 2001) and a previous child care study’s health and safety checklist (Preschool Environment Project, 1997). CCHP research staff developed a question-by-question instruction manual to standardize the use of the CCHP H & S Checklist. The CCHP H & S Checklist was pilot-tested in four child care centers and was found to be a reliable and valid instrument. The CCHP research staff used the CCHP H & S Checklist to evaluate change in health and safety practices in 128 ECE programs in five counties funded by the Child Care Health Linkages Project. Based on the data collected, the CCHP H & S Checklist was revised in 2005 (see Handout: CCHP Health and Safety Checklist-Revised). The CCHP Health and Safety Checklist-Revised (CCHP H & S Checklist-R; CCHP, 2005) is an 82-item assessment tool.
comprised of key National Health and Safety Performance Standards (AAP et al., 2002) and state licensing regulations (State of California, 2002).

The CCHP H & S Checklist-R includes the following subscales:

1. Emergency Prevention/Poisons
2. Staff and Children’s Possessions
3. Special Needs
4. Hand Washing
5. Food Preparation/Eating/Sanitation
6. Oral Health
7. Outdoor/Indoor Equipment
8. Infant/Toddler (General, Diapering, Food Preparation/Eating and Sleeping/Napping)

Scoring is based on a 2-point scale: (1) Completely Meets Standard and (2) Does Not Completely Meet Standard or NA (not applicable). In addition, there is a column for the CCHP H & S Checklist-R user to write notes related to each item.

The CCHP H & S Checklist-R was developed for use by ECE program providers, Child Care Health Consultants (CCHCs), CCHAs, researchers and others interested in health and safety assessment. The CCHP Health and Safety Checklist-Revised User’s Manual: Question-by-Question Specifications includes item-by-item explanations on how to complete the CCHP H & S Checklist-R.

The rating of items 1 through 8 are yes when the information is present and complete or no when the information is not present or incomplete. The scoring for item 9, the screenings, are N for Not Recorded; I for Recorded but Incomplete; Y for Recorded, Not Positive; P for Positive, No Referral; R for Positive, Referred, Pending; and C for Positive, Referred, Complete. The Record Review is accompanied by two forms: the Child Health Record Review: Early Care and Education Program Health Assessment: Guidelines for Completion of Form and the Spreadsheet for Determining Child’s Age in Months (see handouts for these forms). These forms help the reviewer accurately complete the Record Review.

The Child Health Record Review: Early Care and Education Program Health Assessment (Child Care Evaluation Worksheet, Quality Enhancement Project for Infants and Toddlers, 2000)

The Child Health Record Review (see Handout: Child Health Record Review) is a standardized instrument used to track children’s health by reviewing information from health records filed on-site at ECE programs. The form is used to review records in the following areas:

1. Emergency Contact Information
2. Well Child Physical
3. Well Child Physical in Last Year
4. Special Health Care Needs as Defined by the Maternal and Child Health Bureau
5. Whether the Child with a Special Need Has a Special Care Plan
6. Immunization Status
7. Health Insurance
8. Medical Home (a consistent place where medical care is received such as a doctor’s office)
9. Health Screenings: height and weight, hematocrit and hemoglobin, lead, vision, hearing, speech and language, oral health, and general development
WHAT A CCHA NEEDS TO DO

• Review Community Care Licensing requirements, program performance standards, National Health and Safety Performance Standards, accreditation standards and the tools used to measure quality in ECE programs.

• Learn to recognize the signs of quality of care, including health and safety, interactions between children and adults, and learning opportunities. Decide which aspects of quality you would like to work on.

• Know about the greater community’s ECE needs, programs and resources. Visit different ECE programs to learn about their programs, their settings and what they are doing to improve quality. Visit model programs for firsthand knowledge of how a high-quality program works.

• Think of ways to meet the health and safety needs in your program. Work with a health consultant who is responsive to a program’s needs and develop a custom-made plan for your particular mix of staff, children and families.

• Learn to effectively promote a quality ECE program.

• Become involved in discussions locally on how to define and achieve quality care at programmatic, local and regional levels.

• Identify and help develop high-quality programs in the area to serve as models.

• Promote health and safety in discussions of quality child care.

• Attend or conduct workshops at local or regional ECE meetings and conferences.

• Work together with other CCHAs for high-quality child care such as child care resource and referral, community care licensing, local planning councils or the First 5 County Commission and School Readiness Initiatives.

Cultural Implications

CCHAs need to be sensitive to different attitudes and beliefs about what a quality ECE program should look like. Napping, feeding and toileting conflicts may come up for families and ECE providers due to differences in cultural beliefs and practices. CCHAs may need to sensitively negotiate and solve these conflicts while respecting cultural differences.

Implications for Children and Families

Children and families will benefit from high-quality ECE programs. CCHAs can help educate children and families about the importance of health and safety policies and procedures in the ECE program.

Implications for ECE Providers

ECE providers will appreciate a CCHA’s help in improving quality in the ECE program. CCHAs should be sensitive to the needs of the ECE provider and work together with the ECE provider to achieve goals.
ACTIVITY

To familiarize yourself with the *CCHP Health and Safety Checklist-Revised (CCHP H & S Checklist-R)* and the *CCHP Health and Safety Checklist-Revised User’s Manual: Question-by-Question Specifications*, break up into small groups and make one person in each group the reporter. Each group will be assigned one subscale/section of the *CCHP H & S Checklist-R* for discussion. Review subscale items and refer to the *Question-by-Question Specifications* for directions on observing and rating items. Be prepared to report back to the larger group.

What do you need to do in an ECE program to observe all the items and rate them accurately?

What are some areas your ECE program could improve in?
NATIONAL STANDARDS


2.028, 3.004, 3.008, 3.012-3.019, 4.001, 4.007, 4.009, 4.013-4.014, 4.024-4.039, 5.142-5.147, 5.065-5.070, 7.003, Appendix E, Appendix Z.

CALIFORNIA REGULATIONS

From Manual of Policies and Procedures for Community Care Licensing Division

Title 22, Division 12, Chapter 1, Article 6, 101428, 101230,101239.1,101227,101427,101220,101220.1, 101221.
## RESOURCES

### Organizations and Resources

<table>
<thead>
<tr>
<th>Organization and Contact Information</th>
<th>Description of Resources</th>
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</table>
| California Association for the Education of Young Children (CAEYC)  
www.caeyc.org | CAEYC offers opportunities for professional growth and training for early care professionals around the state. |
| California Childcare Health Program  
1333 Broadway, Suite 1010  
Oakland, CA 94612-1926  
(510) 839-1195 office  
(800) 333-3212 Healthline  
www.ucsfchildcarehealth.org | The Child Care Healthline provides health and safety information to ECE providers, the families they serve, and related California professionals. The Healthline team of specialists consults on issues such as infectious disease, health promotion, behavioral health, serving children with disabilities and special needs, nutrition, infant-toddler development, lead poisoning prevention and more. |
| California Childcare Resource and Referral Network  
www.rnetwork.org | Child Care Resource and Referral (R&R) agencies are located in every county in California. Over the last two decades, R&R services have evolved from a grassroots effort to help parents find child care, to a well-developed system that supports parents, providers, and local communities in finding, planning for, and providing affordable, quality child care. |
| California Department of Education, Child Development Division  
www.cde.ca.gov/sp/cd | General child care and development programs are state and federally funded programs that use centers and family child care home networks operated or administered by either public or private agencies and local educational agencies. These agencies provide child development services for children from birth through 12 years of age and older children with exceptional needs. |
| California Department of Social Services, Community Care Licensing  
www.ccld.ca.gov | The Community Care Licensing Division promotes the health, safety, and quality of life of each person in community care through the administration of an effective collaborative regulatory enforcement system. |
| Center for Health Improvement  
1330 21st Street, Suite 100  
Sacramento, California 95814  
916.930.9200 phone  
916.930.9010 fax  
www.centerforhealthimprovement.org | The Center for Health Improvement (CHI) is a national, independent, nonprofit health policy center dedicated to improving population health and encouraging healthy behaviors. CHI uses evidenced-based research as the basis for policy innovation and implementation. |
| Clearinghouse on Early Education and Parenting (CEEP)  
http://ceep.crc.vivc.edu | The Clearinghouse on Early Education and Parenting (CEEP) is part of the Early Childhood and Parenting (ECAP) Collaborative within the College of Education at the University of Illinois at Urbana-Champaign. CEEP (a content provider) and the ECAP Information Technology Group (ECAP/ITG) work closely to build print and online resources for the worldwide early childhood and parenting communities. |
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<th>Organization and Contact Information</th>
<th>Description of Resources</th>
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<tbody>
<tr>
<td>Education Resources Information Center (ERIC)</td>
<td>Sponsored by the Institute of Education Sciences (IES) of the U.S. Department of Education, ERIC produces the world’s premier database of journal and non-journal education literature. The ERIC online system provides the public with a centralized ERIC Web site for searching the ERIC bibliographic database of more than 1.1 million citations going back to 1966.</td>
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<tr>
<td>First 5 California</td>
<td>The California Children and Families Act of 1998 is designed to provide, on a community-by-community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services. Through the integration of health care, quality child care, parent education and effective intervention programs for families at risk, children and their parents and caregivers will be provided with the tools necessary to foster secure, healthy and loving attachments.</td>
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<tr>
<td>Head Start Bureau</td>
<td>Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. They are child-focused programs and have the overall goal of increasing the school readiness of young children in low-income families.</td>
</tr>
<tr>
<td>National Association for the Education of Young Children</td>
<td>The National Association for the Education of Young Children (NAEYC) is dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for all children from birth through age 8. NAEYC is committed to becoming an increasingly high performing and inclusive organization.</td>
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<tr>
<td>National Association for Family Child Care</td>
<td>NAFCC provides technical assistance to family child care associations. This assistance is provided through developing leadership and professionalism, addressing issues of diversity, and by promoting quality and professionalism through NAFCC’s Family Child Care Accreditation.</td>
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<tr>
<td>National Association of Child Care Resource and Referral Agencies</td>
<td>NACCRRRA is the national network of more than 850 child care resource and referral centers (CCR&amp;Rs) located in every state and most communities across the US. CCR&amp;R centers help families, child care providers, and communities find, provide, and plan for affordable, quality child care.</td>
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<tr>
<td>National Center for Early Development and Learning (NCEDL)</td>
<td>NCEDL is a national early childhood research project supported by the US Department of Education’s Institute for Educational Sciences (IES), formerly the Office of Educational Research and Improvement (OERI). Administratively based at the FPG Child Development Institute, NCEDL is a collaboration with the University of Virginia &amp; UCLA. NCEDL focuses on enhancing the cognitive, social, and emotional development of children from birth through age eight.</td>
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<tr>
<td>National Child Care Information Center</td>
<td>The National Child Care Information Center (NCCIC), a service of the Child Care Bureau, is a national clearinghouse and technical assistance center that links parents, providers, policy-makers, researchers, and the public to early care and education information.</td>
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<td><a href="http://www.nccic.org">www.nccic.org</a></td>
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<td>The Program for Infant/Toddler Caregivers</td>
<td>The Program for Infant Toddler Caregivers (PITC) seeks to ensure that America's infants get a safe, healthy, emotionally secure and intellectually rich start in life. The PITC approach equates good care with trained caregivers who are preparing themselves and the environment so that infants can learn. PITC offers training and education to ECE professionals.</td>
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<td><a href="http://www.pitc.org">www.pitc.org</a></td>
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<tr>
<td>Trustline</td>
<td>Trustline is a database of nannies and baby-sitters that have cleared criminal background checks in California. It is the only authorized screening program of in-home caregivers in the state with access to fingerprint records at the California Department of Justice and the FBI.</td>
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<tr>
<td>(800) 822-8490</td>
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<td><a href="http://www.trustline.org">www.trustline.org</a></td>
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<td>Zero to Three: National Center for Infants,</td>
<td>Zero to Three's mission is to promote the healthy development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.</td>
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<td>Toddlers and Families</td>
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<td><a href="http://www.zerotothree.org">www.zerotothree.org</a></td>
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**Publications**


Lombardi, J. (1999). Child care is education...and more. Early years are learning years. *Young Children, 54*(1), 48.


**Audio-Visual**


REFERENCES


## HANDOUTS FOR THE QUALITY IN EARLY CARE AND EDUCATION MODULE

Handouts from California Childcare Health Program (CCHP), Oakland, CA

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<tr>
<th>Page</th>
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<tr>
<td>23</td>
<td>CCHP Health and Safety Checklist: Revised (handed out as a booklet separate from this module)</td>
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<tr>
<td>25</td>
<td>Child Health Record Review</td>
</tr>
<tr>
<td>29</td>
<td>Child Health Record Review: Guidelines for Completion of Form</td>
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<td>31</td>
<td>Child Health Record Review: Spreadsheet for Determining Child’s Age in Months</td>
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<td>33</td>
<td>Health and Safety Notes: Latex Allergy and Sensitivity in the Child Care Setting</td>
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<td>Health and Safety Notes: Supporting Breastfeeding Families</td>
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<td>Types of Out-of-Home Child Care Facilities</td>
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Handout from Child Care R& R Network

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<tr>
<th>Page</th>
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<tr>
<td>37</td>
<td>The 2005 California Child Care Portfolio</td>
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Child Health Record Review:
Early Care and Education Program Health Assessment

Date: __ / __ / ______ Program ID: __-__-_____ Reviewer ID #: __-_____-

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<th>Child with Special Needs (CSN)</th>
<th>Medical Care Plan on file</th>
<th>Immunizations Up-to-Date</th>
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## Child Health Record Review:
### Early Care and Education Program Health Assessment

**Date:** __/__/____  
**Program ID:** ___-___-____  
**Reviewer ID #:** ___-____

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<th>Age in Months</th>
<th>Complete Emergency Contact Information on file</th>
<th>Well Child physical on file</th>
<th>Well Child physical in last year</th>
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</table>
The information you use to complete a Child Health Record Review should come from and be completed for a one early care and education program.

<table>
<thead>
<tr>
<th>Item</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Record the date you are completing this form in the space provided. Record 2 digits for the month, 2 digits for the day, and 4 digits for the year, using the format mm/dd/yyyy. For example, August 11, 2005, would be coded 08/11/2005.</td>
</tr>
<tr>
<td>Program ID #</td>
<td>Record the name or ID number of the program. Please indicate whether you are serving a center or a family child care home by using “C” or “F” after the program name/number.</td>
</tr>
<tr>
<td>Reviewer’s ID #</td>
<td>Record the ID number assigned to you.</td>
</tr>
<tr>
<td>Total # of Children</td>
<td>Use the following criteria for determining a child’s age group:</td>
</tr>
<tr>
<td></td>
<td>0 - &lt;36 months = Infant/Toddler</td>
</tr>
<tr>
<td></td>
<td>36 - &lt;72 months = Pre-school (if not yet in Kindergarten)</td>
</tr>
<tr>
<td></td>
<td>72+ months = School Age (do not review charts for school age children)</td>
</tr>
<tr>
<td>Enrolled</td>
<td>Count the total number of children in each age group enrolled in the program, and record each number separately on the row labeled Infant/Toddler, Pre-school, and School Age, respectively.</td>
</tr>
<tr>
<td>Reviewed</td>
<td>Count the number of children in each age group you recorded on the Child Health Record Review, and record each number on the row labeled Infant/Toddler, Pre-school, and School Age, respectively.</td>
</tr>
<tr>
<td>Age in Months</td>
<td>Record the child’s age in months.</td>
</tr>
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<td></td>
<td>* See the Spreadsheet for Determining Child’s Age Group.</td>
</tr>
</tbody>
</table>
# Child Health Record Review:

## Early Care and Education Program Health Assessment:

### Guidelines for Completion of Form

<table>
<thead>
<tr>
<th>Y= Yes, N= No</th>
<th><strong>For each child, all cells should be completed.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete Emergency Contact Information on file</strong></td>
<td>Place a “Y” in this column if the child’s file has complete emergency contact information. This information should include the name, address, and telephone number of the parent or other person to be contacted in case of an emergency, the responsible party’s choice of health care provider and preferred hospital; any chronic illness the child has and any medication taken for that illness; and any other information that has a direct bearing on assuring safe medical treatment for the child. If information is not present or incomplete, place an “N” in this column.</td>
</tr>
<tr>
<td><strong>Well Child Physical on file</strong></td>
<td>Place a “Y” in this column if there is a complete record of a well child physical, otherwise place an “N” in this column.</td>
</tr>
<tr>
<td><strong>Well Child Physical in last year</strong></td>
<td>If there is a Well Child Physical on File, and the date of that physical is not more than a year prior to the date this form is completed, place a “Y” in this column. Place an “N” in this column if there is no record of a well child physical, or if it was done more than one year ago. Prior to the chart review ask the ECE provider for the most up-to-date records and also for emergency information cards to verify and augment the information in the chart.¹</td>
</tr>
<tr>
<td><strong>Children with Special Health Care Needs (CSHCN)</strong></td>
<td>Defined as children who “have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (Maternal and Child Health Bureau, 1995)². Place a “Y” in this column if the child has special needs. Place an “N” in this column if the child does not have special needs.</td>
</tr>
<tr>
<td><strong>Medical Care Plan on file</strong></td>
<td>If the child has special needs, and there is a record in the child’s file of a medical care plan, place a “Y” in this column. If a child has no special needs or if a child with special needs has no medical care plan on file, place an “N” in this column. A complete medical care plan includes the name of the child and the date that the plan was written, a description of the condition, known triggers and typical signs and symptoms, evidence of an information exchange form completed by a health care provider, persons responsible for the child’s care, other professionals involved in the child’s care, specific medical information such as medication administration forms and use of medical equipment, staff training needs, nutritional and feeding needs, support programs for the child, emergency procedures and situations that might require medical attention right away. For detailed information refer to: Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2002.</td>
</tr>
<tr>
<td><strong>Immunizations Up-to-Date</strong></td>
<td>Place a “Y” in this column if there is a record of immunizations, and the child is up-to-date, according to state regulations, with such immunizations. If there is no record, or the record is incomplete, or child is not up-to-date, place an “N” in this column.</td>
</tr>
<tr>
<td><strong>Medical Home on file</strong></td>
<td>A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatric clinician works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family (American Academy of Pediatrics, 2003)³. Place a “Y” in this column if there is a record in the child’s file that s/he has a medical home (i.e., first point of contact for continuous, comprehensive preventive and primary health services, available 24 hours a day, 7 days a week), otherwise place an “N” in this column. If the reviewer is unable to identify a medical home, but the name of a primary care provider is documented, the reviewer may consider this evidence of a medical home and place a “Y” in this column.</td>
</tr>
</tbody>
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¹ Although some states (e.g., California) do not require yearly, updated Well-Child physicals on file, the National Health and Safety Standards advocate updates on a yearly basis.


### Child Health Record Review:
#### Early Care and Education Program Health Assessment:
#### Guidelines for Completion of Form

<table>
<thead>
<tr>
<th>Health Insurance on file</th>
<th>Place a “Y” in this column if there is a record that the child has health insurance (i.e., private health insurance, Medicaid, CHIP, CHAMPUS, etc.), otherwise place an “N” in this column.</th>
</tr>
</thead>
</table>

**Record of Screenings (Previous 12 months):** For each screening listed on the table, record one of the appropriate codes listed below for each child. Record only one code for each child screening. *For each child, all cells should be completed.*

- **N** = No record of screening is evident in child’s file.
- **I** = Screening was recorded in child’s file, but there is no record of its outcome, so it is incomplete.
- **Y** = Screening was recorded in child’s file, and was not positive.
- **P** = Screening was recorded in child’s file, was positive, but there is no record of a referral.
- **R** = Screening was recorded in child’s file, was positive, there was a referral, but referral is pending.
- **C** = Screening was recorded in child’s file, was positive, there was a referral, and referral is complete.
Child Health Record REVIEW
Spreadsheet for Determining Child’s Age in Months

The numbers in the cells indicate age in months.
A child’s age is the number in the cell where the column of the current month and year intersects with the row of the child’s birth month and year.

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**Child Health Record REVIEW**  
Spreadsheet for Determining Child’s Age in Months

The numbers in the cells indicate age in months.  
A child’s age is the number in the cell where the column of the current month and year intersects with the row of the child’s birth month and year.

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With more child care providers and health professionals following universal precautions to protect themselves from infections such as viral hepatitis and HIV, we are seeing an increase in latex allergies and sensitivities. Universal precautions require that child care providers wear protective gloves for any procedures that put them into contact with blood. The most effective, inexpensive and comfortable protective gloves are made from latex.

What is latex?
Latex is a milky liquid produced by rubber trees. It is used to make a wide variety of common household products such as protective gloves, balloons, disposable diapers, bandage tapes, pacifiers, rubber bands, bottle nipples, tires, toys and elastic in clothing, to name a few.

What is latex allergy?
Latex allergy or hypersensitivity is a reaction of the body’s immune system to proteins found in natural rubber latex. Some people also react to chemicals in the gloves besides the latex itself. Sensitivity to latex can range from a mild skin irritation to a severe allergic reaction.

Reactions can occur from direct contact with products containing latex or from breathing latex particles in the air. Most latex gloves are treated with cornstarch powder to make them easier to put on and take off, and this powder binds with the latex proteins. When gloves are removed or snapped, they release the powder—along with the latex proteins—into the air.

What are the symptoms?
If someone becomes sensitive to latex, symptoms usually begin within minutes of exposure, but they can occur hours later and be quite varied.

- Mild reactions may cause skin redness, hives or itching.
- More severe reactions may cause respiratory symptoms such as itchy eyes, sneezing, coughing and asthma.
- Rarely, life-threatening shock may occur (but this seldom occurs as the first episode).

Who is at risk?
Anyone can develop a latex allergy, but the following groups of people are at increased risk:

- people who wear latex gloves regularly, such as child care providers and health care workers
- children with spina bifida (a birth defect involving the spinal cord or backbone)
- people with other allergies or asthma
- people who have had multiple surgical procedures
- people who have allergies to certain foods, especially avocado, potato, banana, tomato, chestnuts, kiwi and papaya.

Latex allergy should be suspected in anyone who develops symptoms after exposure, and he or she should be evaluated by a medical provider to determine if the reaction was caused by exposure to latex.

What should I do if I am allergic?
If diagnosed with a latex allergy by a medical provider, you should:

- Tell your employer, clients and all health care providers that you are allergic. Do not rely on doctors, nurses or dentists to know this from your chart.
- Wear a medical alert bracelet and carry non-latex gloves for convenience.
- Know which products might contain latex and avoid them.
- If you have staff or children in your program who are allergic, post a list of products containing latex and try to replace as many of them as possible with safer alternatives.
• Consult your child care health consultant or health provider regarding preparation for and responding to emergencies (e.g., having auto-injectable epinephrine such as EpiPen and EpiPen Jr.) ready and knowing how to use it.

How can you avoid latex allergy?

• Reduce your exposure to latex by only using latex gloves when you really need to. Protective gloves of any kind are only one part of universal precautions, and handwashing with soap is the most important infection control practice. Wear vinyl gloves instead of latex for routine diaper changes, food preparation and procedures that do not expose you to blood (such as applying cream to a rash or cleaning up vomit). Remember that vinyl gloves are a less effective barrier after about 15 minutes of wear. Medical-grade vinyl gloves are also available for procedures involving blood.

• Use latex gloves without powder. This will reduce the amount of airborne latex.

• Do not use oil-based hand lotions because they can break down and release the latex in gloves.

• Always wash your hands after removing gloves.

• When you use latex gloves, try a larger size than you would normally wear so that you perspire less and trap less moisture under the glove.

Choosing Gloves

There are several kinds of gloves for you to choose from, and each has advantages and disadvantages. You will need to choose the right glove for the right situation.

• Latex gloves provide the most protection at the lowest cost and are the most comfortable for the majority of people.

• Single-use vinyl and polyvinyl chloride gloves do not contain latex and are appropriate for use in the child care setting when blood is not involved.

• Medical grade non-latex gloves provide maximum protection but are generally more expensive. Consider a bulk purchasing arrangement through your Family Child Care Association.

Any disposable glove is acceptable for food preparation or routine diapering as long as you practice effective handwashing.

The most important point to consider is that not all disposable gloves will protect you from viruses like hepatitis B or C, or HIV. Be sure you are using a medical exam glove that meets EPA guidelines. Talk to a medical supply store or your pharmacist if you’re not sure.

If you are searching for non-latex gloves, keep in mind that the term “hypoallergenic” is not regulated, and does not mean latex-free—it usually means there are fewer chemicals used to make them. Read the label or ask your pharmacist.

Also remember that gloves deteriorate over time, so no matter what kind of gloves you purhase, be sure to check the expiration date on the box and store extra boxes in a cool, dry, dark place.

Resources

American Academy of Allergy, Asthma & Immunology
800-222-2762 or www.aaaai.org

American Latex Allergy Association
888-97-ALERT or www.latexallergyresources.org

References

Latex Allergy: A Preventive Guide. DHHS (NIOSH) publication No. 98-113. (Feb. 1999)


ALERT: Preventing Allergic Reactions to Natural Rubber Latex in the Workplace. DHHS (NIOSH) Publication No. 97-135 (July 1998)

By A. Rahman Zamani, MPH and Lyn Dailey, PHN (3/8/01)
Human breastmilk is the best food for infants and contains ingredients that formula could never duplicate. Scientists and nutritionists describe it as a “living biological fluid” with over 80 identified ingredients that include antiviral, antiparasitic, antibacterial, and many other protective factors, most of which cannot be replicated by formula companies. The American Academy of Pediatrics (AAP) strongly recommends that breastfeeding be the preferred feeding for all infants, including premature newborns. The World Health Organization recommends human milk as the exclusive nutrient source for feeding full term infants during the first six months after birth. And, regardless of when complementary foods are introduced, breastfeeding should be continued at least through the first 12 months.

However, many new mothers return to work before their baby is 6 months old. Returning to work means making choices regarding child care for their infant. For mothers who breastfeed there is an additional concern that returning to work or school means weaning before mother and baby are ready. Many women continue to successfully breastfeed, and provide breastmilk for bottle-feeding in child care. The success of this choice depends on the mother and child care provider communicating well and supporting one another. Together, parents and child care providers can make breastfeeding a healthy priority.

What are the benefits of breastmilk?

**For Infants.** Breastfeeding facilitates optimal infant growth and development and offers lifelong health advantages. Breastfed infants have less colic and fewer illnesses the first year of life. They have a reduced risk for allergies and lower incidence of gastrointestinal and respiratory diseases and ear infections. They have a lower incidence of obesity by age 4 years. Breastfed infants have been shown to have higher IQ in later life, and lower rates of diabetes, obesity and other serious health problems.

**For mothers.** According to the La Leche League, breastfeeding is as healthy for mothers as it is for infants. There is a decreased incidence of breast cancer among women who nurse. Breastfeeding causes an increase in the maternal hormones prolactin and oxytocin, which act to enhance the let-down of milk and to inhibit post-partum bleeding. Mothers who breastfeed report less depression following childbirth. Breastfeeding burns calories, helping a mother get back to her pre-pregnancy weight more quickly. It also delays the return of a menstrual period (although breastfeeding alone is not a reliable method to prevent additional pregnancies). Breastfeeding appears to help build bone strength, protecting against fractures in older age. And importantly, breastfeeding helps mother and baby to bond.

**For child care providers.** Child care providers benefit, too. Breastfed infants are sick less often which means they are contagious less often. They have less colic, less spitting up, and their diapers don’t smell as strong. Parents will feel good about their choice of child care when they feel supported in their choice to breastfeed.

**Support for breastfeeding mothers**
The child care provider plays an essential role in supporting and facilitating the breastfeeding relationship by understanding the parent’s plan for infant feeding. This may include allowing space for mothers to feed their babies, if necessary, at drop off and pick up, timing infant feedings, when possible, to a mother’s schedule for pick up, and providing safe storage and handling of breastmilk.

The feeding care plan for an infant should respect
the parent’s wishes. Some infants will have breast-
milk only, while others may receive supplemental
formula. When infants are fed according to parents’
instructions, parents will feel supported and confi-
dent in the care their child receives.

Support for child care providers
Parents can support their child care provider by
making sure their breastfed baby is ready to feed
from a bottle. Parents should introduce their baby to
the bottle well before the first day of child care. Get-
ing an infant used to a bottle may take several tries
and some persistence on the part of the parents.

Develop feeding policies
Develop your policies around breastfeeding in con-
sultation with your Child Care Health Consultant.
Support each family’s choice in a non-judgmental
manner.
• Allow flexibility in programs and schedules so
  that infants’ needs are met.
• Provide opportunities for communication and
  education of parents and staff.
• Offer staff professional development opportuni-
ties on breastfeeding and nutrition.
• Promote your setting as breastfeeding friendly.

Handling and storing human milk
Mothers should pump and store milk in unbreakable
bottles in the freezer. The bottle should be labeled
with a label that won’t rub off and include the baby’s
name, date milk collected, and date of use for child
care. The amount of milk in each bottle should equal
the amount the baby usually takes at one feeding.
Leftover milk should be disposed of if left out for
more than one hour at room temperature. A few bot-
tles can be frozen with one to two ounces for times
when the baby may want extra nourishment.

Important points for handling and storing:
• Always wash your hands before preparing any
  bottle for feeding.
• Double check that each bottle is clearly labeled
  with child’s name, date, time of collection, and
  that the milk is in an unbreakable, ready to feed
  bottle.
• Bottles of breastmilk should be refrigerated im-
mediately on arrival to program (at 40 degrees
or below).
• Use breastmilk on the day it is brought into the
  program.
• Thaw a bottle of frozen breastmilk under cool
  water and swirl to mix. Never microwave or shake
  breastmilk.
• Do not refreeze breastmilk that was previously
  frozen.
• Use breastmilk only for the infant for whom it
  was intended. In cases where an infant is given
another infant’s breastmilk refer to Caring for
Our Children or call the California Child Care
Healthline at (800) 333-3212.

References and Resources
World Health Organization. www.who.int/child
adolescent-health/NUTRITION/infant.htm.
Caring For Our Children: National Health and Safety

Feeding Infants: A Guide for Use in the Child Nutrition
Programs, United States Department of Agriculture
Food and Nutrition Service. www.nal.usda.gov/
fnic/pubs/bibs/edu/98-child.htm

California State Department of Health WIC pro-
gram. www.wicworks.ca.gov.

Health & Safety Note: Infant Feeding in Child Care.
ucsfchildcarehealth.org.

California Childcare Health Program. www.ucsf
childcarehealth.org.

California Childcare Health Program. www.ucsf
childcarehealth.org.

by Kim Walker, RN, PNP (05/05)
TYPES OF OUT-OF-HOME CHILD CARE FACILITIES

There are a variety of different types of child care facilities, or what is commonly referred to as out-of-home child care facilities, to meet the needs of children and families. “Child care offers developmental care and education for children who live at home with their families” (CFOC, 2002). Out-of-home child care facilities offer a variety of different types of services for families, based on their individual needs and circumstances.

Child Care Centers

Child care centers are facilities that can provide care for infants, toddlers, preschoolers and school-age children all or part of the day. Although generally larger than family child care homes, centers may be large or small and can be operated independently or by a church or other organization. Sometimes child care centers are called nursery schools, preschools, pre-kindergarten, early care and education programs, child development centers or day care programs. Some centers may also offer kindergarten programs. Others may serve as after-school programs for elementary school children and may provide transportation from neighboring schools. Child care centers may differ in their goals, activities and educational philosophies as well as the numbers and ages of children enrolled. Child care centers are licensed by the California Community Care Licensing division of the Department of Social Services (DSS).

The Child Care Health Advocate can empower the child care staff by providing them with the necessary information and skills to keep their center healthy and safe. Directors of child care centers also need vital information in order to appropriately write policies that improve the quality of their centers. Child Care Health Advocates will become an important support to the directors and staff of child care centers.

Family Child Care Homes

A family child care home, also known as family child care or family day care, is child care that is provided in the home of the provider. The number of children a family child care provider can care for at one time depends on the ages of the children and whether or not there is an assistant or a second provider. Often care is provided for a mixed-age group of children. There are no formal educational requirements for family child care providers, though they must complete a 15-hour training course in child health and safety. Persons who take care of children from only one other family (other than their own) in their home are not required to obtain a license. There are two types of family child care facilities that are regulated by the Community Care Licensing division of the California Department of Social Services (DSS).

Small Family Child Care Homes are licensed to care for four infants up to six children when no more than three are infants (if the provider’s own children are younger than 10 years of age, they must be included in the ratio). A small family child care home may care for up to eight children if at least two of the children are 6 years or older and no more than two are infants.

Large Family Child Care Homes are licensed to care for 12 children and must have a second caregiver present. No more than four of the children may be infants. A large family child care home may care for up to 14 children if at least two of the children are 6 years or older and no more than three are infants.

The family child care home owner and providers often work in isolation of other child care professionals, and can significantly benefit from support provided by a Child Care Health Advocate.
Other Types of Early Childhood/Child Care Facilities

Head Start

Established in 1965, Head Start has a long tradition of delivering comprehensive and high-quality early care and education services, providing part-day preschool programs for 3- and 4-year-olds from families with incomes at or below the federal poverty level. Head Start provides child-focused programs and has the overall goal of increasing the school readiness of young children in low-income families. Programs are designed to address the educational, emotional, social, health and nutritional needs of children, and emphasize parent participation through parent education, program planning and operating activities. The entire range of Head Start services is designed to be responsive and appropriate to each child and family’s unique developmental needs, and reflective and respectful of the family’s ethnic, cultural and linguistic heritage and experience. At least 10 percent of enrollment must be children with disabilities. Public schools, private nonprofit agencies and private for-profit agencies may operate Head Start programs. All programs are funded directly by the federal government through the U.S. Department of Health and Human Services, Administration for Children and Families, though in California individual programs may complement their funding through the Department of Education’s “State Preschool” to provide a full-day program.

Early Head Start

Early Head Start (EHS) was established by the 1994 Head Start Reauthorization Act, and it serves to provide comprehensive child development programs for low-income children from birth to age 3 years, pregnant women and their families. EHS has a triple mission: to promote healthy prenatal outcomes, enhance the development of infants and toddlers, and promote healthy family functioning. The program enhances children’s physical, social, emotional and cognitive development, provides parenting education, and enables parents to address their own goals. Early Head Start programs coordinate with Head Start to ensure continuity of care.

Military Child Care

The U.S. Department of Defense subsidizes child care for military personnel throughout the country and abroad through the Military Child Development System. Today, military child development centers operate at more than 300 locations along with more than 9,900 family child care homes and school-age care programs. This network constitutes one of the largest employer-sponsored programs of its kind in the country. It provides daily care to more than 200,000 children from ages 4 weeks through 12 years. The Military Child Development System has three components: child development centers, in-home family care providers and school-age care programs. All caregivers must meet rigid training, health and safety standards and are subject to unannounced inspections. Caregivers’ employment, wages and advancement are tied to training, education and performance, and an “up or out” policy is designed to create child care professionals. Higher wages are offered to reduce turnover. To date, over 95 percent of eligible facilities have been accredited by the National Association for the Education of Young Children (NAEYC).

Child Care Centers for Mildly Ill Children

These centers are licensed to provide non-medical care to mildly ill children of all ages (including some with contagious conditions). In California, Level I centers operate as components of child care centers and may serve only those children who are enrolled in the regular program. Level II centers are free-standing facilities and may care for children regardless of their regular child care arrangements.

Drop-in and Part-Time Facilities

A drop-in center is a child care center that provides care for children on a drop-in, intermittent basis where no child is in regular continuous attendance. Examples include child care offered at a gym or store. Part-time child care facilities, which offer limited hours such as from 8 a.m. to noon, include co-ops, recreation centers, YMCA programs, etc., and can be called preschool.
How THE DATA WAS COLLECTED

Over the course of more than two decades, R&Rs have built strong relationships with families, child care providers, and communities. R&Rs are often viewed as one-stop shops for parents, providers, and policymakers. These ties enable R&Rs to collect data about child care supply and demand, and to gain insight into parent concerns and provider issues. The California Child Care Resource & Referral Network, the statewide association of local R&Rs, works with its members to recruit and train providers and to advocate for quality, affordable, and accessible child care throughout the state. The Network collected the data for this Portfolio in 2004, from the 61 state-funded California R&Rs.

Information on the supply of child care is based on R&R databases of active licensed providers as of January 2004. The child care request data comes from 2004 documentation of the tens of thousands of calls to the R&Rs. Parents often request specific types of care and provide information about their language needs and work schedules. These calls represent an important sample of information about families. However, not all families who need or use child care call their local R&R. They might get information from family or friends.

Census and other demographic information included in the Portfolio complement the R&R data, bringing a more complete picture to each county’s and the state’s need for child care services.

The 2005 Data
Understanding Child Care Issues in California

THE CALIFORNIA CHILD CARE RESOURCE & REFERRAL NETWORK compiled information about the state and individual counties to provide a resource about child care supply and demand and about the demographic issues that impact child care, both at the state level and in each of California’s 58 counties. With information about the demographics of each county and standardized data about the supply and demand of child care, the Portfolio helps policymakers, community leaders, businesses, nonprofit organizations, school districts, and other stakeholders address the challenges of providing quality, affordable care and early education for children throughout the state.

Since 1997, this biennial Portfolio has provided reliable information about the amount of licensed child care and the estimated demand for care in each county. As with the four prior publications, this 2005 report presents data gathered by the 61 state-funded resource and referral (R&R) programs, along with data from the U.S. Census, California Department of Finance, U.S. Department of Housing and Urban Development, and other public and private sources. The R&R data represents a sampling of calls from thousands of parents over a three month period in 2004.

While the data allows us to gain perspective on the families and children of California, it is important to remember that behind each statistic is a child, a parent, or a provider. Every day, staff at California’s R&Rs talk with families who, in spite of challenges, are doing their best to find safe and nurturing learning environments for their children. The R&Rs counsel these parents about child care options and also work with experienced and newly recruited child care providers — helping them to offer the best and highest quality care possible. R&Rs understand local child care issues and concerns, and recognize the trends that can impact families and child care supply. Their collective knowledge and experiences are shared with the Network, which has developed a unique ability to translate local issues into statewide solutions.

The cost of licensed child care is beyond the reach of many families.
The data indicates important trends and needs.

- **Finding licensed care is a challenge, especially for infants.**
  Licensed child care is available for only 26% of children aged birth to 13 years with parents in California’s workforce. (This percentage varies greatly by county. For example, licensed care is available for 44% of the children of working parents in Marin County but for only 19% of the children of working parents in Kings County.) More critical, 64% of the licensed child care slots are in centers, but only 6% of center slots are available to children under two.

- **Licensed child care is unaffordable for many families.**
  On average, a family with two working parents earning minimum wage and one preschooler in a licensed center spends 65% of their combined salaries on housing and child care. If the family is in the Bay Area, the combined cost of housing and child care would actually cost more than the family’s income.

- **California’s diversity outpaces the U.S.**
  California families are far more diverse than their counterparts across the country because the state has the greatest percent of foreign-born residents. (In 2000, 26% of California’s residents were foreign born, compared to 11% in the U.S.) New arrivals tend to concentrate in Bay Area and Southern California counties. This is reflected in linguistic diversity: in Imperial County, 66% of households speak Spanish at home (compared to 22% in the state and 10% in the U.S.); in San Francisco, 22% of households speak an Asian language at home (compared to 9% in the state and 3% in the U.S.).

- **Providers are responding to the linguistic diversity of families.**
  Staff at 53% of licensed centers and 34% of licensed family child care homes speak Spanish. Staff at 24% of centers and 12% of homes speak an Asian language.

- **Families are moving out of communities where the cost of living is most expensive, creating long commutes for parents.**
  The top seven counties with the greatest percentage of domestic migration out of the county were all in the Bay Area. (Los Angeles, Imperial, Santa Barbara, and Orange counties ranked next highest.) These moves have impacted the number of California workers traveling an hour or more to work – an increase of 34% between 1990 and 2000. About 1.5 million California workers spend more than two hours each day commuting.

- **Long commutes and non-traditional work hours create new demands on families and child care providers.**
  While the number of people working night and weekend hours increased 13% between 1990 and 2000, only 3% of child care centers offered care during these times. Although 39% of family child care homes offer care during non-traditional hours, these homes make up only 36% of the total licensed slots in the state.

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**What THE DATA DOESN’T EXPLAIN**

Although the county and state pages provide a detailed snapshot of the demographics and the licensed child care situation in California, they do not tell the whole story. Until research efforts focus on the entire child care marketplace (licensed and license-exempt care) and link particular demographic information with child care, some questions remain unanswered.

**Availability of licensed slots**

The data shows that in most counties, the supply of licensed care does not meet the estimated demand. Because it is based on the assumption that licensed providers keep all of their slots open, it portrays a best-case scenario. In fact, many centers and homes do not operate at full capacity due to reasons such as the shortage of qualified staff, family schedules, and the complexities of caring for young children.

**Use of license-exempt care**

R&Rs only collect data about licensed care, but they are well aware that thousands of families rely on license-exempt care provided by relatives, friends, neighbors, and nannies. To accurately measure the supply of that care would require additional research.
In 2000, 22% of all California households spoke Spanish at home, compared to just 10% of all U.S. households. Nine percent spoke an Asian language at home, compared to just 3% of U.S. households.

Foreign-born residents in California accounted for 26% of the state’s population in 2000, compared to 11% of U.S. residents.

The top 10 counties with the greatest percentage increase of workers traveling an hour or more to jobs are in the Central Valley and the outskirts of the Bay Area. (Overall, 10% of California workers have a one way commute that is greater than one hour.)

The top 7 counties with the greatest percentage change in population due to migration out of the county were all in the S.F. Bay Area. Los Angeles, Imperial, Santa Barbara and Orange Counties ranked next highest.

### The People

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2004</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of residents</td>
<td>33,871,648</td>
<td>36,590,814</td>
<td>8%</td>
</tr>
<tr>
<td>- Population foreign born residents</td>
<td>26%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Population change from natural increase</td>
<td></td>
<td></td>
<td>48%</td>
</tr>
<tr>
<td>- Population change from domestic migration</td>
<td></td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>- Population change from foreign immigration</td>
<td></td>
<td></td>
<td>39%</td>
</tr>
</tbody>
</table>

### The Children

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2004</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-13</td>
<td>7,289,433</td>
<td>7,374,479</td>
<td>1%</td>
</tr>
<tr>
<td>- Under 2</td>
<td>969,730</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2 years</td>
<td>489,336</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 3 years</td>
<td>504,490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 4 years</td>
<td>523,425</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 5 years</td>
<td>531,405</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 6 to 13 years</td>
<td>4,271,047</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children 0-13 with parents in the labor force</td>
<td>3,803,776</td>
<td>3,848,155</td>
<td>1%</td>
</tr>
<tr>
<td>- Under 2</td>
<td>444,898</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2 years</td>
<td>229,891</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 3 years</td>
<td>241,018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 4 years</td>
<td>256,514</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 5 years</td>
<td>269,436</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 6 to 13 years</td>
<td>2,362,019</td>
<td></td>
<td>20%</td>
</tr>
</tbody>
</table>

### The Labor Force

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2000</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of employed residents</td>
<td>13,940,250</td>
<td>14,525,322</td>
<td>4%</td>
</tr>
<tr>
<td>Workers with an hour or more commute</td>
<td>1,059,268</td>
<td>1,416,821</td>
<td>34%</td>
</tr>
<tr>
<td>People working at home</td>
<td>452,867</td>
<td>557,036</td>
<td>23%</td>
</tr>
<tr>
<td>People working non-traditional hours</td>
<td>2,532,254</td>
<td>2,831,021</td>
<td>13%</td>
</tr>
<tr>
<td>- percent working non-traditional hours</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People working 35 hours or more</td>
<td>12,734,654</td>
<td>13,687,903</td>
<td>7%</td>
</tr>
<tr>
<td>- percent working 35 hours or more</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men in the labor force</td>
<td>8,640,866</td>
<td>8,765,269</td>
<td>1%</td>
</tr>
<tr>
<td>Women in the labor force</td>
<td>6,622,034</td>
<td>7,212,610</td>
<td>9%</td>
</tr>
<tr>
<td>Women with a child under 6</td>
<td>1,985,354</td>
<td></td>
<td>55%</td>
</tr>
<tr>
<td>- percent in the labor force</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The Households

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2004</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of households</td>
<td>11,512,020</td>
<td>105,539,122</td>
<td></td>
</tr>
<tr>
<td>- Number of households</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- speaking English at home</td>
<td>62%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>- speaking Spanish at home</td>
<td>22%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>- speaking an Asian language at home</td>
<td>9%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>- speaking another language at home</td>
<td>7%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Number of families with children under 18</td>
<td>4,208,775</td>
<td>35,234,403</td>
<td></td>
</tr>
<tr>
<td>- percent of families with children under 18</td>
<td>53%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>- percent of single parent families</td>
<td>26%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Homeowners with children under 6</td>
<td>14%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Renters with children under 6</td>
<td>20%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Residents over 24 with BA or higher</td>
<td>27%</td>
<td>24%</td>
<td></td>
</tr>
</tbody>
</table>

---

2. California Department of Finance population projections.
3. This number reflects children with either two parents or a single head of household in the labor force.
4. Network estimate based on California Department of Finance (DOF) population projections.
5. U.S. Census Bureau, 1990.
6. Estimate using commute time. Might or might not include weekends.

The 2005 California Child Care Portfolio

For more information about child care, call California Child Care Resource & Referral Network (800) 543-7793; www.rnnetwork.org
Facilities

<table>
<thead>
<tr>
<th></th>
<th>Child Care Centers</th>
<th>Family Child Care Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of sites</td>
<td>10,143</td>
<td>37,494</td>
</tr>
<tr>
<td>Total number of slots (percent)</td>
<td>639,443 (64%)</td>
<td>362,957 (36%)</td>
</tr>
<tr>
<td>Infant slots in centers</td>
<td>35,973 (6%)</td>
<td></td>
</tr>
<tr>
<td>Preschool slots in centers</td>
<td>450,529 (70%)</td>
<td></td>
</tr>
<tr>
<td>School-age slots in centers</td>
<td>152,941 (24%)</td>
<td></td>
</tr>
</tbody>
</table>

Scheduled

<table>
<thead>
<tr>
<th></th>
<th>Child Care Centers</th>
<th>Family Child Care Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time and part-time slots</td>
<td>72%</td>
<td>86%</td>
</tr>
<tr>
<td>Only full-time slots</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Only part-time slots</td>
<td>18%</td>
<td>2%</td>
</tr>
<tr>
<td>Care available during non-traditional hours</td>
<td>3%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Languages

<table>
<thead>
<tr>
<th></th>
<th>Child Care Centers</th>
<th>Family Child Care Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Spanish</td>
<td>53%</td>
<td>34%</td>
</tr>
<tr>
<td>Other</td>
<td>24%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Availability of Licensed Child Care

In California, there are an estimated 3,848,155 children ages 0-13 with parents in the labor force and 1,002,400 licensed child care slots.

Licensed child care is available for 26% of children with parents in the labor force. * Some families choose friends and relatives (license-exempt caregivers) to care for their children, and programs for school-age children are often not licensed by the state. ¹

Parent Requests to the R&R ¹

- Type of care requested: 35% infant/toddler; 42% preschool; 23% school-age
- Schedule requested: 82% full-time (0-5 years); 25% part time (0-5 years)
- Reasons for needing care:
  - 81% employment; 10% school/training; 7% looking for work

Child Care and Family Budgets

How child care fits into a California family’s budget (Housing: $10,800; Child Care ¹ for a preschooler in a licensed center: $7,485)

Annual Income: $14,040
Families with 1 minimum wage earner
Care for one infant in a licensed family child care home: 54% of income

Annual Income: $28,080
Families with 2 minimum wage earners
Care for one infant in a licensed family child care home: 27% of income

Annual Income: $51,844
Families with 2 entry level public school teachers working in the county
Care for one infant in a licensed family child care home: 15% of income

The 2005 California Child Care Portfolio - a project of the California Child Care Resource & Referral Network (800) 543-7793 www.rn-network.org
Glossary
Terms Frequently Used in Discussions about Child Care

Alternative Payment Program (APP)  A program of child care subsidies for low-income families administered through the CA Dept. of Education (CDE).

Before- and after-school care Programs that operate at many elementary schools and other sites where school-age children can be in supervised activities before school begins and after school to the end of the work day.

CalWORKs  California’s welfare-to-work program requires parents receiving welfare to get training and find jobs and provides child care subsidies to enable parents to work. The subsidies can be used for either licensed or license-exempt care (see definition below).

Child Care Initiative Project (CCIP)  Funded by a statewide and local public/private partnership, the program recruits and trains family child care providers to help meet the demand for child care services. Administered by the California Child Care Resource & Referral Network, CCIP works through nonprofit, community-based R&R programs.

Child care centers  Provide care for infants, toddlers, preschoolers, and/or school-age children all or part of the day. These facilities may be large or small and can be operated independently by nonprofit organizations or by churches, school districts, or other organizations. Most are licensed by the California Department of Social Services (DSS).

Child care professional  Defined by the Bureau of Labor Statistics as someone who attends to children at child care centers, schools, businesses, and institutions, and performs a variety of tasks such as dressing, feeding, bathing, and overseeing play. An emphasis on professional development and knowledge of early childhood development as well as health and safety issues has...
positioned the work as a profession rather than a service occupation. (Also see preschool teacher.)

**Domestic migration** Movement of residents from one county (or state) to another, impacting the total population of both the county the resident moved from and the county to which the resident moved. (Positive domestic migration: more people moved in than moved out. Negative domestic migration: more people moved out than moved in.)

**Family child care home** Care offered in the home of the provider, often a parent. Small family child care homes have one adult provider and can accept up to eight children, depending on their ages. Large family child care homes have two adults and can take up to 14 children, depending on their ages. Care is often provided for children of a variety of ages. Family child care homes are licensed by DSS.

**First 5 California** Created by Proposition 10 (a voter-approved initiative passed in 1998) to fund a comprehensive, integrated system of early childhood development services for all children prenatal to five years of age.

**First 5 commissions** Local advisory bodies that disburse Prop 10 funds, for health and early care and education programs for children from prenatal to age five in each county.

**Full-time care** Thirty or more hours per week.

**Head Start** A federally-funded program for low-income families with children three to five years old. In addition to child care and early learning programs, health care and parent training are also offered. Head Start programs are licensed by DSS. Some Head Start programs are full day and some coordinate with other providers or funding sources to provide full-day care.

**Infant** A child under the age of two.

**Infant/toddler care** Care for children under age two.

**In-home care** A friend, relative, babysitter, or nanny cares for a child in the child’s home, full-time or part-time.

**Licensed child care** Care in child care centers and family child care homes that meets health, safety, and educational standards. DSS licenses both centers and child care homes.

**License-exempt care** Child care which does not require a state license (sometimes referred to as “exempt care.”) License-exempt care includes home care (providers may care for children from only one other family besides their own), in-home care (a friend, relative, babysitter, or nanny cares for a child in the child’s home, full-time or part-time), and certain centers for school-age children or military child care programs regulated by agencies other than the state.

**Natural increase** Alteration of the total population of an area, based on the difference between total deaths and total births. A positive change means there were more births than deaths. A negative change means there were more deaths than births.

**Non-traditional hours** Work hours other than 7 a.m. to 6 p.m., including evening, overnight, or weekend shifts.

**Part-time care** Less than 30 hours per week.

**Preschooler** Child aged two to five years.

**Preschool teacher** Defined by the Bureau of Labor Statistics as someone who instructs children (up to 5 years of age) in activities designed to promote social, physical, and intellectual growth needed to attend school. Settings can be preschools, child care centers, or other child development facilities.

**Provider** A person who provides child care in any one of a variety of settings, including child care centers and family child care homes.

**Resource and referral (R&R)** Community-based organizations, agencies, or programs that provide information, training, and support for parents, caregivers, employers, and government. Since 1976, R&Rs have been funded by the California Department of Education, Child Development Division. R&Rs are located in every county in California.

**School-age care** Care for elementary and middle school students which may be provided in homes or center-based settings, sometimes on school grounds.

**Slot** Space for one child in a child care center or family child care home.

**Subsidy** Financial assistance from state or federal funds available to low-income families who meet the state’s income eligibility requirements. (Subsidized care is available in licensed child care centers, family child care homes, and by license-exempt providers.)

**Universal Pre-Kindergarten (UPK)** Sometimes known as Preschool for All. A voluntary preschool program for four-year-olds to encourage early learning and to promote school readiness through activities that develop educational, cognitive, socio-emotional, and physical skills.