CHILDREN'S EQUITY PROJECT

Reimagining State Child Care Licensing

IMPROVING THE FOUNDATION FOR QUALITY AND EQUITY IN EARLY CARE AND EDUCATION ENVIRONMENTS

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SUGGESTED CITATION

Allen, R., Bucher, E.Z., Meek, S., Alexander, B., Ameley-Quaye, A., Soto-Boykin, X., Blevins, D., & Cardona, M. (September, 2024). *Reimagining state child care licensing: Improving the foundation for quality and equity in early care and education environments.* The Children's Equity Project at Arizona State University.

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INTRODUCTION

State child care licensing sets the foundation for health and safety in settings that care for and teach young children and establishes the "floor" from which early childhood systems can build towards quality and equity.

State licensing systems regulate public and private child care providers, including center-based, school-based, home-based or family child care, and group care. These systems are tasked with setting consistent health and safety policies for those caring for and teaching young learners. States require the vast majority of early care and education (ECE) settings to be licensed. There are some states that exempt certain types of care, such as faith-based providers, relative care, and family, friend, and neighbor (FFN) care. Additionally, some child care providers may be regulated through the appropriate territory or tribal agency instead. Though there is substantial variation across states, licensing systems generally cover a core set of health and safety dimensions, including adult-to-child ratios and group sizes, physical space requirements, health and safety indicators, staff education and training requirements, and policies and procedures.

First, **licensing content** should be thoughtfully crafted to play a critical role in keeping children safe and healthy—physically, socially, and emotionally—and establishing a baseline for environments that promote optimal development and learning. Unfortunately, many state licensing systems are falling short of this goal. Too often, the indicators that matter most to child health and safety are not a core part of licensing standards, while other indicators that may not have a meaningful direct impact on health and safety are over-emphasized.

Importantly, current licensing standards across most states omit indicators that disproportionately affect children from historically marginalized communities. These indicators include those associated with bias and harsh discipline, language access for families who speak languages other than or in addition to English, and indicators that ensure full inclusion of children with disabilities. Worse yet, in some cases, licensing standards either directly or indirectly create and exacerbate these inequities. Such is the case with toileting policies in preschool classrooms that indirectly but systematically result in exclusion of children with disabilities from general early childhood settings, thus violating their civil right to learning in the least restrictive environment per the Individuals with Disabilities Education Act (IDEA).

What's more, states' attempts to improve licensing content are sometimes framed as a way to reduce burden on licensees, with little attention and focus on improving licensing standards to better protect and support children. Of course, administrative burden should and can be addressed, but it must never be the sole focus—especially without attention to how those reductions affect the health, safety, and development of children.

Second, biases and inequities exist in **licensing processes** such as training, technical assistance, and accountability processes for child care providers participating in regulatory systems. For example, 60% of child care businesses are owned by people of color, making the child care industry the third largest minority-owned industry in the country.[1] Yet, unfortunately, these very communities are often on the periphery of the licensing process. Anecdotal reports show providers of color experience more cited violations and are more likely to lose their license due to failure to uphold and maintain licensing requirements. The child care workforce is comprised of nearly 38% women of color, which is much higher than their proportion of the general population.[2] Even so, many licensing systems do not provide adequate, culturally responsive and affirming support, despite the fact that the ECE workforce is more racially diverse than the general U.S. population.

Third, thoughtful, intentional **governance and coordination in state ECE systems** among agencies implementing child-serving and family-serving programs is important to ensure child care providers have a streamlined, easy-to-navigate, supportive experience no matter where they are in the ECE system—becoming licensed and entering into formal systems, continuing to maintain compliance with licensure requirements, or working towards enhancing the quality of their programs. However, inconsistencies among licensing regulations for child care providers and varying requirements across ECE funding streams can result in fragmentation. This presents

a challenge for child care providers to access the multiple resources needed to provide quality, responsive care in their communities and to fully participate in publicly funded early learning programs.[3]

Despite these shortfalls, child care licensing has the potential to play a critical role in ensuring children are safe, healthy, and well cared for in their early learning environments. The ECE system should have a baseline of accountability that is consistent across states and aligned with current research and shared guidelines. However, the functionality of the licensing system depends on the right content that unequivocally prioritizes child health, safety, and well-being. Further, it must be implemented fairly, equitably, and through an anti-bias approach, with coordination among all agencies tasked with implementing early childhood programs.

This report reviews the current state of child care licensing across the nation and provides recommendations on:

1. **Licensing content** to better align indicators with the research on physical and emotional child health and safety, de-emphasize trivial and less important bureaucratic indicators, and lift up those that deeply impact children's and early childhood educators' experiences.
2. **Licensing process** to better understand licensing procedures, identify where and how licensing implementation falls short, and recommend ways to improve the system to ensure a fair, transparent, bias-free process for all early care and learning providers.
3. **Governance and coordination in state ECE systems** to establish minimum health and safety requirements across agencies involved in state early learning systems and to ensure alignment focused on equity indicators to improve quality and better serve children and families and support the ECE workforce.

State child care licensing sets the foundation for health and safety in settings that care for and teach young children and establishes the "floor" from which to build toward quality and equity.

SECTION I

LICENSING CONTENT

The intent of child care licensing should be, first and foremost, to protect and support children's positive growth and development. Licensing plays a critical role in the ECE system, but it is only effective in protecting child health and safety if the indicators that are regulated and monitored are relevant and meaningful. Otherwise, the system misses important flags that could risk child health and safety, while overly penalizing providers for trivial violations that do not pose harm. Because of this, it is crucial for licensing standards to be aligned with the latest research that supports the well-being of children in licensed spaces.

Overall, we recommend that states align their licensing regulations with the indicators in the core set of research-based standards *Caring for Our Children Basics*. States should also create a plan for improvements to their licensing regulations—driven by the input of early childhood professionals, parents of young children, and other community partners—to build toward full alignment with the comprehensive guidelines in *Caring for Our Children*.

In 2019, the American Academy of Pediatrics and several other national partners published the fourth edition of *Caring for Our Children* (*CFOC*), a comprehensive set of voluntary guidelines on the development and evaluation of the health and safety of children in ECE settings (see Appendix B for an abridged list of the overall content areas in *CFOC Basics* and Appendix C for additional details). The content in *CFOC* is extensive, with a focus on guidelines that should be followed in child care centers and family child care homes. Yet, unfortunately, there are no states that fully align with *CFOC*, leaving many gaps across the nation in ensuring basic health, safety, and well-being for children.

In 2015, the U.S. Department of Health and Human Services (HHS) published a set of core standards from the extensive set of *CFOC*. The more narrow set of standards is called *Caring for Our Children Basics* (*CFOC Basics*) and represents a set of research-based standards that can serve as a starting point for state child care licensing standards. The HHS Office of Head Start requires that Head Start programs comply with *CFOC Basics*. The HHS Office of Child Care recommends that states use *CFOC Basics* as the basis for state licensing, especially as it relates to partnerships established as part of the federal Child Care and Development Fund (CCDF), partially in service of the goal to reduce redundancy across ECE funding streams. *CFOC* and *CFOC Basics* are common resources for states when creating licensing requirements. The most recent National Association for Regulatory Administration (NARA) Child Care Licensing survey of state administrators found that 94% of states reported using *CFOC* and 77% reported using *CFOC Basics* when constructing rules and regulations for licensing child care facilities.[4] Still, using the standards or incorporating some of them is not the same as full alignment, resulting in gaps in child health and safety and in an uneven landscape across state lines.

While *CFOC Basics* is a promising foundation for child care licensing, it is nearly a decade old. This presents an opportunity for growth and improvement, especially in domains that address environmental health, considering ever-increasing shifts in the climate that are harmful to children's health and development. Other domains that should be updated include provider qualifications, fairer wages and benefits, working conditions, and other areas that disproportionately impact children and educators from marginalized communities, such as language access and harsh discipline.

In 2021, the Children's Equity Project (CEP) published ***Equity is Quality and Quality is Equity: Operationalizing Equity in Quality Rating and Improvement Systems***, which details an array of equity-focused indicators that can be used by states to bolster licensing, quality rating and improvement systems, programmatic standards, and monitoring and accountability structures.

In this section, we integrate *CFOC*, *CFOC Basics*, and the CEP's previous report in the context of child care licensing. We ground our analysis in the latest science of child health and development and in ensuring fair and equitable systems for children. **We emphasize seven areas for states to consider to improve the content in their licensing regulations**

and ensure children are safe, healthy, and supported while in child care settings. These seven areas are core to and should be integrated in child care licensing content, but states should also ensure they maintain other foundational requirements relating to health and safety, including safe sleep practices and building and physical premises safety.

1. **Ensure Clean Water and Mitigate Lead Exposure**
2. **Address Air Quality**
3. **Cap Ratios and Group Sizes**
4. **Promote Emotional Safety and Well-Being**
5. **Ensure Inclusion, Safety, and Accessibility for Children with Disabilities**
6. **Support Emergent Bilinguals and Dual Language Learners**
7. **Enhance Provider Qualifications, Training, and Working Conditions**

Each main licensing content area is organized into three sections: (1) the research base and alignment with *CFOC* or *CFOC Basics*, (2) the current landscape in child care licensing across the U.S. and Washington, D.C., and (3) example indicators that can be added to or amended in state child care licensing regulations. Where appropriate, we offer examples of state or local measures to ensure providers have the resources needed to meet these minimum health and safety regulations.

1. ENSURE CLEAN WATER AND MITIGATE LEAD EXPOSURE

There is no safe lead level for children.[5] Even from low levels of exposure to lead, children can suffer serious and permanent health issues like behavior and learning problems, hyperactivity, slowed developmental growth, hearing problems, and anemia. Lead is especially dangerous to young children because their brains and nervous systems are more sensitive to lead's damaging effects, and their bodies are able to absorb more lead than adults. Once ingested, lead can be stored in bones, teeth, and organs for decades, making lead poisoning very difficult to treat.[6]

CFOC Basics includes a standard that clean and sanitary water is accessible to children indoors and outdoors. This includes testing water for exposure to lead. In many cases, however, state licensing does not actually test the water or require evidence of a clean water test. This places young children at risk for an array of issues associated with toxic water consumption. This is also a particularly salient issue in historically marginalized communities, which are more likely to suffer from historical and contemporary underinvestment to address health risks like lead exposure.

Additionally, *CFOC* addresses the mitigation of the exposure to lead in paint, soil, and consumer products, along with exposure to lead in water in child care and early education environments. Young children can also be exposed to lead through paint, chip and dust particles from deteriorating lead-based paint, and certain consumer products. This is especially concerning since lead use in plastics has not yet been banned in the United States.[7] The likelihood of young children being exposed is also increased because they explore the world using their hands and placing objects in their mouths. Research shows that children of color and children in low-income communities have a higher risk of experiencing the toxic effects of lead. This is due to disproportionate exposure to lead hazards in older homes and buildings and under-resourced areas that may contain lead pipes and contaminated soil.[8] Facilities built before 1978 (when lead-based paint was banned) and home-based child care programs operating in pre-1978 residential settings create conditions for the increased potential of exposure to lead.

Current Landscape in Lead Mitigation

Eleven states and D.C. already test water in child care facilities.[9] California, one of the more recent states to implement a lead testing requirement as part of child care licensing, recently published data showing about one in four child care centers exceed acceptable lead levels in drinking water for infants, toddlers, and preschoolers. A U.S. Government Accountability Office (GAO) report published in 2020 found that over one quarter of Head Start centers in a nationally representative survey had water above the lead threshold that would require remedial action.[10] These two large-scale reviews of lead in water in child care and early learning programs indicated a large number of programs with unsafe water, impacting thousands of infants, toddlers, and preschoolers in potentially severe and lasting ways.

Considering these data, in addition to countless other local stories of contaminated water in schools and communities, it is imperative to embed water testing and remediation in child care licensing regulations. Failing to test water is negligent to the health and safety of young children—and protecting the health and safety of young children is the principal purpose of licensing.

To address mitigation of lead in water, the U.S. Environmental Protection Agency (EPA) awards non-competitive grants to states, tribes, and territories for voluntary school and child care program lead testing and remediation of lead in drinking water. State child care licensing agencies should collaborate with applicable local and state health agencies, agencies managing water systems, and early childhood providers to ensure their states are leveraging these funds and aligning licensing requirements to effectively reach all child care providers and schools.

Due to changes undertaken through the Infrastructure Investments and Jobs Act (IIJA), commonly known as the Bipartisan Infrastructure Law, there are additional resources available specifically for child care facilities to identify and remediate lead in water and paint. WIIN includes a Voluntary School and Child Care Lead Testing and Reduction program that provides non-competitive funds to states, territories, and tribes. Prior to IIJA, funds were available solely for testing and identification of lead. However, following IIJA, facilities may also use these funds for remediation.[11] Additionally, EPA provides funding on a competitive basis through its Reducing Lead in Drinking Water Grant program, which received additional funding through IIJA. The grant program is geared toward reducing lead in drinking water in historically marginalized communities through infrastructure, treatment improvements, and/or facility remediation in schools and child care facilities. Eligible applicants under this program include local water systems, municipalities, and state administrative agencies.[12]

The Secretaries of both HHS and EPA have issued a joint letter encouraging governors to apply for the unprecedented $15 billion made available through IIJA to identify and remediate lead in child care facilities.[13]

NORTH CAROLINA: LEAD AND ASBESTOS INSPECTION, TESTING, ABATEMENT, AND REMEDIATION IN PUBLIC SCHOOLS AND LICENSED CHILD CARE FACILITIES

States are in a better position than ever before to identify and mitigate lead, as demonstrated by the actions of state elected officials in North Carolina. In 2022, Research Triangle Institute International and the Division of Public Health in North Carolina released a report documenting the presence of lead in 4,000 of the state's licensed child care facilities—representing the largest peer-reviewed data set of its kind in the United States.[14] The report found that 56% of facilities had at least one water source with levels of lead exceeding one part per billion, the reference level set by the American Academy of Pediatrics. The samples were taken in 2020–2021 during the period of time the state was undergoing implementation of a rule that required all child care facilities, including state-based preschool and Head Start agencies, to test all drinking and food preparation water sources for lead.[15] The first round of testing conducted was free to all facilities, leveraging funds made available under the EPA's Water Infrastructure for Improvements to the Nation (WIIN) program. North Carolina went further by leveraging funds made available under the American Rescue Plan. Governor Cooper directed that funds under the American Rescue Plan Act (ARPA) State and Local Recovery Funds, a flexible pot of funding made available to states and municipalities, be used for lead identification and remediation in all public schools and licensed child care facilities in the state[16].

North Carolina took advantage of one-time funding to initiate changes that are likely to benefit generations of young children who attend child care and public school facilities in the state. However, ARPA funds were time-limited. Still, there are other resources that state and local leaders can access to identify and remediate lead in early learning facilities.

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Ensures water is colorless, clear, and free from any type of odor or smell before administering to children and staff.
- Regularly checks the U.S. Consumer Product Safety Commission's website for warnings of potential lead exposure to children and recalls of play equipment and toys.

EXAMPLE STATE OR LOCAL GOVERNMENT ACCOUNTABILITY

The licensing agency, in collaboration with the appropriate health agency:

- Conducts a water test approved by the EPA on a consistent schedule for all licensed providers. Water testing should be conducted at least annually if feasible and more often if there is a concern.
- Consults and collaborates with a laboratory that is EPA-recognized as a National Lead Laboratory Accreditation Program to conduct testing on paint chips, dust, and soil. This includes testing bare soil around ECE facilities and, where necessary, ensuring the provider covers bare soil with mulch, plantings, or grass.
- Uses a certified lead inspector or certified risk assessor to inspect and test for lead-based paint hazards in the interior and exterior of facilities that were built before 1978. If lead is identified, consultation is provided by the state or local childhood lead poisoning prevention program, public health agency, and/or a certified risk assessor to determine next steps for lead hazard control and abatement, including developing a protection plan for occupants of the building.

Given ample data and countless stories of contaminated water in schools and communities, it is imperative to embed water testing and remediation in child care licensing regulations.

2. ADDRESS AIR QUALITY

Outdoor Air Quality

The health and well-being of staff and children can be greatly affected by air quality. Similar to exposure to environmental toxins, poor air quality has a particularly strong impact on the youngest children. The health impacts from being subjected to air pollution can include decreased lung function, asthma, bronchitis, emphysema, learning, and behavioral disabilities, and even some types of cancer.[17] Children are particularly vulnerable to air pollution because of their developing respiratory and central nervous systems; they also breathe in more air than adults relative to their weight. Prenatal exposure to poor outdoor air quality can negatively impact in-utero lung development and lead to lower lung volume and function in early childhood.[18] Exposure to outdoor air pollution in early childhood has been associated with increased risks of leukemia, high blood pressure, asthma, and heart disease.[19]

The impact of poor outdoor air quality is felt disproportionately by children and families of color, who are more likely to live in neighborhoods with higher levels of exposure to toxic chemicals and air pollution.[20] For example, Black children are two times more likely to be diagnosed with asthma and four times more likely to die from asthma than White children.[21] Additionally, a new report showed that there are significant racial disparities in deaths related to air pollution, finding that "Black Americans are significantly more likely to die from causes related to air pollution, compared with other racial and ethnic groups" as a result of both disproportionate exposure to air pollution and higher susceptibility to its damaging effects due to disadvantages they face from racism and racist systems (n.p.).[22]

According to the National Institutes of Environmental Health, outdoor air quality can be adversely affected by a variety of both human-made pollutants. These include emissions from vehicles, manufacturing, and power generation; and natural emissions, such as smoke from wildfires and gasses that are emitted by organic matter in soils.[23] In 2023, millions of children in the United States were affected by adverse air quality due to a combination of wildfire smoke and existing pollution, amplified by a changing climate.

With increased wildfires and pollution, it is critical for child care providers to monitor and mitigate exposure to poor outdoor air quality. The U.S. Air Quality Index (AQI) is a tool that indicates air quality levels. The higher the AQI value, the greater the amount of air pollution and the greater the risk of health concerns.[24] Several free and reliable tools are available to child care providers to monitor outdoor air quality. All of these are available on a smartphone or tablet, and using them can be as simple as checking the weather daily.

Indoor Air Quality

The air inside a building can be contaminated with microbes shared among occupants, including chemicals emitted from common consumer products, and migration of polluted outdoor air into the facility. Indoor air pollution is often greater than outdoor levels of air pollution due to a lack of adequate air filtration and ventilation, including lingering and built-up air contaminants emitted from certain long-term furnishings. The presence of dirt, moisture, and warmth encourages the growth of mold and other toxins, which can trigger allergic reactions and asthma.[25] Children who spend long hours breathing contaminated or polluted indoor air are more likely to develop respiratory problems, allergies, and asthma.[26] As much fresh outdoor air as possible should be provided in rooms occupied by children to prevent these conditions.[27] Screened windows should be opened whenever weather and outdoor air quality permits, or when children are out of the room.[28] When windows are not kept open, rooms should be well-ventilated and include air filtration units.

CFOC Basics references recommends that child care providers conduct an environmental audit during new construction; making renovations to existing spaces; and after natural disasters, remedying any hazards to children and staff, such as air, soil, or water contamination.[29] Further, *CFOC* addresses both well-ventilated spaces indoors as well as mitigations to air pollution when children are playing outdoors. Indoors, *CFOC* suggests providers maintain a constant circulation of fresh air into early learning settings and, when possible, open screened windows when the outside air permits or when children are not in the room. Additionally, *CFOC* recommends that unnecessary chemicals be minimized such as the use of air fresheners or cleaning products with harmful chemicals. Outdoors, child care providers should monitor the air quality index to determine if it is safe for children outside.[30]

Current State Licensing Landscape in Air Quality

The 2020 Child Care Licensing Survey did not include indicators specifically related to air quality indoors or outdoors. Forty-nine of 50 states and D.C. did require general smoking policies in licensed child care centers, while 43 states do so in family child care homes, and only 37 do so in group child care homes.[31] Worse yet, a mere 29 states explicitly prohibit smoking on facility grounds for center-based settings, 28 states prohibit it for home-based providers, and 26 prohibit it for group settings.[32]

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Monitors outdoor air quality daily to inform the use of outdoor activity areas, including whether children should be kept inside for the day, whether masks should be used outdoors, and whether windows can be kept open.[33]
- Ensures appropriate air circulation into each room within the facility at the recommended rates (ranging between 15 to 60 cubic feet per minute per person depending on the activities that normally occur in that room).
- Screens indoor air quality and keeps it as free as possible from unnecessary chemicals, including those emitted from air fresheners and fragrances, cleaning products, aerosol sprays, and some furnishings.[34]
- Implements preventive measures to improve indoor air quality,[35] such as:
  - Ensuring new furnishings and materials are low formaldehyde products.
  - Turning on the range hood when using gas stoves.
  - Increasing ventilation with outdoor air, when outdoor air quality is appropriate.
  - Cleaning frequently to minimize dust.
  - Using "clean" cleaning products that are low in volatile organic compounds (VOCs).
  - Reducing use of pesticides.
  - Installing carbon monoxide detectors, particularly in areas where children sleep.
  - Properly disposing of old pesticides, solvents, and cleaning products.

3. CAP RATIOS AND GROUP SIZES

Adult-to-child ratios and group sizes are among the most important factors in maintaining safe and enriching environments for children. Ratios not only affect physical safety and supervision; they also influence the quality and quantity of adult-child interactions. Developmental science and neuroscience have shown the importance of positive adult-child interactions for positive child development. Studies have also found that smaller ratios may result in more of these essential interactions, including improved classroom quality.[36] Specifically, a meta-analysis of studies on adult-to-child ratios worldwide found that smaller adult child ratios were associated with improved quality in ECE settings.[37] Smaller ratios and class sizes may also be associated with improved child outcomes. For example, a reduction in preschool classroom size by five children was found to positively impact children's literacy outcomes and increased teacher-child interactions.[38] Additionally, researchers have found that classrooms with ratios lower than eight children to one adult and class sizes of 15 or less lead to better overall outcomes. Particularly, children received more attention, the quality of adult-child interactions was enhanced, behavioral incidents decreased, and social interactions improved.[39] It was also found that reducing the ratio and class size by just one child can result in improved cognitive achievement outcomes of 0.22 standard deviations and 0.10 standard deviations.

Small adult-child ratios are most critical for infants and toddlers, who require a higher level of supervision and interaction for safe care.[40] It is also important to note that large ratios and group sizes not only negatively affect children, they also adversely impact teachers and are an important dimension of working conditions in early childhood settings.[41]

CFOC Basics recommends that proper ratios be maintained during child care hours of operation including a maximum child-to-caregiver ratio for each age range of children.[42] *CFOC Basics* also recognizes that children with disabilities or special healthcare needs may require additional staff based on their individual needs and their family service or educational plan.[43]

Current State Licensing Landscape in Ratios and Group Sizes

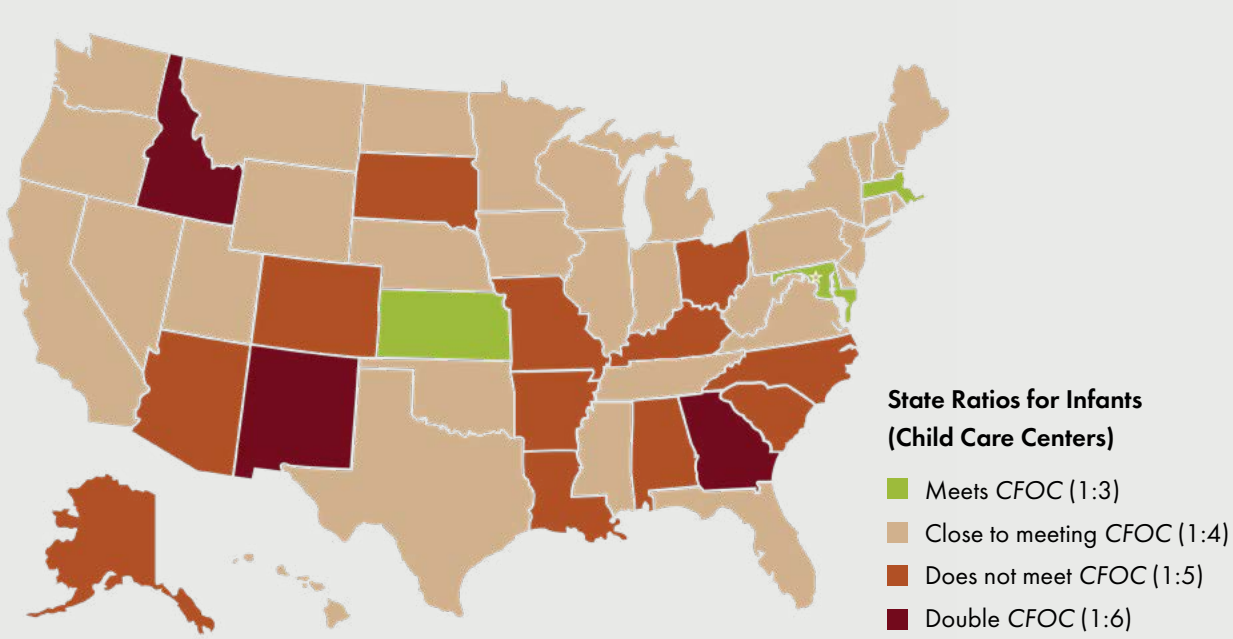
RATIOS

Some child care providers choose to limit ratios, while others, such as Head Start grant recipients and providers accredited by early childhood accreditation organizations, are required to do so. Child care licensing regulations must also set an appropriate maximum ceiling for the number of children who can be with each educator. **Alarmingly, few state licensing standards align with the maximum caregiver-to-child ratios specified in the American Academy of Pediatrics' *Caring for our Children (CFOC), 4th Edition*.** In fact, no state fully meets the *CFOC* recommendations for the ratios of adult-to-child in child care center settings, though some states are closer than others. Only three states meet the 1:*7 CFOC* recommendation for three-year-olds, one state meets the recommended ratio of 1:8 in a four-year-old classroom, and no states meet the five-year-old recommended ratio of 1:8.

As of 2023, for infants between six weeks and 11 months in center-based care, only three states had *CFOC*-aligned ratios of three infants to one caregiver (see Figure 1). Only seven states and D.C., about 13% of states, had *CFOC*-aligned ratios for toddlers at 18 months of age. For toddler-age children, ratios in more than half of states (55%) were double or more than the recommendations in *CFOC*. For example, in Florida, Louisiana, and Texas, a toddler teacher can have up to eleven two-year-old children in their care. Mississippi had the highest caregiver-to-child ratio for two-year-old children at 12:1. Connecticut and D.C. are the only two states that required ratios for two-year-olds (up to 35 months) that were aligned with *CFOC*.

For preschool-age children in child care centers, three states (New York, North Dakota, and Vermont) have ratios of seven children to one educator, or less, which aligns with the *CFOC* recommendations. Only New York is aligned with *CFOC* with a ratio of 8:1 for four-year-old children in pre-Kindergarten. Fifteen percent of states have maximum ratios that are at least two times more than what is recommended in *CFOC* for four-year-olds, while more than 1/3 of states (37%) have a maximum ratio that is double or more than the *CFOC* recommendation for five-year-olds.

Figure 1: State Ratios for Infants in Child Care Centers, 2023



For mixed-age groupings in center-based settings, 47 states and D.C. include caregiver-to-child ratio requirements. However, only 1/4 of states (25%) required that ratio be based on the youngest child in the group. Eleven, or 21.5%, of state child care licensing regulations identified a specific ratio for mixed-age groups.

According to the National Database of Child Care Licensing Regulations, ratios in family child care settings are reported by the maximum number of children allowed per one provider. Half of states (26 or 50% of states including D.C.) either do not require a maximum group size by age or do not have child care licensing requirements and policies for relating to ratios for family child care homes.[44]

GROUP SIZES

Large group sizes can influence supervision, safety, and the quality of interactions with children. Group sizes that are too large can be chaotic and difficult to manage, which can impact children's behavior and stress levels, as well as that of their providers.[45]

As of 2023, 45 out of 50 states and D.C., or 88% of states, had group size limits for some or all ages of children in licensed or certified child care centers.[46] Forty-four states, including D.C., had a minimum and maximum group size requirement for family child care homes, while 38 states did so for group child care homes.[47]

For infant care in center-based settings, only one state (Maryland) had a group size requirement at the recommended *CFOC* cap of six infants. In 14 states (31% of states) with group size requirements for this age group, the limit for infants under 12 months was two times higher than the *CFOC* recommendations. Caps in these 14 states ranged from 12 (Georgia, Illinois, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New Jersey, Ohio, Virginia, and Wyoming) to 15 in Louisiana, up to a high of 20 in South Dakota. *CFOC* also recommends that no more than eight children ages 13 to 35 months in child care centers, with no more than 12 children ages 24 to 35 months in family child care homes. For toddlers between 12 and 35 months of age, group sizes vary from state to state, with seven states having no regulations related to toddler group size.[48] States that do

have group sizes for toddlers vary. For example, Maryland allows a group size of up to nine one-year-olds, while New York's maximum group size is 12 for children 18 months of age. In six states, the group size limit for toddler-age children is double or more than the *CFOC* (Arkansas, Georgia, Texas, New Jersey, South Dakota, and Louisiana).

For preschool-age children, *CFOC* recommends a maximum group size of 14 for three-year-olds and 16 for four- to five-year-olds in center-based care, and no more than 12 three- to five-year-old children in large family child care settings. However, there is significant variation in maximum group size across states. **Unfortunately, no state meets the *CFOC* recommended group size limit for four- or five-year-olds.** For example, a review of Florida's child care licensing rules revealed no specified group sizes for any age,[49] while Illinois allows up to 20 three- to four-year-olds in a group.[50] The maximum group size for preschoolers in Mississippi is 14 three-year-olds and 16 four-year-olds, which are both two times higher than the *CFOC* guidelines. Four states have group size limits for three-year-olds that are more than double the *CFOC* guidelines (Georgia, Michigan, Texas, and Virginia). Three of those states also have four-year-old group size caps that are more than two times higher than the *CFOC* recommendations (Georgia, Michigan, and Texas).[51]

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Adheres to ratios and group sizes that align with *CFOC* or better (see Table 1).
- Maintains ratios and group sizes during staff break time to ensure ratios are met throughout the entire day.
- Provides additional staff for children with special health needs or who require more attention due to certain disabilities, depending on their individualized family service or education plan and the extent of their disabilities.
- Staffs at least one adult who has current certification in pediatric first aid, including cardiopulmonary resuscitation (CPR), as part of the ratio at all times.

Table 1: *Caring for Our Children* Recommended Ratios and Group Sizes by Age

***CFOC* Ratio and Group Size**	**Infants** (under 12 months)	**Toddlers** (13–24 months)	**Toddlers** (24–35 months)	**Preschool** (three-year-olds)	**Pre-K** (four- and five-year-olds)
Center-Based[52]	3:1, with a max group size of six	4:1, with a max group size of eight		7:1, with a max group size of 14	8:1, with a max group size of 16
Small Family Child Care[53]	If one child under age two, then up to three children over two years of age			If no children under age two, then up to six children over two years of age	
	If two children under age two, then no children over two years of age				
Large Family Child Care[54]	2:1, with a max group size of six	2:1, with a max group size of eight	2:1, with a max group size of 12	2:17, with a max group size of 12	8:1, with a max group size of 12

Note: According to *CFOC Basics*, "In family child care settings where there are mixed age groups that include infants and toddlers, a maximum ratio of 6:1 should be maintained and no more than two of these children should be 24 months or younger. If all children in care are under 36 months, a maximum ratio of 4:1 should be maintained and no more than two of these children should be 18 months or younger. If all children in care are 3 years old, a maximum ratio of 7:1 should be preserved. If all children in care are 4 to 5 years of age, a maximum ratio of 8:1 should be maintained." (p. 8)

4. PROMOTE EMOTIONAL SAFETY AND WELL-BEING

Emotional safety is a defining feature of a positive learning environment and is associated with children's psychological well-being and positive academic and social outcomes. In the early childhood setting, emotional safety is developed through supportive relationships and clear boundaries.[55] The adult-child relationship serves as an essential enabler for the positive impacts of ECE.[56] A strong understanding of developmentally and culturally appropriate behavioral, social, and emotional expectations for children are essential in preventing harsh discipline and effectively supporting children's emotional health, development, and learning.[57]

States should refine and revise their definitions of discipline with the goal of promoting positive developmental growth. This includes ensuring children's emotional safety and well-being, rather than punishment or inappropriate adult reactions to children's behaviors. This is critically important because research shows that the use of harsh discipline practices compromises emotional safety and learning. Harsh discipline can include a range of adult behaviors and policies, including suspension and expulsion; corporal punishment; seclusion; inappropriate use of restraint; belittling and humiliating; shaming; and withholding attention, play, outdoor time, or snacks. Racial disparities exist in the use of harsh discipline practices including restraint, seclusion, expulsion, and suspension. For example, Black children are disproportionately impacted by harsh discipline, despite the fact that they do not engage in worse or more frequent misbehavior.[58] Robust research points to the role of bias in the perceptions of child behavior and discipline decisions.[59] It is critical that adults be trained on the role of implicit and explicit bias in perceptions of behavior and discipline decisions.

CFOC Basics includes a section on harsh discipline. However, **a recent review found that most states—32 of them—do not require policies for expulsion as part of child care licensing.**[60] Of those that require expulsion policies, many lack the quality to provide minimal protection to children. Indeed, suspensions and expulsions are rooted in a complex array of biases, policies, practices, and importantly, lack of preparation and support for educators in addressing behaviors they deem problematic.[61] Addressing these factors requires a multidimensional approach that includes, but is not limited to, prohibiting exclusionary discipline; conducting developmental screening and referrals; using developmentally appropriate support plans; family engagement; and requiring professional development on bias and social emotional development. Many state child care licensing systems do not address similarly harsh but categorically different forms of harsh discipline, like corporal punishment, seclusion, and restraint.[62]

Positive working conditions for teachers must also be addressed to support their emotional safety and well-being (e.g., appropriate ratios, adequate breaks, paid time off, fair compensation) to ensure their own emotional safety and well being.[63]

Current State Licensing Landscape in Discipline and Emotional Safety

Currently, there is no measure in the national licensing survey for licensing requirements regarding discipline and emotional safety. However, every state and territory has a set of unique regulations that address suspensions, harsh treatment, and other responses to undesired behaviors. There is also a wide array of policy and legislative approaches related to discipline across states, including variations in the terminology used to describe those approaches. Certain methods of discipline may be prohibited in licensing regulations (e.g., corporal punishment), while other practices may be required (e.g., early childhood mental health consultation, parent notification).

According to the most recent NARA report and a comprehensive review of licensing across states, most states prohibit the use of corporal punishment.[64] A handful of states ban other negative practices such as shouting or withholding food.[65] Notably, five states—Alabama, Hawaii, Idaho, Kentucky, and Maryland—do not have any regulations on exclusionary discipline. A total of 31 states require a policy on addressing the permanent removal of a child from a program due to behavioral issues, with 13 states requiring both a suspension and an expulsion policy. Eighteen states require an expulsion policy only. Forty-three states address in-program exclusions in a dedicated section of the facility dedicated to discipline actions. Twenty-seven states provide clear instructions on what is permitted and what is not regarding excluding a child while 13 states only addressed prohibited exclusions. New Jersey was the only state that described permissible exclusions in a way that also prohibited isolation and confinement.

The majority of states that required a policy on exclusion did so without guidance on alternative strategies or interventions. Conversely, Massachusetts requires programs to take four preventative steps before excluding a child—meeting with the family, referring for developmental services, providing consultation or teacher training, and developing a behavior plan for home and school. While children receive care and education in a variety of settings (e.g., home-based, community-based), most legislation focuses on pre-kindergarten or school-based services. There is a need to ensure children in all settings receive the protection afforded by comprehensive discipline policies.

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Has a written policy prohibiting expulsions and limiting suspensions, including incremental steps to prevent and address behaviors deemed problematic.
- Disallows the use of corporal punishment.
- Provides professional development for staff focused on discipline and guidance strategies, including training and coaching on the causes and effects of exclusionary and harsh disciplinary practices, its disproportionate application, and effective interventions.
- Conducts universal developmental screenings and refers children to additional evaluations or supports as needed.
- Ensures ethical and healthy working conditions for teachers, including small group sizes and ratios, adequate breaks, and paid sick leave.

5. ENSURE INCLUSIVE, SAFE, ACCESSIBLE ENVIRONMENTS FOR CHILDREN WITH DISABILITIES

Young children with disabilities, including those with healthcare needs, have many strengths and capabilities that must be recognized and affirmed in early childhood settings. **To maximize their potential as lifelong learners, children with disabilities and those with healthcare needs have the right to participate in and enjoy the benefits of the least restrictive early learning settings alongside their peers.** Special education services and supports are a civil right of infants, toddlers, and preschoolers. These rights are codified by IDEA, a federal law with funding appropriated by Congress, administered by the U.S. Department of Education, and granted to states. First authorized in 1975, IDEA states that children with disabilities have the right to a free, appropriate public education in the least restrictive environment, and to early intervention services in their natural environment during their earliest years. Decades of research show that children with disabilities benefit significantly from comprehensive, timely early intervention and quality special education services in general early childhood settings alongside their peers without disabilities.[66]

Despite nearly 50 years of legal foundation and robust research highlighting the benefits of inclusion for both children with and without disabilities, just over 43% of preschool-age children with disabilities receive their special education services in *segregated* early care and learning settings.[67]

Licensing systems should incorporate indicators specific to including and supporting children with disabilities. Too often, licensing systems incentivize exclusion of children with disabilities, even if done inadvertently. Few states include regulations with an emphasis on ensuring inclusion of children with disabilities. State licensing systems should explicitly address this issue by having a standard that requires programs to be accessible to children with disabilities. This includes ensuring access to the facility, but should go beyond that to also ensure children with disabilities can access all spaces inside and outside the classroom or family child care home. All activities, materials, and learning opportunities should be accessible for all children, including those with disabilities.

For example, toileting policies should ensure adequate private space for children with disabilities who might need additional support to use the restroom. This may require a bathroom with an accessible toilet and sink and a changing table, as well as staff trained on how to support toileting. Programs should ensure staff training on medication administration, use of assistive technology and medical devices, and supporting the full inclusion of children with disabilities across all activities. They should also establish multi-disciplinary collaboration among general and special educators and related personnel, such as speech-language pathologists and physical therapists. This ensures children's developmental goals and modifications

in the Individualized Family Service Plan (IFSP)/Individualized Education Program (IEP) are generalized and supported in the general learning environment.

While *CFOC* includes an entire chapter of guiding principles for serving young children with a disability or a special healthcare need, standards that enable individualized accommodations and afford full participation of all children are integrated throughout. Ultimately, states should review their licensing regulations to ensure there are no discriminatory policies or policies that exclude or segregate children with a disability or special healthcare needs. Rules should clarify and specify the practices child care providers can implement to achieve safe and full inclusion.

Current State Licensing Landscape in Inclusion of Children with Disabilities

Physically accessing a child care space is the first step in setting up an inclusive environment. Yet, only five states require centers be accessible to children with disabilities, and only two require it for family child care homes.[68]

Forty-four states have general requirements for child care centers and 36 states have general requirements for family child care homes that address caring for children with disabilities. However, the requirements for individualized lesson plans, appropriate materials, and training to support children with disabilities are dismal. Only about a third of states require providers to develop individual activity plans or provide activity accommodations that ensure children with disabilities are included in classroom experiences. That percentage is even lower in family child care homes, with just 10 states that include this requirement. Only 12 states require center-based providers and four states require family child care providers to use appropriate materials and equipment to meet the needs of children with disabilities.[69]

Some young children with disabilities require an additional staff member for support. However, very few states have ratio requirements for settings in which children with disabilities are attending. Seven states have this requirement for centers, and eight states include the requirement for family child care. Out of all 50 states and D.C., only Virginia requires group size limits in centers. Illinois is the only state that requires group size limits in family child care homes for children with disabilities.[70]

Educators provide warm, nurturing interactions to ensure inclusion of children with disabilities in early learning experiences. This requires ongoing training and professional development to help educators identify the strengths of children with disabilities, scaffold their development through individualized education plans, and provide an inclusive and responsive environment. Licensing regulations have failed to keep up with this indicator, as only a quarter of states require all center-based staff to have training related to caring for children with a disability, and only 17% of states require family child care providers to complete training on this topic.[71]

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Has a written policy including children with disabilities with specific procedures to ensure individualized support and services in inclusive settings with non-disabled peers.
- Does not cap the number of children with disabilities enrolled and instead applies a natural proportion principle in which the number of children with disabilities reflects the natural rate of people with disabilities in the general population.
- Establishes connections to the early childhood special education system to refer children, as needed for evaluations or supports and partners with the early childhood special education system to provide inclusive services.
- Does not exclude children due to toileting age restrictions or developmental stage and has a private area for children to use the restroom, including accessible toilets, sinks, and a changing table.
- Ensures the building, playground, and all activities are physically accessible to all children, including children with physical disabilities.
- Adapt curricula, instruction, and learning materials to meet the needs of children with disabilities and ensure their meaningful inclusion in the learning environment, aligned with Universal Design for Learning (UDL).
- Participates in training and demonstrates competence around inclusion of children with disabilities, assistive technology, use of medical devices, and medication administration for each child with a disability or special healthcare need.

6. SUPPORT EMERGENT BILINGUALS AND DUAL LANGUAGE LEARNERS

Child care providers must be prepared to work with children who are dual language learners (DLLs) and their families, whether or not they share the same home language. Indeed, **research shows that support for DLLs' emerging bilingualism is associated with a range of cognitive, academic, social, and economic benefits over their lifetime.**[72]

Licensing systems should also include specific standards focusing on DLLs and emerging bilinguals, or children learning two or more languages at the same time. Children who are DLLs benefit the most when supported in their home language and English, even when providers do not speak their home languages. Particularly for the youngest children, exposure to their home language can impact emotional security and their ability to build strong relationships with their teacher. Further, research indicates that when children who are DLLs (with and without disabilities) receive support in their home languages, they have better academic, cognitive, and social-emotional outcomes, and they acquire English faster. However, most licensure systems offer very little guidance on how to support the bilingual development of DLLs, or they only focus on translating materials sent home in the families' languages.

While children who are DLLs are not explicitly referenced in *CFOC Basics* or *CFOC*, there are several culturally responsive and language-affirming practices that help child care providers create a safe, trusting, and welcoming environment for children and their families who are learning or already speak more than one language. For example, *CFOC* encourages providers to make efforts to communicate with parents who speak a language other than English and to provide resources where necessary to support the learning of English. *CFOC* recommends that at least one staff member be able to communicate with families in their home language or for providers to work with an adult translator to communicate effectively—not using the child as a translator. Moreover, *CFOC* states that developmental screenings and comprehensive assessments to determine special needs should be conducted in culturally and linguistically responsive ways. Coaches and other external partners such as child care health consultants should also be trained in culturally affirming practices that ensure educators are implementing responsive, developmentally appropriate, and language-rich environments and interactions.

Current State Licensing Landscape in Support for Dual Language Learners

Missing from most licensing regulations are indicators to support DLLs. Thirty-four states for center-based programs and 24 states for home-based programs require that language development be addressed in early learning activities. However, specific experiences, teaching strategies, assessment procedures, and materials to promote multilingual development are largely absent.[73] In fact, dual language learner supports are not captured at all in the NARA Child Care Licensing Survey, which leaves a gap in understanding of how licensing regulations are supporting this population of children.

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Embeds all of the languages represented by enrolled children and families in the learning environment, including American Sign Language, into environmental print, books and materials, and family communication.
- Establishes policies to embed children's home languages in songs, daily routines, and lessons used in the learning environment by collaborating with community partners, families, or interpreters as needed.
- Hires a bilingual staff person if more than a third of children share the same home language other than English.
- Collects information on children's home language to inform programming, including hiring and professional development.
- Provides written and verbal communication with families in their home languages with the aid of interpreters, community partners, or translation software, as needed.
- Confirms that all education staff participate in ongoing professional development on bilingual language development for children who are DLLs (with and without disabilities), and on embedding the home language in assessments and instruction, even when staff does not speak children's home languages.

7. ENHANCE PROVIDER QUALIFICATIONS, TRAINING, AND WORKING CONDITIONS

The relationship between early educators and the children they serve is the most essential dimension of the early care and education experience. As such, licensing regulations should ensure teachers have the qualifications and access to training and support they need to engage in warm, responsive, and enriching interactions with all children.

Foundational knowledge of child development and effective teaching practices helps teachers provide safe, responsive, enriching early learning environments for children. A minimum base of knowledge at entry level into the child care field is necessary to maintain consistency across settings that serve children. Additionally, those working with children should also have a criminal background clearance, including a fingerprint check, as recommended by *CFOC Basics* and required for providers receiving CCDF federal child care subsidies.[74]

In 2015, the National Academies of Science, Engineering, and Medicine published a consensus report on the ECE workforce. Regarding qualifications, it states, "The Child Development Associate (CDA) credential may contribute to some aspects of quality and may be beneficial for child outcomes" (p. 431). Research shows that the CDA increases the positive interactions between children and their teachers with limited formal education and improves self-reported developmentally appropriate practices among participating teachers.[75]

CFOC includes qualifications for directors, teachers, and other child care staff before they can work in settings with young children. These comprise education levels as well as requirements for knowledge, skills, and participation in ongoing training. For example, *CFOC* recommends that directors of centers have a minimum of a baccalaureate degree with hours in administration, leadership, and child development. It also recommends directors have knowledge of health and safety, community resources, facility management, and curriculum design and administration. Indeed, Head Start, the nation's largest comprehensive federal ECE program, requires Early Head Start and Head Start directors to attain a bachelor's degree and demonstrate experience in staff supervisions, fiscal management, and administration.[76]

Current State Licensing Landscape in Provider Qualifications and Training

Nearly ¼ (24%) of states and D.C. require a CDA or equivalent certification pre-service for teachers in licensed center-based settings. For family child care providers, 12.5% of states and D.C. require this minimum educational level as well.[77] Administered by the Council for Professional Recognition, the CDA provides credentialing for the ECE workforce across settings and age ranges, including infant/toddler and preschool endorsements for center-based programs, family child care, and home visiting programs. Teachers working in bilingual early learning settings also can earn a bilingual specialization to promote the development of dual language learners. The CDA incorporates multiple competencies that teachers need to work with young children birth to age five, such as health and safety foundations, social and emotional development, relationships with families, and professionalism.[78]

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

Credentials

- Lead teachers have at least a CDA with experience with the age group served, or an associate's or bachelor's degree specializing in young children and early development.
- All staff who work directly with children either have or are on track to have a child development credential (e.g., CDA) at the minimum.

Training

The provider:

- Provides onboarding training and ongoing professional development on child development; warm, responsive relationships; appropriate behavioral expectations and management; enriching and stimulating interactions; and understanding bias and its impacts on relationships and interactions.

EXAMPLE STATE OR LOCAL GOVERNMENT ACCOUNTABILITY

The licensing agency:

- Requires all child care staff to engage in professional development or coursework that include the following content:

  - Optimal, holistic child growth and development
  - Social-emotional development, including developmentally appropriate behavioral expectations
  - Anti-bias, culturally responsive, and affirming practices
  - Family and community engagement, including partnering with diverse families (e.g., disability, racial, ethnic, and linguistic diversity)
  - Health, safety, and nutrition
- Provides technical assistance and financial support for child care providers to participate in credit-bearing college coursework and complete certification and degrees, in collaboration with other state agencies in the early childhood system, the state's quality rating and improvement system, and legislative bodies.

Working conditions affect providers' ability to care for and teach young children, their own health, mental health, economic security, overall wellness, and teaching efficacy. In other words, the safety, health, and financial well-being of early childhood educators impacts their ability to keep children safe and healthy and to support optimal growth and learning. Working conditions include an array of areas, such as adequate breaks and physical spaces to take a break; small group sizes and ratios; access to paid time off and sick leave; compensation and benefits; and access to dedicated paid professional development time, staff collaboration, and career advancement.[79]

Some of these factors are addressed in *CFOC Basics* indirectly. For example, when physical environments and supplies are safe and free from hazards for children—and written policies are in place for addressing illness, infestation, or toxic materials—educators also experience a safer, healthier work environment. Moreover, *CFOC* recommends written policies that address occupational hazards for workers in child care settings, including accommodations for pregnant workers. To lower stress for the early childhood workforce, *CFOC* suggests measures including fair wages and benefits, job security, training on managing and reducing stress, and identifying and limiting occupational hazards. It also includes regular breaks and paid time off, appropriate staff-to-child ratios, and a staff lounge that is separate from spaces with children for breaks, to name a few.[80]

Other indicators of positive working conditions may be best addressed by Occupational Safety and Health Administration (OSHA) requirements or may be beyond the scope of licensing. However, licensing can set the foundation for states to build up other investments and interventions in parts of the system, like child care subsidies, quality improvement, and early childhood professional development.

Current State Licensing Landscape in Provider Working Conditions

The 2020 Child Care Licensing Survey did not directly capture and report data related to working conditions for the early childhood workforce across states.[81] Decisions around setting working conditions are left to states and, in most cases, local child care providers to determine rather than the licensing agency. In the 41 states with a Quality Rating and Improvement System (QRIS), working conditions, especially ongoing educational and professional development requirements and salary scales, are included in the QRIS. These variances across states result in an uneven field where educators in some states have access to several indicators of a quality work environment, while those in other states do not.

EXAMPLE INDICATORS FOR CHILD CARE PROVIDERS

The provider:

- Adheres to OSHA standards, including hazard communication, emergency action plan, fire safety measures, and health and safety training.
- Has ratios and group sizes aligned with *CFOC Basics* and ensures sufficient staff to cover ratio and group size regulations during breaks.
- Shares break policies with staff in the employee handbook and ensures that all employees take adequate breaks based on the length of their day.
- Has policies for paid time off for staff, including personal, sick, parental, and family and medical leave.
- Provides dedicated space for staff to take breaks with adult-sized furniture.
- Coordinates to ensure staff have access to dedicated paid professional development opportunities and specialized support as needed.
- Ensures staff have paid planning time that allows preparation and planning when they are not responsible for supervising children.

SECTION II

LICENSING PROCESSES

In addition to ensuring the right content is emphasized in licensing systems, the process of licensing is critical to the success of potential and existing licensed providers. States must ensure that there is an infrastructure that supports the administrative functions related to licensing, monitoring, and enforcement throughout the licensing process. States must also acknowledge existing inequities that negatively impact potential providers including language barriers, licensing fees, and the complex language of the rules. An effective licensing process informs and supports providers beginning with information related to licensing requirements, the initial application process, and available support throughout the duration of the license. The process includes providing information that increases the applicant's knowledge, understanding, and ultimately compliance with licensing rules and regulations. This process includes an informed regulator/licensor workforce with skills and knowledge to positively engage providers, provide technical assistance, and ensure compliance. **States should engage in culturally responsive practices that are equity-driven to ensure that the cultural, linguistic, and racial diversity of providers is affirmed and supported throughout the licensing process.**

Most states have no formal educational requirements for those responsible for licensing and monitoring child care facilities. Colorado requires a degree in early childhood education or a related field. Alaska requires a high school diploma and five years of experience in child care licensing, while states like Virginia and Connecticut have no minimum educational requirements beyond a high school diploma. **No states require training on implicit bias, cultural humility, or anti-racist/anti-bias practices for licensing agency staff.**

To fully support providers in obtaining a license, ensuring compliance, and avoiding closure, regulators must have the skills and knowledge to fully support providers at each juncture of the licensing process. The process for becoming licensed and the requirements that determine whether a provider is required to be licensed should be easily accessible on the issuing entity's website. It also should be available in the language of potential providers with contact information to request support, if necessary.

Too often, those seeking to be licensed are already engaged in unlicensed care to serve children and families in their communities. They are usually informed of the licensing process after receiving a cease and desist letter from the state, and the licensing regulator provides information on the licensing process. However, the information is usually in English, and very little technical assistance support is provided. A provider may enter the formal process already on probation for engaging in unlicensed care, creating a negative experience and possibly a contentious relationship between the licensor and the provider.

CULTURALLY RESPONSIVE COMMUNITY BASED LICENSING

Culturally Responsive Community Based Licensing is a model that promotes respectful interactions and reduces the adversarial relationship between licensors and providers that is often experienced in early childhood facilities. This model ensures that licensors are recruited from the community, with a preference for those who are culturally, linguistically, and racially matched with the providers they serve. Ideally, licensors should have experience in early childhood education, knowledge of and experience implementing state rules and policies, and administrative skills and knowledge. Training should be provided regularly to ensure consistency in the application and interpretation of the rules and avoid potential biases that may manifest in licensing visits.

In this section, we describe the current process and make recommendations for states to consider to enhance the licensing process, increase child care capacity, and provide support to licensed providers.

PRE-LICENSING TRAINING

Pre-licensing training is designed to assist potential applicants with the initial licensing application and overall process. Pre-licensing training refers to the education and training requirements that must be completed prior to operating a child care facility. This training is designed to ensure that providers have the necessary knowledge and skills to create a safe and supportive environment for children. The specific requirements for pre-licensing training can vary depending on the state where the child care facility is located, as regulations and licensing standards differ. However, some common elements of pre-licensing training for child care providers may include:

- **Child Development:** Training in child development, including developmentally appropriate activities, nutrition, and behavioral expectations.
- **Health and Safety:** Information on health and safety practices, emergency procedures, and general guidelines to create and maintain a clean and healthy environment.
- **Licensing Regulations:** Information about the licensing rules, requirements, and regulations for operating a child care facility.
- **Business Practices:** Information on administrative and business aspects of operating a child care facility, such as record-keeping, financial management, and staff management.
- **Child Abuse Prevention:** Training on recognizing and reporting child abuse or neglect, and their role as mandated reporters.
- **Background Checks:** Completion of background checks, including fingerprinting and criminal history checks, to ensure that individuals working with children have no disqualifying offenses.
- **Parent Communication and Engagement:** Guidance on effective communication with parents or guardians of the children in their care and on engaging with families and partners in the care of the child.
- **CPR and First Aid Certification:** Information on how to obtain current CPR and first aid certification to respond to medical emergencies effectively.
- **Child Care Philosophy:** Discussion of the provider's approach to child care, including educational philosophies, curriculum, family engagement, and discipline techniques.

Additionally, federal regulations mandate the following training for contracted providers under the Child Care and Development Block Grant (CCDBG) before a license can be issued or a provider can be left alone with children. Training topics that must be addressed are:

- Prevention and control of infectious diseases (including immunization)
- SIDS and safe sleep practices
- Administration of medication
- Prevention/response to food allergies
- Building and physical premises safety, including identifying electrical hazards, bodies of water, and vehicular traffic
- Shaken baby syndrome and head trauma
- Emergency preparedness and response planning, for natural or human-caused events
- Storage of hazardous materials and bio contaminants
- If applicable, precautions in transporting children
- First aid and CPR

Once pre-licensing training has been completed and requirements are met, potential providers can apply for a child care license. The licensing authority will review their application, conduct inspections, and assess their qualifications before granting or denying the license. Ongoing training and professional development are often required for licensed child care providers to ensure they stay up-to-date with best practices and continue to provide quality care to children.

Inequities Related to Pre-Licensing Training

For potential providers from historically marginalized communities, including those who are racially, linguistically, and culturally diverse and who have low incomes, the requirements for becoming licensed can be daunting. Some of the inequities in the pre-licensing training include:

- **Financial Barriers:** Pre-licensing activities can involve significant costs, such as application fees for background checks, inspections, architectural plans and permits, and training. These expenses can be prohibitive for individuals with limited incomes.
- **Access to Training:** Access to quality pre-licensing training is not always equitable. Training may not be available in some communities, especially evenings or weekends.
- **Language and Cultural Barriers:** Language and cultural barriers can hinder individuals from diverse backgrounds from navigating the licensing process effectively. Materials and information may not always be available in multiple languages and may not be delivered in culturally responsive ways.

State Trends

Pre-licensing training varies from state to state. For example, in Florida, all child care personnel must complete 40 hours of training one year from the date the training began. They must also pass exams for the 40 hours of training to demonstrate their competency or receive an educational exemption. In North Carolina, pre-licensing workshops are required as a prerequisite for opening a child care center or family child care home. The training includes a comprehensive review of the North Carolina Child Care Requirements and critical information pertaining to the operation of a child care facility. Colorado requires a 15-hour Family Child Care Pre-Licensing Course approved by the Colorado Department of Early Childhood. To obtain a child care license in California, an applicant must be familiar with the rules and regulations and complete an in-person or online orientation.

STATES SHOULD:

- Allocate funding to ensure pre-licensing training is free or low-cost.
- Offer trainings at least monthly, in person and online, with an emphasis on serving historically marginalized communities.
- Ensure training is culturally responsive and customized to meet the cultural, racial, and linguistic needs of the community.
- Mandate training on implicit bias and anti-racist/anti-bias practices during the pre-licensing phase for all potential providers.
- Create public service announcements informing the public of the need for licensing, the process for becoming licensed, and the benefits of being a licensed program.

THE APPLICATION PROCESS

A critical part of pre-licensing is the application process. This is the gateway to becoming a formally licensed provider and can open access to resources and supports like child care subsidies and state Pre-Kindergarten dollars that contribute to sustainable operations. To improve access to child care in areas with low supply, states should conduct targeted outreach and offer individualized technical assistance that helps potential child care providers effectively and successfully navigate the application process.

During pre-licensing training, the application process should be discussed. This phase of the licensing journey is foundational for those seeking to obtain a license. The application should be simple, easy to understand, and offered in the language of the potential provider. There should be step-by-step directions for each section of the application and a support system in place when providers have questions. Understanding the application process is fundamental, as it outlines the steps, requirements, and documentation needed for becoming licensed. This process ensures that the applicant has a full understanding of the requirements and is prepared to successfully operationalize the licensing rules, avoid common pitfalls, and minimize delays and resubmissions.

INEQUITIES RELATED TO THE APPLICATION PROCESS

Access: Providers may experience insufficient access to financial resources to support the application and other fees. Loans and grants for potential providers may not be equally distributed. Those who are historically marginalized or who are racially, culturally, and linguistically diverse may have difficulty accessing financial support due to language barriers and challenges understanding or navigating the application process.

Discrimination, Bias, and Racism: Discrimination and bias can manifest at various stages of the licensing process. This includes potential bias from state personnel reviewing the licensing application, licensing regulators, and trainers who may have preconceived notions or stereotypes about individuals from historically marginalized groups. In fact, 94.3% of the child care workforce were women in 2022, 13.5% were Black, and nearly a quarter were Hispanic or Latine. These are populations who already experience disadvantages via sexism and racism within the ECE field and within institutions and systems more broadly.[82]

Lack of Support: Potential providers from historically marginalized communities often need additional support with the application process. Support may be limited or unavailable, leaving providers with little ability to navigate the licensing process, address challenges, and advocate for their rights.

STATE CHILD CARE LICENSING AGENCIES SHOULD:

- Prioritize funding to potential providers from historically marginalized communities, especially those seeking to increase child care capacity in these communities. Funding should include waivers for application fees, special consideration for state grants and other funding, and financial support for required trainings.
- Collect disaggregated data related to child care applications to determine the number of providers from marginalized communities and those who are racially, culturally and linguistically diverse who are denied a child care license during the application process. Data should be analyzed for trends based on race, language, application errors, and zip codes to determine if there are disproportionate trends based on these variables.
- Provide multiple modes of submission of the application (e.g., online, in person, written on paper, using a portal, through a digital document).
- Provide cultural brokers to assist providers from marginalized communities and those who are racially, culturally and linguistically diverse with the application process. Cultural brokers should be familiar with the language, culture, and needs of the applicant.
- Create a web page dedicated to the licensing process that includes current licensing rules and regulations, fees, licensing checklist, pre-licensing trainings, contact information, chat features, and commonly asked questions/answers.
- Provide a pre-licensing consultation that includes an assessment of the proposed facility to prevent investments in facilities that may not meet licensing standards.

Pre-Licensing Consultation Visit

The pre-licensing consultation visit is often a provider's first formal inspection and may be their first interaction with a representative of the licensing agency—setting the tone for the entire licensing and monitoring process. The goal of the pre-licensing visit is to ensure the provider and facility are fully prepared for the original licensing visit so that a license can be issued without unnecessary delays. Therefore, the pre-licensing visit should be focused on consultation that builds a positive, reciprocal relationship between the provider and the licensing staff. It should be conducted through a strength-based lens, highlighting the positive aspects of the visit in addition to concerns. In contrast, for example, when corrections are cited as "violations" rather than areas for improvement to meet minimum health and safety regulations, it may create a negative tone and negatively impact the provider-inspector relationship. A thorough walk-through of the premises should be conducted, and explanations should be provided where concerns might arise and gaps may exist.

Several inequities exist within the pre-licensing consultation process. For example, providers from historically marginalized groups may face economic challenges, making it difficult to provide a fully operational facility before becoming licensed. There may be a need to open one room at a time, so the program can open gradually while also generating income. Further, because of the complexity of licensing rules, providers may not fully understand space requirements, staffing and ratios, or storage needs. An informal pre-licensing consultation will provide the support needed to adhere to licensing regulations. Finally, inspectors may not speak the language or understand the culture of the potential providers. This may lead to inspections based on bias and stereotypes, leading to discrimination and more stringent application of licensing rules.

STATE CHILD CARE LICENSING AGENCIES SHOULD:

- Provide an informal pre-licensing consultation that does not result in a Report of Inspection. The walk-through should be conducted to support applicants and ensure their understanding of how to implement licensing rules in their environment.
- Make funding available to assist potential providers in meeting licensing requirements and remedying identified gaps, especially for those opening facilities in underserved areas.
- Ensure a cultural broker, translator, or other needed support person is available during the pre-licensing consultation visit.

The pre-licensing visit should focus on building a positive, reciprocal relationship. It should be conducted through a strength-based lens, highlighting the positive aspects of the visit in addition to any concerns.

LICENSING INVESTIGATIONS

To ensure compliance with licensing regulations, each state creates strategies and timelines for monitoring licensed facilities, which should include guidance, support, and technical assistance to ensure providers maintain compliance.[83] Annual visits should review all licensing requirements, or, at the very least, a random selection of policies and procedures. These visits are unannounced and monitor providers' adherence to rules and regulations. The focus of the inspections can vary depending on the state and specific regulations, but they generally include:

- A walk-through of the facility to ensure compliance with health and safety regulations; safe storage of hazardous materials; safe toys and equipment; staff/child ratios; and physical environment requirements, including indoor and outdoor spaces, proper ventilation, sanitation, and fire safety measures.
- Review of staff files to ensure that required background checks are completed and staff qualifications are up to date, including educational requirements; ongoing trainings; and certifications, medical information, and emergency contacts.
- Review of children's files for compliance-related medical records, immunizations, emergency contact information, and consent forms.
- Review of facility files and information to ensure compliance with state and local licensing regulations, such as zoning, fire, and health department inspections and approvals. Regulators also verify required licenses and permits are obtained, such as business licenses, etc.
- Technical assistance to support the success of providers in applying licensing rules.
- Working with providers to clarify licensing rules, why they exist, and what successful application and compliance looks like.

INEQUITIES RELATED TO LICENSING INSPECTIONS

Access to Resources: Providers in low-income and marginalized areas may not have access to the resources needed to address violations to maintain their licenses. The cost of complying with licensing regulations can be steep, especially for new providers who are required to provide the upfront cost to operate a child care facility. This includes the cost for the facility, trainings, background checks, toys and materials, and even personnel that must be in place before a license is issued. Maintaining licensing compliance is costly and may lead to disparate care in quality, safety, and compensation of staff members.

Access to Information: Information related to licensing rules and regulations, regular rule updates, and changes to rules may not be readily available, especially if the materials are only provided in English. Providers may have limited knowledge on how to access the information due to technological issues and language barriers. There may also be confusion related to the intent or application of the rules due to the complexity of the language used in the rules. This may lead to increased violations, more frequent inspections, and higher penalties.

Language Barriers: Providers and parents who speak languages other than English may struggle during the inspection to fully understand the rules and how to comply with licensing requirements. They may also have difficulty reading the report of inspection and interpreting how to correct cited violations.

Bias and Discrimination: Regulators may be influenced by implicit bias, stereotypes, and racism that can negatively impact licensing inspections. Discriminatory practices can include stringent application of rules, harsh interactions with providers and personnel, overreaching, citing vague rules to justify violations, and eliciting fear based on power dynamics.

Systemic and Institutional Policies: Some systemic and institutional policies privilege some and oppress others. Burdensome rules that have little impact on health, safety, or quality can create additional burdens on small facilities in marginalized communities.

STATE CHILD CARE LICENSING AGENCIES SHOULD:

- Provide startup assistance funds to providers opening in marginalized communities with the greatest needs. States should coordinate efforts to prioritize higher child care subsidy rates to those that open and maintain high-quality services as reflected in the state's QRIS.
- Ensure providers have easy access to rules and regulations. They should be posted on the state's website, and a listserv should be used to inform providers of rule changes and updates. The information should be offered in a variety of languages.
- Use a cultural broker or translator during licensing inspections to ensure providers fully understand the inspection process, cited violations, and expected remedies to come into compliance.
- Review and reduce rules that have little impact on children's health, safety, or development.
- Provide 30- or 60-day notices to licensees informing them of an upcoming unannounced licensing visit. Include a checklist and copies of other forms that will be used during the inspection so that licensees can ensure they are prepared for the visit.
- Extend the role of the licensor beyond citing rule violations to enhanced technical assistance. This includes ensuring the licensor is available to answer questions, offer support, and review files prior to the licensing visit and throughout the year as part of the ongoing symbiotic relationship between the inspector and provider.
- Ensure licensees have access to their licensing regulator, including email and state-provided cell phone numbers. Mandate a 48-hour response time.
- Hold quarterly Licensing 101 training or training on introduction to licensing processes to support new providers, and keep existing providers abreast of rules, changes to rules, and how rules are interpreted.

ADVERSE LICENSING ACTIONS

At times, providers may fail to adhere to licensing rules and regulations, and it may even appear that some providers consistently and willfully violate rules. State licensing agencies should take caution and identify if there may also be systemic issues, bias, and discrimination impacting the provider's ability to effectively comply with licensing rules and regulations. Biases can influence licensing decisions when taking adverse actions, and cultural disconnects between the regulator and provider can also occur. When cultural practices are neither appreciated nor understood, non-compliance may be misinterpreted as intentional and willful.

As these steps are implemented, it is critical that bias and discrimination in child care licensing actions are minimized and addressed. States must ensure that regulations do not create undue hardships and that every effort is made to ensure all providers are treated equitably. The steps that lead to either compliance or revocation of the child care license are typically as follows:

- **Probationary License:** Requires monthly visits to ensure compliance with regulations where violations are consistently cited. These violations are documented as stipulations of the Probationary License and are resolved prior to the issuance of a permanent license. Licensors ensure that providers are supported and have the necessary resources to successfully complete the six-month probationary period. In some cases, the probationary period is extended for an additional six months.
- **Revocation:** If the provider fails to successfully complete the probationary period, the license is revoked. Once revoked, the provider must cease care and relinquish the license.
- **Summary Suspension:** A summary suspension takes place when children are in imminent danger. The provider's license is suspended by the regulatory agency or by a judge, and the facility is closed immediately to ensure children's safety.

STATE CHILD CARE LICENSING AGENCIES SHOULD:

- Require training on culturally responsive licensing, balancing authority, and implicit bias for all licensing inspectors.
- Allow licensees access to the same forms inspectors use during licensing visits so that providers know what to expect and what is being monitored, and so they have the opportunity to fully comply with all rules and regulations.
- Collect disaggregated data to determine the number of adverse licensing actions by race, percentage of children receiving subsidy, language, rule violations that lead to adverse action, and zip code.
- Analyze data to determine disparities by race, language, community, and children served and to assess which rules are more likely to lead to adverse actions to determine if rule changes are necessary.

INEQUITIES IN ADVERSE LICENSING ACTIONS

Bias, Discrimination, and Cultural Disconnects: Regulators may be influenced by implicit bias, stereotypes, and racism that can negatively impact licensing inspections. Discriminatory practices can include stringent application of rules, harsh interactions with providers and personnel, and overreaching in how rules should be implemented. There may also be cultural disconnects and misalignments when the provider, staff, or director is judged through the cultural biases of the inspector.

Inadequate Resources: Providers in low-income and marginalized areas may not have access to the resources needed to address violations and make the corrections necessary to maintain their licenses. The cost of complying with licensing regulations can be steep, especially for those with a high percentage of children receiving child care subsidies.

Misunderstanding Rules and Regulations: Providers may not fully understand the intent or application of the rules due to their complex language. This may lead to increased violations, more frequent inspections, and higher penalties.

Colorado's Culturally Responsive Community Based Licensing©

IMPLEMENTED BY THE INSTITUTE FOR RACIAL EQUITY AND EXCELLENCE (IREE)[84]

Vision Statement: Culturally Responsive Community Based Licensing©, housed at The Institute for Racial Equity and Excellence (IREE), provides services to ensure the highest levels of compliance with Colorado's Rules Regulating Child Care Centers. We meet the needs of childcare providers while engaged in respectful, reciprocal, and informative interactions.

Culturally Responsive Community Based Licensing© focuses on providing licensing services that are culturally responsive using four Cs: Competence, Caring, and Compassion while ensuring Compliance.

Child care providers should use culturally responsive practices that are respectful, reciprocal, and informative (see Figure 2).

Figure 2

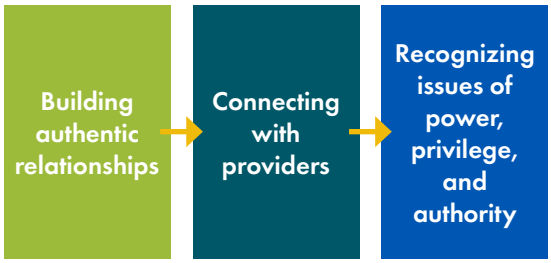
CULTURALLY RESPONSIVE PRACTICES CHILD CARE PROVIDERS SHOULD USE

This is done by building authentic relationships, connecting with providers, and recognizing issues of power, privilege, and authority (see Figure 3).

This model ensures the needs of providers, families, and children are met, while also ensuring licensing compliance. It reduces the adversarial relationship between licensors and providers that is often experienced in early childhood facilities. Moreover, this model ensures licensors are recruited from the community, with a preference for those who are culturally, linguistically, and racially matched with the providers they serve.

Figure 3

HOW CHILD CARE PROVIDERS IMPLEMENT CULTURALLY RESPONSIVE PRACTICES



Examples of culturally responsive practices include:

- All licensors engage in quarterly anti-bias and anti-racist training.
- All licensors and IREE staff have earned or are working towards a Racial Equity Certificate.
- The licensing agency holds quarterly meetings with licensors to ensure consistency in how rules are interpreted and applied.
- The licensing agency conducts quarterly peer reviews to determine reliability in inspections.

The licensing team provides the following services that are above and beyond state requirements:

- Monthly open forum/town hall meetings to discuss licensing rules, compliance issues, and consistent interpretation of rules. The agenda is determined by providers

- Providers can make an appointment with licensing specialists and the licensing director to discuss concerns, ask questions, etc.
- Quarterly webinars on current issues and for licensing updates
- Follow-up customer satisfaction calls
- Personalized information meetings with school districts
- Personalized training on rules and regulations for providers
- Bi-monthly Licensing 101 trainings to clarify rules and regulations
- Annual customer service survey to ensure the licensing team is meeting its customer service goals

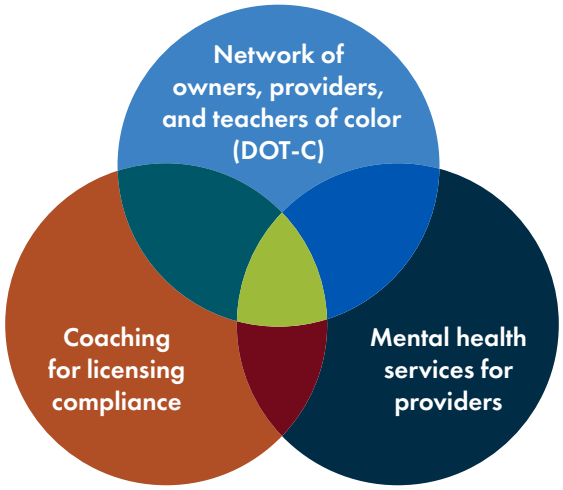
IREE's three-pronged approach addresses systemic issues impacting the early childhood workforce, especially for people from marginalized communities who have difficulty becoming and maintaining licenses, accessing tools and resources to grow in the field, and accessing mental health services to counter the effects of racial and generational trauma.

To address the systemic inequities impacting the early childhood workforce, IREE supports providers to use a three-pronged approach (see Figure 4):

- Network of owners, providers, and teachers of color
- Coaching for licensing compliance
- Mental health services for providers

Figure 4

THREE-PRONGED APPROACH TO ADDRESS SYSTEM INEQUITIES IN THE ECE WORKFORCE



SECTION III

GOVERNANCE AND COORDINATION IN STATE ECE SYSTEMS

State child care licensing should be connected to and a foundation for the broader ECE system. **Having a central entry point for all ECE providers enables a common baseline for health and safety on which to build quality services.** For example, specifying licensing as the first level of QRIS—state systems that rate ECE program quality—creates a natural integration point. This alignment is simplified if child care licensing is integrated under the same agency as ECE quality and child care subsidy programs, and ideally, broader ECE initiatives such as state-funded preschool programs and the state's Head Start Collaboration Office.

When this is not the case, it can result in a lack of coordination across agencies and fragmented standards that may not be aligned with the latest science of child development. Recently, some states have made progress in reviewing their ECE governance structures and moving in the direction of consolidating agencies that manage ECE programs (see Table 2). Of note, 61% of states have two or fewer agencies administering the three major ECE dimensions of licensing, subsidy, and quality improvement initiatives, while 51% have them all under the same agency.[85]

Table 2: ECE Governance Structures for Licensing, Quality, and Subsidies Across States

ECE Governance	Percent of States, Including D.C.	
How states house the three major ECE initiatives (licensing, quality, subsidies)	Licensing, child care subsidy, and quality together	51%
	Licensing and child care subsidy together	27.4%
	Licensing separate from child care subsidy and quality	19.6%
	Licensing and quality together	Less than 2%

Note: Table data adapted from Walsh, B., Smith, L., & Mercado, K. (2023). *Revisiting integrated efficient early care and education systems.* Bipartisan Policy Center. https://bipartisanpolicy.org/report/early-care-education-systems/.

ENHANCING QUALITY BY BUILDING ON THE LICENSING FOUNDATION

Licensing should be at the foundation of—not separate from—state quality frameworks. States should develop strategies to ensure licensees have access to resources and clear and concrete paths toward higher levels of quality.

Quality Rating and Improvement Systems

One way states can ensure alignment and continuity is by embedding licensing into their state's early childhood QRIS as the baseline first level of quality. This can contribute to a roadmap for providers to reach higher levels of quality, if desired, and can provide access to support and resources needed to ensure health, safety, and quality. Currently, 21 states take this approach with center-based care, and 20 states do so with family child care.[86] Nearly half of states require all licensed providers or all providers receiving child care subsidies to participate in the QRIS. Approximately a third of states have voluntary participation in QRIS.[87]

Wages and Compensation

Fair wages and appropriate benefits are key to retaining a qualified ECE workforce, reducing educator turnover, and ensuring that educators are well-supported and financially stable—which contributes to their own health and well-being, as well as the quality of their interactions with young children.[88]

Across the nation, the median wages of early childhood educators ranged from $11.65 to $14.67 per hour in 2019. This is near the bottom when compared to nearly every other workforce, despite ECE providers' specialized knowledge and skill and their essential role in helping parents get to work—thus boosting the economy.[89] This also means most of the ECE workforce lives below the federal poverty level, leading to economic insecurity. What's more, there are wage disparities among different populations of early childhood educators, disproportionately impacting educators of color and educators working with very young children. For example, the 2019 National Survey of Early Care and Education found that racial wage gaps exist for Black educators who were paid on average nearly one dollar less per hour than White teachers in center-based settings.[90] Hispanic ($12.94), Black ($12.18), and White educators ($13.16) also earned significantly less per hour than Asian educators ($17.16) in center-based settings.[91] Additionally, wage disparities exist depending on the age of children served, with infant and toddler teachers being paid on average nearly $2.50 less per hour than preschool teachers.[92] Though many states have made progress in improving ECE workforce wages using pandemic relief funding from 2020–2023, low wages and varying levels of working conditions have resulted in two-thirds of the nation's ECE providers experiencing a workforce shortage that leaves many working families without access to child care and inconsistent staffing—threatening the quality of early care and learning programs.[93]

Fifty-one percent of states with early childhood QRIS included standards for salary scales or benefit options for center-based ECE programs in 2020.[94] About one-fourth, or 26%, included these standards for home-based providers in 2020.[95] Even if these standards are included in the QRIS, states may still be missing specific guidelines related to the minimum wage floor for the workforce or what constitutes fair wages and benefits. Paid professional development opportunities provide dedicated time for staff to develop their skills and enhance their knowledge. It also allows time for providers to engage in critical reflection with their colleagues while staying updated on the latest research. This ensures educators can provide the highest quality care and education to young learners. Only 15 states included paid professional development opportunities as a benchmark for quality for centers in 2020;[96] worse yet, only one state (Vermont) measured paid professional development time as a quality indicator for home-based care. During paid planning and preparation time, educators can organize the materials and activities necessary to support children's optimal development and individualize instruction to children's strengths and needs. In fact in 2020, 16 states measured paid planning and preparation time as a benchmark for quality for center-based care, and eight states included home-based providers.[97]

At the most basic level, state licensing agencies should work with the state early childhood QRIS and other state early childhood agencies to ensure that all child care providers have the resources and guidance to compensate the ECE workforce fairly. This includes providing healthcare, mental healthcare, retirement, vacation, and other paid time off (including parental leave; paid training and planning time; and appropriate facilities, adequate breaks, and manageable ratios and group sizes). Additional measures

that contribute to positive, supportive working conditions can be built into the quality improvement benefits as providers progress through the levels of quality in QRIS.

Head Start and the Early Head Start-Child Care Partnerships

Head Start is a federally funded, holistic ECE program that reaches children and families in nearly every zip code across the nation. The Head Start Program Performance Standards (HSPPS) are a set of quality standards that Head Start grant recipients are required to implement and which allow for flexibility based on the strengths and needs of local communities. The uniqueness of the HSPPS when compared to other program standards is that they underscore the implementation of comprehensive services that meet young children's and their families' needs around education, health, and well-being, including child development and early learning services.

The comprehensive services approach builds on the basic foundation of health and safety measures and addresses an array of responsive practices that are particularly important for children from historically and contemporarily marginalized communities. These include requirements for lower ratios and group sizes than most state child care licensing standards and provision of bilingual and home language supports for emergent bilinguals and dual language learners. They also include full inclusion of children with disabilities, and prohibitions on expulsion and harsh discipline. First established in 2014, Early Head Start-Child Care Partnerships (EHS-CCP) pair Early Head Start programs with local licensed center-based and family child care providers to increase access to high quality infant and toddler care. The EHS-CCP model provides funding and resources to child care programs that agree to implement the holistic Head Start model. **States should explore establishing and investing in EHS-CCP and Head Start partnerships (with child care providers serving children ages three to five) as a next step in expanding access and reaching higher levels of quality beyond licensing.**

The "Building Supply, Enhancing Quality, and Advancing Equity: The Early Head Start-Child Care Partnership Series" from The Children's Equity Project, Bipartisan Policy Center, and Start Early highlights the promising work of the EHS-CCPs to date, particularly related to pandemic recovery and stabilization, and provides a roadmap for states to establish and expand their own CCPs.

Accreditation

Early childhood accreditation systems generally require providers to demonstrate that they meet comprehensive, quality standards—building upon the minimum regulations set by licensing agencies. Accreditation measures health and safety, teacher-child interactions and relationships, environmental design, curriculum and learning activities, operations and administration, and professional competencies and qualifications for staff.[98] Additionally, providers pursuing accreditation often conduct a self-study assessment through which they identify programmatic strengths and areas for improvement. They also participate in an on-site visit from the accrediting body led by someone with experience and expertise in the accreditation standards and the type of setting being accredited.[99] There are a variety of national accrediting bodies, including the National Association for the Education of Young Children (NAEYC) early learning program accreditation, National Association for Family Child Care (NAFCC) accreditation, and National Early Childhood Program Accreditation (NECPA). Approximately 43% of states with QRIS include national early learning accreditation programs as part of their QRIS system. This inclusion highlights uniformity and consistency across these states, ensuring high quality experiences for young children.[100] **States can invest in accreditation support for licensed providers as a pathway to help them reach higher levels of quality beyond licensing.**

To integrate licensing as the foundation of states' quality frameworks and move toward an aligned, efficiently managed system, states should:

- Coordinate—and to the extent possible, integrate—the state departments responsible for monitoring, technical assistance, and investigations of licensing violations and those managing child care subsidies and the state early childhood QRIS to ensure consistent, streamlined support for child care providers and clear, easy-to-navigate enrollment systems for families.
- Ensure that licensing is the foundation for the state's early childhood QRIS. For example, a state with a five-star rating system can align licensing regulations with the measures for a one-star rating as the baseline expectation for all participating child care providers.
- Coordinate monitoring and accountability efforts among agencies that manage child care licensing, child care subsidies, and QRIS; where possible and when contextually appropriate, consolidate the governance structures.

CONCLUSION

Children, families, and the early childhood workforce tasked with caring for and teaching our nation's youngest learners need and deserve healthy, secure, and supportive environments in order to thrive. Child care licensing plays a critical role in making this a reality throughout state ECE systems. Child care licensing can and should serve as the foundation of each state's quality improvement framework to protect child health, development, and well-being; give parents peace of mind that their children are safe and properly cared for in their child care setting; and support child care providers in delivering safe, formative, and developmentally-promotive care.

Of note, state licensing systems are only as useful as the content that is included in them and the processes used to ensure accountability to the licensing regulations. Too often, critical indicators that deeply impact children's experiences, health, development, safety, and well-being are left out of content, while indicators that do not directly impact children's safety or well-being, or which may be overly burdensome to providers, are centered. This mismatch creates a system with gaps in its foundation, while also being unnecessarily punitive for less important indicators. States should take the lead in transforming their licensing systems in partnership with ECE providers, families, and community partners that contribute to early childhood programming. In order to advance equity, states must address important facets like clean water, lead-free spaces, air quality, inclusion of children with disabilities, culturally responsive practices, linguistically responsive care for emergent bilinguals and dual language learners, and wages and working conditions for early childhood educators.

This report provides states with recommendations to enhance their child care licensing systems, aligning them with recent research and effective practice, across **1) licensing content, 2) licensing process,** and **3) governance and coordination in state ECE systems.** With updates and key modifications, states can improve experiences and outcomes and advance equity by reimagining their child care licensing regulations and systems to serve as the bedrock on which to build quality early care and learning.

APPENDIX A

ABBREVIATIONS

ARPA	American Rescue Plan Act
AQI	Air Quality Index
CCDBG	Child Care and Development Block Grant
CCDF	Child Care and Development Fund
CCP	Child Care Partnerships
CDA	Child Development Associate
CEP	The Children's Equity Project
CFOC	*Caring for Our Children*, 4th Edition
CFOC Basics	*Caring for Our Children Basics*
CPR	Cardiopulmonary resuscitation
D.C.	Washington, District of Columbia
DLL	Dual language learner
ECE	Early care and education
EHS-CCP	Early Head Start-Child Care Partnerships
EPA	U.S. Environmental Protection Agency
FFN	Family, friend, and neighbor
GAO	U.S. Government Accountability Office
HHS	U.S. Department of Health and Human Services
HSPPS	Head Start Program Performance Standards
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
IIJA	Infrastructure Investments and Jobs Act
IREE	The Institute for Racial Equity and Excellence
NAEYC	National Association for the Education of Young Children
NAFCC	National Association for Family Child Care
NARA	National Association for Regulatory Administration
NECPA	National Early Childhood Program Accreditation
OSHA	Occupational Safety and Health Administration
QRIS	Quality Rating and Improvement System
UDL	Universal design for learning
WIIN	Water Infrastructure for Improvements to the Nation

APPENDIX B

CARING FOR OUR CHILDREN BASICS OVERVIEW

Caring for Our Children Basics Standards		
Content Area	**Example**	**Standard**
Staffing	Ratios for centers and family child care	**Child:Adult Ratio for Centers** • ≤ 12 months: 4:1 • 13–23 months: 4:1 • 24–35 months: 4:1-6:1 • Three-year-olds: 9:1 • Four- to-five-year-olds: 10:1
Program Activities for Healthy Development	Preventing Expulsions, Suspensions, and Other Limitations in Services	Programs should have a discipline policy based on developmentally appropriate expectations for child behavior and should provide specific guidance on how teachers can respond to challenging behaviors. Practices and procedures should be communicated with staff, families, and the community without bias or discrimination. Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline. These should only be used in extraordinary circumstances based on serious safety concerns that cannot be addressed by reasonable modifications.
Healthy Promotion and Protection	Care Plan for Children with Special Health Care Needs	All adults in the ECE setting should follow American Academy of Pediatrics practices for safe sleep. Cribs must be in compliance with the U.S. Consumer Product Safety Commission and ASTM International safety standards.
Nutrition and Food Service	Available of Drinking Water	Clean, sanitary drinking water should be readily accessible in indoor and outdoor areas throughout the day. On hot days, infants receiving human milk in a bottle may be given additional human milk, and those receiving formula mixed with water may be given additional formula mixed with water. Infants should not be given water, especially in the first six months of life.
Facilities, Supplies, Equipment, and Environment Health	Environmental Audit of Site Location	The audit should include assessments of air, soil, and water contamination; hazardous or toxic materials, such as lead and asbestos; and safety hazards in the community surrounding the site. The audit should be conducted before the construction or renovation of a building, after a natural disaster, and additionally as necessary. A report should be kept on file.
Play Areas/ Playgrounds and Transportation	Inspection of Indoor and Outdoor Play Areas and Equipment	Play areas/playgrounds and transportation should be inspected daily for basic health and safety, including for rust, sharp edges, stability, visible cracks, vandalism or trash, or other hazards. These problems should be addressed before use by children.
Infectious Disease	Immunization Documentation	Programs should require that documentation of age-appropriate vaccination be provided as specified by the CDC and others.
Policies	Frequency of Inspections for Child Care Centers and Family Child Care Homes	Inspection should occur prior to licensing, and there should be no less than one unannounced inspection annually. Additional inspections should follow any violations or if the program is closed. Complaints should be investigated in a timely manner based on the severity of the complaints. Licensing inspections and complaints should be posted online by states for public review.

APPENDIX C

CARING FOR OUR CHILDREN BASICS INDICATORS

Child Care Topics	Child Care Indicators
Staffing	
Staffing	Background screening should include background check, criminal records, child abuse and neglect, licensing history, sex offenders registry, and court records. • Background screening should be completed within 45 days and should include: • A search of the state criminal and sex offender registry or repository • A search of State-based child abuse and neglect registries and databases • A Federal Bureau of Investigation fingerprint check using Next Generation Identification
Records and Report	N/A
Staff Qualification	• Lead Teacher: 21 years+; bachelor's degree OR associate's degree and working toward bachelor's; one year on-the-job training; one or more years of supervised experiences serving young children; certificate in pediatric first aid, including CPR and medication administration training • Assistant Teachers, Teacher Aides: 18 years+, high school diploma or GED, participation in on-the-job training. At least 50% of persons in these roles must have or be working toward a CDA or associates or higher degree • Volunteers: 16 years+, orientation, on-the-job training; works under supervision, not counted in child:staff ratio
Training Requirement	Training should address health and safety issues for early care and education settings, including but not limited to: typical and atypical child development; pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); poison prevention; shaken baby syndrome and abusive head trauma; standard precautions; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs.
Staff-to-Child Ratios for Child Care Centers	• ≤ 12 months: 4:1 • 13–23 months: 4:1 • Three-year-olds: 9:1 • Four- to five-year-olds: 10:1

Program Activities for Healthy Development	
Monitoring Children's Development/ Obtaining Consent for Screening	Programs should have a process in place for age-appropriate developmental and behavioral screenings for all children at the beginning of a child's enrollment in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. Providers may choose to conduct screenings themselves, partner with a local agency/health care provider/specialist who would conduct the screening, or work with parents in connecting them to resources to ensure that screening occurs. This process should consist of parental/guardian education, consent, and participation, as well as connection to resources and support, including the primary health care provider, as needed. Results of screenings should be documented in child records.
Personal Caregiver/ Teacher Relationships for Birth to Five-Year-Olds	Programs should implement relationship-based policies and program practices that promote consistency and continuity of care, especially for infants and toddlers. Early care and education programs should provide opportunities for each child to build emotionally secure relationships with a limited number of caregivers/teachers. Children with special health care needs may require additional specialists to promote health and safety and to support learning.
Methods of Supervision of Children	In center-based programs, caregivers/teachers should directly supervise children under age six by sight and sound at all times. In family child care settings, caregivers should directly supervise children by sight or sound. When children are sleeping, caregivers may supervise by sound with frequent visual checks. Developmentally appropriate child-to-staff ratios should be met during all hours of operation, and safety precautions for specific areas and equipment should be followed. Children under the age of six should never be inside or outside by themselves.
Supervision Near Water	Constant and active supervision should be maintained when any child is in or around water. During swimming and/or bathing where an infant or toddler is present, the ratio should always be one adult to one infant/toddler. During wading and/or water play activities, the supervising adult should be within an arm's length providing "touch supervision." Programs should ensure that all pools have drain covers that are used in compliance with the Virginia Graeme Baker Pool and Spa Safety Act.
Preventing Expulsions, Suspensions, and Other Limitations in Services	Programs should have a comprehensive discipline policy that includes developmentally appropriate social-emotional and behavioral health promotion practices as well as discipline and intervention procedures that provide specific guidance on what caregivers/teachers and programs should do to prevent and respond to challenging behaviors. Programs should ensure all caregivers/teachers have access to pre- and in-service training on such practices and procedures. Practices and procedures should be clearly communicated to all staff, families, and community partners, and they should be implemented consistently and without bias or discrimination. Preventive and discipline practices should be used as learning opportunities to guide children's appropriate behavioral development. Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline (including limiting services); these exclusionary measures should be used only in extraordinary circumstances where there are serious safety concerns that cannot otherwise be reduced or eliminated by the provision of reasonable modifications.

Prohibited Caregiver/ Teacher Behaviors	The following behaviors should be prohibited in all early care and education settings: • The use of corporal punishment, including but not limited to: – Hitting, spanking, shaking, slapping, twisting, pulling, squeezing, or biting – Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures – Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances – Exposing a child to extremes of temperature • Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised • Binding, tying to restrict movement, or taping the mouth • Using or withholding food or beverages as a punishment • Toilet learning/training methods that punish, demean, or humiliate a child • Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child • Any abuse or maltreatment of a child • Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family • Any form of public or private humiliation, including threats of physical punishment • Physical activity/outdoor time taken away as punishment • Placing a child in a crib for a time-out or for disciplinary reasons
Health Promotion and Protection	
Active Opportunities for Physical Activity	Programs should promote developmentally appropriate active play for all children, including infants and toddlers, every day. Children should have opportunities to engage in moderate to vigorous activities indoors and outdoors, weather permitting.
Safe Sleep Practices and SIDS Risk Reduction	All staff, parents/guardians, volunteers, and others who care for infants in the early care and education setting should follow safe sleep practices as recommended by the American Academy of Pediatrics (AAP). Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards. See Standard 5.4.5.2 for more information.
Nutrition and Food Service	
Use of U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP) Guidelines	Programs should serve nutritious and sufficient foods that meet the requirements for meals of the child care component of the USDA CACFP, as referenced in 7 CFR 226.20.
Availability of Drinking Water	Clean, sanitary drinking water should be readily accessible in indoor and outdoor areas, throughout the day. On hot days, infants receiving human milk in a bottle may be given additional human milk, and those receiving formula mixed with water may be given additional formula mixed with water. Infants should not be given water, especially in the first six months of life.

Care for Children with Food Allergies	Each child with a food allergy should have a written care plan that includes: a. a) Instructions regarding the food(s) to which the child is allergic and steps to be taken to avoid that food. b. b) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of prompt administration of any medications. The plan should include specific symptoms that would indicate the need to administer one or more medications. Based on the child's care plan and prior to caring for the child, caregivers/teachers should receive training for, demonstrate competence in, and implement measures for: • Preventing exposure to the specific food(s) to which the child is allergic • Recognizing the symptoms of an allergic reaction • Treating allergic reactions
Preparing, Feeding, and Storing Human Milk	Programs should develop and follow procedures for the preparation and storage of expressed human milk that ensures the health and safety of all infants, as outlined by the Academy of Breastfeeding Medicine Protocol #8; Revision 2010, and prohibits the use of infant formula for a breastfed infant without parental consent. The bottle or container should be properly labeled with the infant's full name and date and should only be given to the specified child. Unused breast milk should be returned to the parent in the bottle or container.
Preparing, Feeding, and Storing Infant Formula	Programs should develop and follow procedures for the preparation and storage of infant formula that ensures the health and safety of all infants. Formula provided by parents/guardians or programs should come in sealed containers. The caregiver/teacher should always follow the parent or manufacturer's instructions for mixing and storing of any formula preparation. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines. Bottles of prepared or ready-to-feed formula should be labeled with the child's full name, time, and date of preparation. Prepared formula should be discarded daily if not used.
Warming Bottles and Infant Foods	Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, or if a parent requests they be warmed, bottles should be warmed under running, warm tap water; using a commercial bottle warmer, stove top warming methods, or slow-cooking device; or by placing them in a container of warm water. Bottles should never be warmed in microwaves. Warming devices should not be accessible to children.
Foods that are Choking Hazards	Caregivers/teachers should not offer foods that are associated with young children's choking incidents to children under four years of age. Food for infants should be cut into pieces ¼ inch or smaller, food for toddlers should be cut into pieces ½ inch or smaller to prevent choking. Children should be supervised while eating in order to monitor the size of food and ensure that they are eating appropriately.
Food Preparation Area Access	Access to areas where hot food is prepared should only be permitted when children are supervised by adults who are qualified to follow sanitation and safety procedures.
Compliance with U.S. Food and Drug Administration (FDA) Food Code and State and Local Rules	The program should conform to applicable portions of the FDA Food Code and all applicable state and local food service rules and regulations for centers and family child care homes regarding safe food protection and sanitation practices.

Facilities, Supplies, Equipment, and Environmental Health	
Overall Requirements	
General Location, Layout, and Construction	Before an early care and education (ECE) space is made accessible to children, a qualified inspector should ensure compliance with applicable building and fire codes for all newly constructed, renovated, remodeled, or altered buildings. ECE programs should follow all applicable local and state requirements. The facility must be in compliance with fire code and ADA accessibility, and an assessment of the Environment at the Site Location should be conducted before construction or renovation or after a natural disaster.
Space per Child	42 square feet of usable floor space per child is required, and 50 square feet per child is preferred.
Openings	ECE spaces should: • Ensure weather and water-tightness of openings when closed • Limit exit from windows openings to less than four inches or protect them by guards that do not block outdoor light • Ensure screens are installed • Ensure glass within 36 inches of the ground has safety guards • Install finger-pinch protection • Ensure doors from a building area with more than fifty persons and exit stair enclosure doors swing in the direction of egress travel (the path for going out)
Quality of the Outdoor and Indoor Environment	
Ventilation, Heating, Cooling, and Hot Water	ECE spaces should: • Ensure access to fresh air indoors • Improve ventilation • Maintain 68°F to 75°F at thirty to fifty percent relative humidity during the winter months; a draft-free temperature of 74°F to 82°F should be maintained at thirty to fifty percent relative humidity during the summer months • Inspect and clean air conditioning and ventilation equipment before each cooling and heating season by a qualified heating, ventilation, air conditioning (HVAC) consultant • Ensure that areas where arts and crafts activities are conducted are well-ventilated • Ventilate of recently carpeted or paneled areas • Control odors in toilets, bathrooms, diaper changing areas, and other inhabited areas of the facility through ventilation and appropriate cleaning and disinfecting • Place thermometers that will not easily break and that do not contain mercury on interior walls in every indoor activity area at children's height • Avoid using unvented gas for heating purposes • Use heating safety (portable heaters, fireplaces, stoves) with appropriate safety measures in place and ensure they are not within reach of children • Ensure hot water temperature at sinks used for handwashing, or where the hot water will be in direct contact with children, is at a temperature of at least 60°F and not exceeding 120°F

Lighting	ECE spaces should: • Provide natural lighting in rooms where children work and play for more than two hours at a time. Wherever possible, windows installed at child's eye level should be provided to introduce natural lighting • Use shielded or shatterproof bulbs in light fixtures • Provide emergency and exit lighting approved by the local authority in corridors and stairwells and at building exits. Open flames should not be used as emergency lighting in early care and education programs
Noise	ECE spaces should maintain the decibel (db) level at or below 35 decibels for at least 80% of the time as measured by an acoustical engineer or, more practically, by the ability to be clearly heard and understood in a normal conversation without raising one's voice.
Electrical Fixtures and Outlets	ECE spaces should: • Ensure all electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning are a type called "tamper-resistant electrical outlets" • Install Ground Fault Circuit Interrupters (GFCIs) in areas where electrical products might come into contact with water • Discourage the use of extension cords and keep electrical cords out of children's reach

State Ratios of Children to Caregivers in Center-Based Settings

Infants and Toddlers (Center-Based)

Age Group	Number of Children per 1 Adult	Number of States + D.C.	Percent
6 weeks	3	3	6%
	4	33	66%
	5	12	24%
	6	2	4%
11 months	3	3	6%
	4	32	64%
	5	12	24%
	6	3	6%
18 months	3	1	2%
	4	11	22%
	5	14	28%
	6	15	30%
	7	5	10%
	8	2	4%
	9	2	4%

35 months	4	2	4%
	5	6	12%
	6	8	16%
	7	7	14%
	8	15	30%
	9	1	2%
	10	7	14%
	11	3	6%
	12	1	2%

Note: Idaho does not specify

State Ratios of Children to Caregivers in Center-Based Settings			
Preschool Ages 3–5 (Center-Based)			
Age Group	**Number of Children per 1 Adult**	**Number of States + D.C.**	**Percent**
3 years	6	1	2%
	7	2	4%
	8	3	6%
	9	2	5%
	10	23	46%
	12	12	24%
	13	2	4%
	14	1	2%
	15	4	8%
4 years	8	1	2%
	10	18	36%
	12	13	26%
	13	3	6%
	14	2	4%
	15	5	10%
	16	2	4%
	17	1	2%
	18	3	6%
	20	2	4%

5 years	9	1	2%
	10	6	12%
	12	7	14%
	13	1	2%
	14	4	8%
	15	13	26%
	16	2	4%
	17	1	2%
	18	3	6%
	19	1	2%
	20	7	14%
	21	1	2%
	22	1	2%
	25	2	4%

Note: Idaho does not specify

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