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American Academy of Pediatrics

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Pennsylvania Chapter

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INDEPENDENT REGULATORY REVIEW COMMISSION

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Dear Mr. Coccodrilli:

On March 10, 2008, the Department of Public Welfare submitted final-form child care facility regulations to the General Assembly and to the Independent Regulatory Review Commission (IRRC). The child care facility regulations provide minimum standards for the operation of approximately 9,000 child care centers, group child care homes and family child care homes that serve over 300,000 children. The child care facility regulations are intended to protect the health, safety and rights of children and reduce risks to children in child care facilities. The regulations were last updated in April 1992. The Department correctly notes in their comments that many changes have occurred since the last update, especially in the evidence about what is needed to protect children against significant risk.

The Pennsylvania Chapter of the American Academy of Pediatrics supports and commends the Department on updating the regulations. The changes made regarding definition of special needs, SIDS prevention, swimming, staff tuberculosis testing, reduced frequency of staff health appraisals, removal of recalled toys and equipment, inclusion of disposable gloves in the first aid kit, maximum indoor temperature, diapering, transportation, and removal of a requirement for syrup of ipecac reflect current evidence for risk control. However, some of the requirements do not correctly reflect current research findings, and some need rewording for clarity to enable providers, the public and Department staff to understand expectations for compliance. We recommend that the Department build on the good work done so far by making some additional improvements to the final-form child care regulations so that all concerned can fully benefit from their implementation.

The Pennsylvania Chapter of the American Academy of Pediatrics offers the following recommendations and rationale for further changes:

§ 3270.17, §3280.16, §3290.15. Service to a child with [a disability] special needs. We support the Department's reference to federal law and the broadening of the definition of the term "special needs" to include children with special health needs. However, further wording is needed in the regulation to address child care practice with regard to the information that the provider must collect to be able to serve a child with a special health need, and to allow provision of services on the facility premises to children with special health needs who do not qualify for an IFSP or IEP or behavioral services.

It is essential to have written plans to provide care for children with special needs in child care. As defined in these regulations, children with special needs who do not have an IFSP or IEP include children with asthma, epilepsy, diabetes and other conditions that require specific instructions from a health care professional that must be known and understood by teachers, substitutes and others who are involved in the care of the child. Unless a written plan is developed in collaboration with the child's providers of specialized health services, the health care professional cannot ensure that the recommended care is feasible in the setting in which the child is receiving care. The plans specified by the health care professional cannot be effectively communicated to child care providers solely by parents. Studies of parent compliance with medical care instructions show that many parents have difficulty implementing instructions they receive. Further, even when they have an accurate understanding of what their children require in the child care setting, they cannot be assumed to have the skills to instruct others about how to provide appropriate care. Written care plans brought by parents from the health professional to the child care provider enable communication and collaboration. This is not a theoretical problem. In a study conducted by ECELS in 2002 of 134 child care centers across the state, half to two-thirds of the children identified by directors as having asthma, seizures or other significant special needs had no written care plan or plan for management of their condition if an emergency occurred while the children were in the facility. This is a significant health and safety risk that must be addressed.

Having a written care plan that includes preparation for an emergency is a minimal requirement. Requiring that child care providers allow health care professionals to deliver services and instruct both families and other caregivers at the child care facilities should be viewed as an essential component of accommodation. For example, a child who requires long-term physical therapy because of a congenital abnormality should be able to receive therapy services at child care and to have the therapist directly instruct the family and caregivers at the child care facility.

We recommend the following modification to the regulatory language:

(a) The operator shall make reasonable accommodation to include a child with special needs in accordance with ~~the Americans With Disabilities Act of 1990 (ADA) (42 U.S.C.A. §§ 12101—12213)~~ APPLICABLE FEDERAL AND STATE LAWS. This accommodation shall include development of a written plan to provide for the child's special needs in the program, developed collaboratively with parent consent, with the child's parents and the child's providers of special services.

(b) The operator shall permit an adult individual who provides specialized services to a child with special needs to provide those services on the facility premises as specified in the child's ~~Individualized Education Program~~ IEP, ~~Individualized Family Service Plan~~ IFSP, ~~formal~~ OR WRITTEN behavioral plan or as specified in writing by a licensed physician, CRNP or physician's assistant for health and related services of a type or amount beyond that required by children generally.

§3270.27, §3280.26, §3290.24. Emergency plan. The Department incorporated into the final-form regulation the existing statement of policy at §§ 3270.21a, 3280.20a and 3290.18a (relating to emergency plan - statement of policy) requiring emergency plans that was published at 33 Pa.B 6428 (December 27, 2003) and has been in effect since June 2004. However, since 2004 the understanding of the requirements for emergency planning has become much more sophisticated as a result of repeated breeches of security at child care facilities and experience with a variety of different types of emergencies. These adverse experiences have made it clear that each facility must assess the risks specific to its locale and circumstances and include in its plan preparation for managing those risks. For example, a facility near a prison must have a plan to handle a lock-down in the event of a prison escape. All facilities should have a plan for what to do to prevent entrance of a threatening individual and what to do

to contain a threatening individual while notifying and awaiting the arrival of the police. Angry and violent parents or other individuals familiar to the staff have been admitted to child care facilities with frightening and sometimes tragic consequences. Programs located along a railroad track or major highway must plan for the possibility of a chemical spill that will require evacuation out of the neighborhood. It is not enough to require a plan to address emergencies that might require shelter in place and a vague requirement for shelter in other locations. The plan must include arrangements for local and community-wide disasters that require evacuation out of the neighborhood as well.

The required elements in the currently proposed regulation are insufficient. The regulation must include an assessment of risk which the emergency plan should then address and include a requirement for evacuation to local and out-of-the-neighborhood shelter locations.

§3270.70, §3280.70, §3290.68. Indoor temperature. We applaud the Department's adoption of 82 degrees as the maximum allowable indoor temperature. However, we urge the Department to reconsider the opposition to regulating control of humidity as a matter of environmental health with some more valid information about what would be required. Humidity in the indoor environment is easily measured with inexpensive devices that can be purchased in hardware stores, usually costing less than $10. The Department argues than none of the neighboring states consider humidity in their regulations. This does not mitigate the health problem caused by unhealthful humidity. We doubt that many of the regulators would willingly spend long days in facilities where the temperature may be as high as 82 degrees F. and the humidity is above 50%. Also, such conditions support mold growth. Similarly, when humidity is below 30% in the winter, the air dries mucus membranes of the nose and throat, making people more susceptible to infectious disease.

§3270.102(c), §3280.102(c) and §3290.102(c). Condition of play equipment; §3270.233, §3280.215, and §3290.212. Play surfaces. The Department wisely referenced the Consumer Product Safety Commission (CPSC) playground standards for surfacing. However, the wording related to embedded outdoor equipment was carried over from the 1992 regulation without regard for the intended protection of surfacing under equipment from which children can fall. The CPSC playground standards do not limit the surfacing requirements to embedded equipment or equipment that is outdoors. They state that the only equipment to which surfacing recommendations do not apply is equipment that requires the child to be standing or sitting at ground level during play. It is the fall height that determines the need for surfacing, not the location of the equipment indoors or outdoors, or the embedding or surface placement of the equipment. The Department states that 90% of the programs have embedded equipment. However, many programs also use surface placed climbers that put children at heights which require impact absorbing material to prevent significant injury. The determinant of impact absorbing surfacing is not embedded mounting or location of the equipment, but height above the surface from which the child can fall. This requirement should apply to all equipment that children may use to climb, wherever it is located and however it is stabilized. The issue is climbing and falling. We recommend the following wording:

(c) [delete Outdoor e] Equipment that children may use to climb above the surface [delete requires embedded mounting] [shall] must be mounted over [at least 6 inches of loose-filled, impact-absorbing materials,] a loose-fill or unitary playground protective surface covering that meets the recommendations of the United States Consumer Product Safety Commission. The equipment must be anchored firmly and be in good repair.

§3270.104, §3280.108. Furniture. The Department has introduced new wording to address the need for furniture to be suitable for children with special needs. However, this regulatory revision does

not correct the intrinsic problem with the vague nature of the requirement which leaves the user to define what measure will be used to determine that furniture is "durable, safe, easily cleaned, and appropriate for the child's size, age and special needs." We recommend that the requirement include a reference to how these criteria will be determined.

An example of such wording is: "When there are concerns about the appropriateness of furniture, appropriateness will be determined by national standards or recommendations of consultants approved as sources of expert technical assistance in the field by the Department."

§3270.106, §3280.106, §3290.105. Rest equipment. We commend the Department for the regulatory language on sleep position and adding language at §§ 3270.106(j), 3280.105(J) and 3290.105(j) (relating to rest equipment) to prohibit toys, bumper pads and pillows in a crib while an infant is sleeping in the crib. This is consistent with recommendations of the American Academy of Pediatrics and the National Institutes of Child Health and Development. National studies have found an increased incidence of infant deaths in child care settings given the proportion of time infants spend in child care. Many of these deaths occurred when infants were put to sleep prone and when they were put to sleep in places not intended for infant sleeping. SIDS risk is significantly increased when infants are put to sleep on soft bedding, couches, bean bags and other places not intended as infant sleep equipment. The excellent wording about crib safety will be ineffective without a requirement that infants sleep in cribs or comparable infant sleep equipment.

To make these requirements effective in prevention of SIDS, we urge the Department to add wording that says: "Infants shall be put to sleep in rest equipment labeled by the manufacturer as intended for infant sleeping."

We also remind the Department that a 3 foot separation between rest equipment has been shown to reduce the risk of spread of infection between sleeping children. In ***Caring for Our Children*** Standard 5.144 which says, in part: "...Cribs, cots, sleeping bags, beds, mats, or pads shall be placed at least 3 feet apart, unless screens separate them. If screens are provided, arrangements shall permit the staff to observe and have immediate access to each child...." The rationale for the standard includes the explanation for the 3 foot separation: "... Because respiratory infections are transmitted by large droplets of respiratory secretions, a minimum distance of 3 feet should be maintained between cots, cribs, sleeping bags, beds, mats, or pads used for resting or sleeping. Maintaining a 3-foot distance between cots in military barracks limits the transmission of group A streptococcal (GAS) infections (ref 48). It is reasonable to assume that this spacing will reduce the likelihood of transmission of other respiratory disease agents spread by large droplets and will be effective in controlling the spread of infectious disease in the child care environment. A space of 3 feet between cribs, cots, sleeping bags, beds, mats, or pads also will provide access by the staff to a child in case of emergency..." Similar findings about the essential distance for spacing between cribs have been documented in hospital nurseries. Since military barracks house adolescents and the residents of hospital nurseries are babies, this finding of necessary spacing to prevent droplet transmission between individuals who are lying down seems to cover a broad age range. Facilities may use screens to separate the children, if the screens should prevent air flow that would permit the transmission of respiratory infections by large droplets. The space taken by a cot or crib and three feet on one side and one end of rest equipment does not consume the required 40 square feet per child of floor area that the regulations require. Placement of rest equipment during rest periods can use cupboards, shelves, other furniture and equipment as separations between children with storage of the rest equipment elsewhere (e.g. stacking cots) at other times. For cribs, it is unusual for all the babies to be napping at the same time, so the spacing needs to be accomplished for the occupied cribs only. We recommend that the Department modify the existing wording as follows:

"(f) At least [2] 3 feet of space is required on three sides of a bed, cot, crib or other rest equipment when the equipment is in use."

§3270.113, §3280.113, §3290.113. Supervision of children. The revised wording greatly reduces risk and supports the development of socio-emotional health by requiring supervision of children at all times on the premises and during excursions, with each staff person assigned to supervise specific children whose names and whereabouts that staff person must know and with whom the staff person must be physically present, with maintenance of staff to child ratios at all times. However, as proposed by the Department, the (probably unintended) meaning of (e) in this requirement precludes the use of gates or doors to restrict children from leaving a child care area which is part of or connected with another area in a facility, or to restrict child access to a hazard such as a stairwell. Gates and doors enclose children in a confined space that defines the child care area for a group, and are required barriers to separate one group of children from other groups or preventing them from entering areas which are unsafe. We recommend amending the wording as follows:

"(e) A facility person may not restrain a child by using bonds, ties or straps to restrict a child's movement or by enclosing the child in a confined space, closet or locked room except for the use of barriers that meet national safety standards to contain children within the child care area approved by the Department for the child's group or to restrict the child's access to hazards. The prohibition against restraining a child does not apply to the use of adaptive equipment prescribed for a child with special needs."

§3270.122, §3280.122, §3290.122. Admission interview, §3270.124, §3280.124, §3290.124. Emergency contact information We applaud the addition of the requirements for children with special needs, but suggest modified wording related to a requirement for the development of a special care plan for such children in 3270.131 and for information needed in an emergency in 3270.124. There must be a plan developed collaboratively for how to meet the child's needs if an emergency occurs in the child care setting of any type, including evacuation or a health care emergency for the child, and what information that the child care provider must have available for emergency medical service professionals who might be called to respond to an emergency for the child with a special need. The EMS system recognizes the critical nature of having such information in written form both to provide care on site and to carry with the child to the Emergency Department to render appropriate care. A written care plan for a child with a special need should include these elements (routine and emergency care plans) and should be used as an orienting tool for staff and substitutes. It is important to engage the thinking of all those involved with the child in the development of such a plan before the child begins to receive service in the program and for those children who develop a special need while enrolled. We recommend amending the proposed wording as follows:

"3270.124 (5) Information on the [disability of the child] child's special needs, how these needs are routinely addressed and how the routines must be adjusted in an emergency situation, as well as information that must be available to emergency medical service providers, as specified by the child's parent [or], physician, physician's assistant or CRNP, and developed in collaboration with the child's parent and caregivers. ~~which is needed in an emergency situation.~~"

§3270.131, §3280.131, §3290.131 Health information We commend the Department for attempting to reduce the burden on child care providers for ensuring that children in their care have received recommended preventive health care services. Unfortunately, education settings remain the

safety net for children who, for a variety of reasons, have not received the health care they need to be healthy and ready to learn. In Pennsylvania, the expansion of CHIP has removed much of the insurance barrier to receiving preventive health care. Under-insured children are eligible for CHIP which pays for care that meets AAP recommendations. The Department's claims about long waiting periods for check up visits are not confirmed by physicians who practice across the state, unless the family has a very restricted schedule of availability for appointments.

We challenge the Department to substantiate the claims of long waits for well care and unaffordable co-pays in Pennsylvania. The Pennsylvania Chapter of the American Academy of Pediatrics has been working with insurers and with the Rendell administration to provide access to preventive services for children with considerable success. However, there is ample evidence that for many families, even those who can easily afford co-pays, obtaining preventive health care for children becomes a priority when school participation requires it. Note that form completion charges are usually applied when parents do not ask to have forms completed at the time of the check-up, requiring that the child's chart must be retrieved and the office staff perform a record review that is more time-consuming than completing the form at the time of the visit. The modest fees charged in such situations are legitimate payment for a service rendered when the parent does not bring the form to the check up visit.

We appreciate the Department's amended language that recognizes the relationship between the services and findings that are the result of routine preventive health care and the well being of children in child care. We urge the Department to continue to advocate for the well being of children by requiring that child care providers ensure that enrolled children receive nationally recommended preventive health care services.

Some further amended language is needed. We do not believe that the Department expects that child care providers will provide "treatment" for children with special health needs. However, child care providers do need a plan to manage the special health needs of the child while in child care. This plan should include information about actions required for routine care as well as information required in the event of an emergency that involves the child.

The Department is to be commended for requiring the report of abnormal results of sensory screening and lead testing. However, a requirement for anemia testing which is done at the same time and more universally than blood lead tests was omitted from the list of screening tests for which abnormal results are to be reported. The medical literature is clear about the adverse impact of anemia on cognitive and socio-emotional development. Anemia screening is a simple and inexpensive test usually done at 12 months of age by a finger stick or from the same blood draw if a blood lead test is being done as the lead screening test. (For lead, pre-screening for the need for a blood lead test may be done by taking a history of exposure to environmental risk for lead.) While a child who is found to be anemic is being treated, caregivers may provide opportunities to encourage the child to eat iron-rich foods.

The request for a statement from a health professional that a child is free of communicable disease and able to participate in child care is an archaic concept. A child may have a cold during a health assessment and would not then be free of communicable disease, but that would be of no consequence to the child care provider. A statement that a child is able to participate in child care presumes that the health professional knows enough about the program that the child care provider offers to make such a judgment. This is unlikely to be the case in most instances and so the need for a statement creates unnecessary paperwork. What the health professional can do is to assess and report the health status of the child, and make recommendations for the care that the child requires in the child care setting.

The addition of the statement from the health professional that the child has received age-appropriate screenings recommended by the American Academy of Pediatrics is a nice reminder to practitioners to

check the schedule in an effort to free the child care provider from the burden of understanding the schedule. We support this approach. The national consensus for the schedule of services in well child care was updated and published as the Recommendations for Preventive Pediatric Health Care in *Pediatrics*, December 2007. This updated set of recommendations represents a consensus by the American Academy of Pediatrics and the federal Maternal and Child Health Bureau, HRSA, HHS in *Bright Futures*. It is the first major update in the schedule in over a decade, and addresses the concerns about holistic child health that impact on life-time potential. We recommend that the Department use this opportunity to make the language of the regulation consistent with current preventive health care concepts. Summarizing these concerns, the following wording changes should be made:

"Health information. (d) The health report shall include relevant findings to child care and follow-up care needed as a result of the following:

(1) A review of the child's health history
(2) The evaluation of the child using measurements of growth, indicators of obesity and blood pressure
(3) The child's age-appropriate hearing, vision, lead, and anemia screening
(4) The child's developmental/behavior assessment
(5) The child's physical examination
(6) Assessment of the child's oral health
(7) An assessment of any acute or chronic health problem or special need with recommendations for care, specific actions or services required related to the special health need, including information pertinent to an emergency
(8) A review of the child's immunized status according to recommendations of the ACIP

The health report shall include a statement that age-appropriate routine preventive health care recommended by the American Academy of Pediatrics has been provided."

§3270.133, §3280.133, §3290.133. Child medication and special diets. We agree with the Department that medication training is not necessary for all staff. However such training is necessary for those staff persons who perform medication administration in the child care setting so that they do so safely and correctly. Giving medications in a group care setting presents special risks. We are aware of reports of a medication-associated death and inadvertent serious medication errors that occurred in child care in the past few years. The possibility of giving the wrong medication to the wrong child exists. The caregiver cannot be expected to rely on parents to instruct them on medication administration since ample evidence exists in the medical literature that often parents do not give medication correctly themselves. Even if parents know how to administer medication, they cannot be expected to have the skills to teach others how to administer medication or to know the safeguards and documentation requirements that must be followed in a group care setting which are not applicable when medication is given only at home. Any of the other skilled individuals mentioned in the Department's response might give medication, but if the child care staff do so, they should be trained to receive, store and return the medication safely, give the right medication, in the correct dose, using the appropriate method, to the right child in the group, at the right time and document the administration appropriately.

The 'wait and see' approach proposed by The Department puts young children at significant risk. We recommend the Department require training of those who give medication in child care as some other states have done, and as the Department requires in facilities covered by the 3800 regulations. The Department's plan to monitor the number of children in care who need medication during the day does

not justify postponing adopting a medication administration training requirement for those who administer medication. In 2001-02, the Pennsylvania Chapter of the American Academy of Pediatrics conducted a federally-funded study of child care centers across the southern half of the state in which 95% of center directors reported that medication is administered by some staff in the center. What further evidence does the Department require of significant risk from this frequently performed practice?

In closing, The Pennsylvania Chapter of the American Academy of Pediatrics has been a partner of the Department in the development of child care regulations for more than thirty years. We have experienced and contributed to the development of new evidence that informs the revision of the requirements. Our comments recognize the long process of the regulation development. We applaud the progress made in understanding protection that children in child care require against significant risk. We continue to offer our help to continue to work with the Department so that these regulations can be appropriately modified, adopted and implemented as effective safeguards for Pennsylvania's most important resource, our children.

Sincerely,

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cc: House Children and Youth Committee

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