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October 18, 2006

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INDEPENDENT REGULATORY REVIEW COMMISSION

Mr. Alvin C. Bush
Chairman
Independent Regulatory Review Commission
333 Market Street
14th Floor
Harrisburg, PA 17101

Dear Mr. Bush:

RE: Regulation ID No. 14-506 (#2539)

Thank you for the opportunity to comment on the Final Form Regulation #14-506 Child Care Facilities, Department of Public Welfare (Chapters 3270, 3280, and 3290).

ECELS supports and commends the Department on the changes to the proposed regulations in the following areas: Emergency Plan Requirements, Condition of Play Equipment (reference to CPSC Recommendations), First Aid Kit Items, Rest Equipment and Infant Sleep Position, Diapering Requirements, and Staff Health Assessment. The Department's revisions in these areas will help promote health of children and staff and reduce harm to children.

ECELS has the following comments/concerns/suggestions for the proposed regulations below:

§3270.17, 3280.16, 3290.15 Service to a Child with Special Needs

The revisions to this regulation are well done related to definitions of children with special needs and informing families when staff have reason to believe that the child has a health, behavioral or developmental problem, as well as referring them to sources of service.

However, adults who provide service to children with chronic health conditions should also be allowed to provide those services at the child care facility. The proposed regulatory change references an IEP or IFSP which exists if the child has a developmental delay. The early intervention system does not usually become involved or provide an IEP or IFSP if a child has a chronic health condition that is not associated with a developmental delay. Thus, the requirement as currently stated does not address a child who requires prolonged physical therapy for an injury but who is not developmentally delayed, respiratory treatment for a child with a chronic condition such as bronchopulmonary dysplasia from prematurity, or assistance for blood sugar management of a diabetic child. Any of these conditions might require direct services from nurses or therapists in the child care setting and instruction/oversight of

management from health professionals for child care staff providing care for such children. Such children would not be qualified by an IEP or IFSP, but would require services that a health professional would prescribe. Here is suggested wording:

(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 program plan as defined in § 3270.119 (relating to program plan).~~ , or as specified in writing by a licensed physician, physician's assistant or CRNP for health and related services of a type or amount beyond that required by children generally.

§ 3270.70, 3280.70, 3290.68 Indoor Temperature

The Department could use the heat index as provided by sources of local weather advisories. This information is available to the provider by community broadcasts on radio and TV. The Department's rejection of this suggestion was based on the cost of humidity measuring tools. Local hardware stores carry humidity reading devices for less than $5, which would give facility humidity readings that could be adjusted to maintain healthful 30-50% levels by using air conditioning or fans in summer, and the addition of water to the air when heating dries the air out in winter.

§ 3270.82 Toilet Areas

§ 3270.113 Supervision of Children requires children on facility premises and on facility excursions off the premises shall be supervised by a staff person at all times. While supervision is implicit in § 3270.82, removing the reminder reference about supervision by physical presence of an adult with the young child who must use a toilet on a different floor may put children at risk. We recommend keeping the statement, "If the toilet area is not on the same floor as the child care space, an adult shall accompany toddler and preschool children going to and from the toilet area."

§ 3270.102 Condition of Play Equipment

The proposed language in this regulation does not address the entire risk of injury and harm to children. The concern is falls to the surface, not just situations where the facility has climbing equipment that requires embedded mounting or is found outside. ECELS recommends changing the wording to, "***Any*** equipment (outdoors or indoors) that could be used by children for climbing to an elevation above the surface shall have under and around the structure 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.

In the Final Form Preamble, page 9 states, "Each child day care center and GDCH must certify that no hazardous equipment is on the premises. The Department will provide a certification form for this purpose. The form will take no more than 10 minutes for the facility to complete." ECELS is concerned about the purpose and scope of this hazard evaluation, as well as the frequency of its use, and its intent to protect children and staff. A thorough evaluation of the facility for hazardous equipment would take longer than 10 minutes to check off the belief of the provider that no risks are present. Risk management would include not only what equipment on the premises is potentially hazardous, but how is it used and who is permitted to use it. Staff could and should evaluate the premises for hazardous equipment. More importantly, what is done if hazardous equipment is observed? ***ECELS recommends***

changing the word "certify," to the phrase "evaluate and take corrective action to ensure that no hazardous equipment is on the premises." Certification of the playground area as safe requires a technically trained individual known as a Certified Playground Safety Inspector (CPSI) who inspects for hazards that might include not only the equipment, but also the layout of the equipment, surfacing under it and the intended users. Requiring CPSI inspections would be a great step forward in risk reduction, but the Department has not proposed this measure.

§ 3270.131 (a)-(d), 3280.131(a)-(d) and 3290.131(a)-(d) Health Information.

The Department's changes to this regulation will significantly reduce the safeguards for young children's health and readiness to learn. The regulation wording no longer requires documentation of routine preventive health care. It requires only that if screenings were done, that abnormal results are reported. This presumes that each child will receive age-appropriate screenings for which results will be available. Having to complete the form that documents the results of each age-appropriate screening test as normal or abnormal helps to make sure that these screenings occur. The regulation is additionally flawed by omitting from the list of required reporting the results of anemia and growth screenings. This is unwise for a program that is responsible for the care of young children, since anemia is directly tied to developmental delay and obesity in children is epidemic.

Physicians currently document weight and height data required for Body Mass Index (BMI) on the CY51- Child Health Assessment as an indicator of obesity awareness and prevention to share with the child care provider. Without this documentation from the Child Health Assessment, there is a key void of information that contradicts the PA Governor's Office obesity prevention efforts through BMI tracking.

Children with undetected conditions due to failure to obtain these screening tests are at risk. This young, vulnerable population of early childhood program participants needs early detection services, but often misses the screenings due to missed appointments, lack of cooperation by the child with the procedures at a check-up visit, or because the health provider overlooks them when other matters seem more pressing. Children should not wait until they reach school age for the screenings to be done.

As stated in our June 29, 2006 comments, removing the requirement for a child health assessment is not consistent with national Head Start Performance Standards that guide performance of PA Head Start programs and PA NAEYC Accredited/STAR 4 programs. The discrepancy in requirements between child (day) care and PA Head Start programs and PA NAEYC Accredited/STAR 4 programs would not give children and families the same level of protection in making sure children are healthy and ready to learn. The burden imposed on providers to document up-to-date status with recommended preventive care protects children from harm and impairs the child's ability to learn and develop normally. To help reduce this burden, the PA AAP has worked over many years with the Department to achieve the now-available low-cost ($1.50/child/year) Internet application that allows providers to track up-to-date status with a one-time 2-4 minutes of data entry per child. PA DOH already requires that center-based providers give the DOH manual documentation of immunization doses – documentation that the Internet application prints out automatically and accurately, saving considerable personnel time for providers. By removing the requirement for documentation of up-to-date preventive care including ***screening*** services, the Department is denying children in DPW- certified early childhood programs protection from significant harm.

Here is suggested wording:

(d) The health report shall include the following information:

(1) A review of the child's [previous] health history.

(2) [The results of a physical examination] A list of the child's allergies.

(3) [An assessment of the child's growth patterns] An assessment of the child's growth and risk for obesity

A list of the child's current medication and the reason for the medication.

(4) [The physician's or CRNP's] An assessment of [a disability or a] an acute or chronic health problem or special need and recommendations for treatment or services, INCLUDING INFORMATION REGARDING [NORMAL OR ABNORMAL] RESULTS OF SCREENING TESTS FOR VISION, HEARING, ANEMIA AND [OR] LEAD POISONING.

The requirement for a statement that "age-appropriate screenings recommended by the American Academy of Pediatrics were conducted since the time of the previous health report," conflicts with the required frequency of the health report proposed by the Department. The timing of screenings is tied to the well-child visits according to the American Academy of Pediatrics schedule. For example, the parent of an 18-month old toddler who had a well-child visit at 12 months, doesn't have to provide any documentation of the 15-month old visit when an anemia screening would have been done for a child at risk. The parent would not be required to bring any documentation to the child care center staff until the child is 18 months of age. For a 15 month old toddler with anemia, three valuable months have passed in which the child's health professional could offer information to the child care center staff about how to meet the special nutritional needs of this child while he is in care.

The Department's argument about lack of insurance is not persuasive in a state in which all children can be covered by private or public subsidized insurance. The concern about waiting for appointments is addressed by the 60 day waiting period after enrollment before the requirement must be met. We challenge the state to document the locations and numbers of families in the state who experience routine waiting times for well-child appointments that exceed two months so that public health authorities can take action to remedy such shortages. Insurance may not pay for all services, although most of PA health insurance does cover preventive care. However, where insurance does not cover preventive health care, parents must provide the protection their children require. Doing so is a recognized responsibility of parents to provide for the needs of their children.

Families may still be faced with paying minimal fees for requesting documentation of a child's visit to meet DPW requirements if the request is made after the actual visit. Such charges cover the health professional's cost of retrieving and summarizing the chart as a separate service. Form completion is most efficiently accomplished at the time of the preventive care visit, but it requires work effort for which compensation may justifiably be expected.

3270.131(e), 3280.131(e) and 3290.131(e). Health information.

Consistent language in these regulations with those of the Department of Health is a good change. The Department should plan to work with the PA DOH to ensure that compliance is achieved. At present, PA DOH collects data on immunization doses to report to the CDC on the level of compliance, but does not give feedback to the child care provider who submits these data to PA DOH about children who are not up-to-date with needed vaccines, either as guidance or enforcement of their regulation.

§ 3270.133, 3280.133 and 3290.133. Child medication and special diets

The Department's rationale for refusal to require medication administration training is not persuasive. Medication administration training is currently available to providers through the Pennsylvania Keys to Professional Development system, but very few request it, in spite of data gathered by the PA AAP in a statewide survey of providers that indicated 95% of providers report giving medication. This high level of involvement in medication administration is the reality despite the fact that child care is provided for only a portion of the day, and that some medication schedules might be adjusted to not include the hours a child is in care. Staff persons do need specialized training or instruction in administration. Reported deaths and injury from medication errors in child care are a reminder that staff need training they may not realize is necessary. The well-known problems that occur in child care include giving the wrong medication to the wrong child in the wrong dose, at the wrong time, or by the wrong route. Studies of medication errors that parents commit precludes reliance on parents as instructors for medication administration. Even when they know how to administer medication themselves, parents cannot be assumed to have the skills to teach child care staff or to address the risks of medication errors in group settings. Requiring training in medication administration from a medical professional who works with the child or another qualified health professional is a safeguard that other states are adopting in their regulations (e.g. Delaware, New Jersey, Connecticut.) ***How has/will The Department monitor medication administration in child care facilities to determine whether it is necessary to require medication administration training for facility staff persons?*** The data are already available to justify a requirement for training of staff in medication administration.

RE: Regulation ID No. 14-505 (#2549) Chapter 168, Child Care

It is essential that all children in the Commonwealth are protected from health and safety risks while in group child care settings. Regardless of the type of facility they attend, non-profit or for-profit, PA children and families deserve this protection. No group child care setting should be exempt from the regulations.

Sincerely,

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