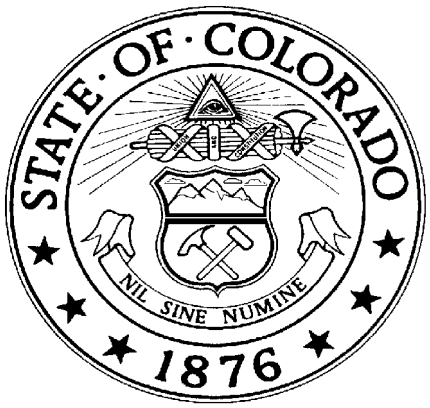

REPORT OF

THE

STATE AUDITOR

CHILD CARE LICENSING
DEPARTMENT OF HUMAN SERVICES

PERFORMANCE AUDIT
AUGUST 1998

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STATE OF COLORADO

J. DAVID BARBA, CPA
State Auditor

OFFICE OF THE STATE AUDITOR
(303) 866-2051
FAX (303) 866-2060

Legislative Services Building
200 East 14th Avenue
Denver, Colorado 80203-2211

August 20, 1998

Members of the Legislative Audit Committee:

This report contains the results of the performance audit of child care licensing in the State of Colorado. The audit was conducted pursuant to Section 26-6-107 (1.5), C.R.S., which requires the State Auditor to conduct a performance review of the risk-based approach to monitoring and inspecting child care facilities. This report presents our findings, conclusions, and recommendations, and the responses of the Child Care and Child Welfare Divisions and the Department of Human Services.

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OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

J. DAVID BARBA, CPA
State Auditor

CHILD CARE LICENSING
PERFORMANCE AUDIT
August 1998

Authority, Purpose, and Scope

This audit was conducted under the authority of Section 26-6-107 (1.5), C.R.S., which requires the State Auditor to conduct a performance review of the risk-based approach to monitoring and inspecting child care facilities by December 1, 1998. We conducted the audit according to generally accepted government auditing standards. Our procedures included reviewing documentation, interviewing staff at the Child Care Division and other state agencies, and analyzing data. Audit work was performed between January 1998 and August 1998.

The purpose of this audit was to evaluate the risk-based approach to inspections and to follow up on the recommendations made during the 1995 performance audit of the Division. This report contains findings and 19 recommendations for improving the operations of child care licensing in the State. We acknowledge and appreciate the cooperation and assistance provided by the staff at the Child Care and Child Welfare Divisions, the Colorado Bureau of Investigation, and the Judicial Department. The following summary provides highlights of the audit comments and recommendations.

Risk-Based Inspections of Licensed Facilities

As part of our audit, we reviewed the progress made by the Division in adopting a risk-based approach to inspecting licensed child care facilities. We found that the Division has made progress in implementing a risk-based approach. Specifically, in response to the statutory mandate, the Division has identified critical indicators for inspections, assigned risk factors to about 8,200 facilities, and developed automated systems for scheduling inspections. We also noted that improvements could be made. These include:

- Refining criteria used to determine which facilities present the greatest risk. Currently the Division is primarily using length of time a facility has been open, rather than the statutorily required mandate to focus its inspections on those facilities that "have been found to be the subject of complaints or to be out of compliance with standards."

- Ensuring that all facilities have a risk factor assigned. We found that 758 licensed facilities did not have a risk factor assigned and consequently were not in the inspection pool.

- Tracking completed inspections by risk factor. The Division has not developed a system to collect, analyze, and use data on the facilities to predict which facilities present the greatest risk.

- Improving the timeliness of inspections. Of the 721 facilities in our sample assigned to higher-risk categories, 187 were at least three months past due for an inspection.

We recommend that the Division take steps to improve its management of the risk-based inspection approach by evaluating and refining criteria, ensuring all facilities are assigned a risk factor, designing an approach to evaluate the predictive value of the core indicator checklists, and analyzing providers in each risk category to ensure that only those with high risks are assigned to categories needing frequent inspections. The Division agrees with our recommendations. Its complete responses can be found in Chapter 1.

Complaints and Investigations

We reviewed the Division's procedures for following up on complaints and investigating licensing issues related to allegations of institutional abuse and neglect (Stage II investigations). We identified several areas for improvements. These include:

- Refining complaint severity levels. We found that 5 of the 25 complaints in our sample were assigned an incorrect severity level. All five should have been assigned a higher level, which would have resulted in quicker follow-up.

- Improving the timeliness of follow-up on complaints. We found that the Division did not investigate 10 of the 25 complaints in our sample within its own mandated time requirements. Division management does not hold its staff accountable for compliance with the complaint investigation time frames. The Division does not comply with the state statute requiring annual staff performance evaluations.

- Establishing formal time requirements for Stage II investigations. Currently the Division cannot ensure that serious allegations are investigated promptly.

We recommend that the Division take steps to improve its management of follow-up on complaints and Stage II investigations. It should identify ambiguities and overlaps in the complaint severity levels and make appropriate adjustments, require that all staff receive annual performance evaluations, and develop and enforce time standards for Stage II investigations. The Division agrees with our recommendations. Its complete responses can be found in Chapter 2.

Enforcement of Child Care Standards

We reviewed the Division's policies and procedures for enforcing child care standards. We found that the Division needs to improve many aspects of its enforcement activities. These include:

- Ensuring that staff follow up on violations. We found that the Division's records did not reflect any follow-up on serious violations found at 29 of 58 facilities with licensing violations that we reviewed. The Division has not developed written policies and procedures for follow-up on violations. Additionally, it has not designated time limits for providers to correct problems.

- Taking appropriate negative licensing action when needed. We found the Division does not always take appropriate negative licensing action on substantiated problems related to serious allegations of institutional abuse and neglect.

We recommend that the Division take steps to improve its enforcement activities. It should establish policies, procedures, and time frames for complaint follow-up and develop comprehensive Stage II investigation guidelines. Decisions not to conduct a Stage II investigation should be reviewed. The Division agrees with our recommendations. Its complete responses can be found in Chapter 3.

Licensing Issues

We reviewed the Division's licensing activities and found that improvements are needed. These include:

- Obtaining more complete criminal history data. We found that the criminal record screening process done by the Colorado Bureau of Investigation (CBI) does not provide the Division with information on all applications or providers who have been convicted of serious crimes. We matched records of individuals who had been processed for child care by the CBI with conviction records in the Judicial Department's Integrated Colorado On-line Network (ICON) system. We found that CBI did not have arrest records for 20 individuals who had been convicted of serious crimes, including child abuse.

- Analyzing its licensing fees annually as required by statute. The Division does not have a systematic process for setting, monitoring, and revising child care licensing fees or tracking all direct and indirect costs associated with child care inspections.

We recommend that the Division take steps to improve its licensing activities. It should work with the Judicial and Public Safety Departments to ensure that it receives complete information on individuals convicted of serious crimes and comply with the statutory requirement to develop and implement an objective and systematic approach for setting, monitoring, and revising child care

licensing fees. The Division agrees with our recommendations. Its complete responses can be found in Chapter 4.

Management Issues

In 1988 and 1995 we conducted performance audits of the Division. Many of the problems we identified in these two audits are still major issues today, including backlogs of inspections, handling of complaints, oversight of counties, criminal background checks, data tracking and analysis, incomplete licensee files, financial management, and staff procedures.

We recommend that the Division take immediate action to begin solving these key regulatory issues. Specifically, it should develop an implementation plan which ensures that problems identified in this report are addressed. The plan should include key review dates and identify staff accountable for ensuring that improvements are made. The Division agrees with our recommendation. Its complete response can be found in Chapter 5.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	17	Evaluate the current criteria for assignment of risk factors to facilities; identify and assess the risks for facilities that have been licensed less than one year; and assign the highest risk factors based on complaints and problems identified through on-site visits.	Child Care Division	Agree.	Within 6 months of full implementation of the Children, Youth & Families (CYF) system
2	19	Use oversight by another regulatory agency as a criterion in assigning risk factors.	Child Care Division	Agree.	June 1999
3	20	Identify pending applications and facilities that have not been assigned a risk factor, implement controls to ensure that all facilities are assigned a risk factor, and develop core indicator checklists for the 24-hour facilities.	Child Care Division	Agree.	December 1999
4	21	Identify and track the number of inspections by risk factor and report results of analysis as part of budget narrative by October 1999; design an approach to evaluate the predictive value of the core indicator checklists.	Child Care Division	Agree.	October 1, 1999 for report, and within six months of full implementation of CYF for evaluation approach.
5	24	Analyze the providers in each risk category and assign only those with high risks to the categories needing frequent inspections; consider expanding the risk-based model to include four-year inspection schedules for very low-risk providers; develop guidelines for staff to use to ensure that priority is given to high-risk facilities; and provide training on risk factors and criteria to licensing staff.	Child Care Division	Agree.	Six months following full implementation of CYF for first two parts and June 1, 1999, for third and fourth parts.
6	25	Investigate the cause of the missing data fields for the 30 facilities, and implement controls to ensure that all facilities have complete records for inspection scheduling.	Child Care Division	Agree.	June 1, 1999

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
7	27	Require that the new Children, Youth, and Families system include the capability to track risk factors and inspection dates; require regular monitoring of risk-factor changes; and require that changes to risk factors be documented in the file, including reasons for changes.	Child Care Division	Agree.	December 1999
8	32	Evaluate the severity level descriptions in the *Complaint Investigation Guidelines* for overlaps and ambiguities and make adjustments; develop a more detailed description of each severity level; and provide additional training to the complaint intake workers.	Child Care Division	Agree.	June 1, 1999
9	35	Require performance evaluations be completed for those staff not reviewed in 1997, and take appropriate disciplinary actions as required by statute for those supervisors who have not evaluated subordinate staff in over one year.	Department of Human Services	Agree.	January 1, 1999
10	38	Propose statutory changes to the Child Care Licensing Act that would restrict alcohol use during child care hours and allow the Division to take negative licensing action if alcohol is used during child care hours.	Child Care Division	Agree.	December 1999
11	41	Develop time standards for completing Stage II investigations; incorporate those standards in the Stage II Coordinator's follow-up procedures; monitor system files to ensure all required data are included; and train Division staff on the standards.	Child Care Division	Agree.	December 1999
12	42	Identify consistency issues and training needs for counties. Provide regular training to counties on abuse and neglect investigations for less-than-24-hour facilities.	Division of Child Welfare	Agree.	December 1999

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
13	43	Require supervisory review of data entry into the Complaint Tracking System, and require licensing staff to complete investigation forms and data entry staff to return incomplete investigation forms to licensing staff.	Child Care Division	Agree.	January 1, 1999
14	47	Establish written policies, procedures, and time frames for appropriate follow-up for both Division staff and child care providers. Ensure that there is follow-up on all founded violations.	Child Care Division	Agree.	June 1, 1999
15	50	Develop comprehensive guidelines for conducting Stage II investigations; establish procedures to review decisions not to conduct Stage II investigations and final Stage II reports; and review the Stage II reports for the last year that were not included in our sample.	Child Care Division	Agree.	July 1, 1999
16	52	Issue regulations regarding violations and fining authority or propose statutory change.	Child Care Division	Agree.	December 1999
17	55	Work with the Judicial and Public Safety Departments to ensure that complete information on individuals convicted of serious crimes is received; access the new Criminal Justice Information System to obtain criminal history information on applicants and child care providers; follow up on the 20 individuals already identified as being convicted of serious crimes.	Child Care Division	Agree.	December 1999

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
18	58	Develop and implement an objective, systematic approach for setting, monitoring, and revising child care licensing fees; track all direct and indirect costs associated with child care inspection and fees; reassess costs and fees annually; and report the results to the State Board of Human Services annually.	Child Care Division	Agree.	June 1, 1999
19	62	Improve regulation of child care in Colorado by ensuring that the Child Care Division develops a comprehensive plan to address implementation of the recommendations in this report.	Department of Human Services	Agree.	Fall 1999

Description of Colorado Child Care Licensing

Overview of the Division's Responsibilities

The Department of Human Services has the statutory responsibility for regulating child care in Colorado. The Department has delegated its responsibility to the Child Care Division in the Office of Children, Youth, and Families. The mission of the Division is "to promote quality, accessible and affordable child care services for Colorado families" through:

- **Regulation of providers.** The Division licenses and monitors child care facilities in the State. These include day facilities such as child care homes and centers, preschool and school-age child care programs, and summer camps; and 24-hour facilities such as residential child care facilities, child placement agencies, secure residential treatment facilities, and day treatment centers. The Division also contracts with seven counties (Archuleta, Delta, Denver, El Paso, Jefferson, Summit, and Weld) to monitor day care homes and centers in their jurisdictions.

- **Colorado Child Assistance Program (CCAP).** The Division establishes policy and procedures, trains county department staff, and supervises implementation of the CCAP. CCAP provides financial assistance for child care to low-income families who are working or are in training, are transitioning off welfare, or need child care to avoid public assistance. CCAP is administered through county departments of social services.

- **Expansion of child care services.** Under the federal Child Care and Development Block Fund (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, PL 104-193) and other federal child care resources, the Division provides grants and contracts to local communities and organizations to expand child care services.

The Division's Fiscal Year 1998 child care services appropriation was about $62 million and 42 FTE. About $58 million of the appropriation supports CCAP. The other $4 million supports child care services, such as regulation of providers; information resource, and referral programs; start-up and/or enhancement of early

childhood development and before-and-after school child care programs; and child care provider training. As shown in the following table, these services were funded by General, Cash, and Federal Funds in Fiscal Years 1995 - 1998.

Source of Appropriated Funds Child Care Services				
Description	**1995**	**1996**	**1997**	**1998**
General	$944,627	$901,914	$969,253	$1,105,486
Cash Funds[a]	$309,500	$316,865	$330,328	$329,889
Federal	$2,490,380	$2,522,276	$2,560,332	$2,572,449
Total	$3,744,507	$3,741,055	$3,859,913	$4,007,824

Source: The 1995-1998 General Appropriations Bills.
a. These amounts are from child care licensing fees

Regulatory Oversight

Regulation is not intended to guarantee the quality of child care. As stated in the Child Care Licensing Act, the "the general assembly finds that regulation and licensing of child care facilities contribute to a safe and healthy environment for children." The Division's regulatory oversight consists of four major functions:

- **Inspections** include periodic, routine on-site visits to help ensure child care facilities meet state standards and comply with regulations. Our review of inspections is discussed in Chapter 1.

- **Investigations** include complaint follow-up and investigations of licensing issues related to institutional abuse and neglect allegations. Our review of complaints and investigations is discussed in Chapter 2.

- **Enforcement** includes activities designed to ensure violations of state standards are corrected and sanctions are imposed. Sanctions are penalties imposed when a provider does not comply with state standards. Penalties include fines and negative licensing actions (downgrade, suspension, or revocation of licenses). Our review of enforcement activities is discussed in Chapter 3.

- **Licensing** includes screening potential providers, assessing fees, and setting standards. The Division screens child care licensee applicants to determine suitability. Licensees must meet certain requirements, such as certification in first aid, safety, and cardiopulmonary resuscitation (CPR). Standards specify

the minimum level of care that licensees must provide. Our review of licensing is discussed in Chapter 4.

As of July 1998 the Division's records showed that there were 8,988 child care facilities which it oversees. The following chart shows the number of facilities by type of facility:

Division of Child Care Licensed Facilities	
Facility Type S Day Care	**Number of Facilities**
Day Care Center	1,160
Day Care Home	5,870
Infant Toddler Home	114
Large Day Care Home	75
Preschool	563
Resident Camp	121
School-Age Child Care Center	739
Subtotal Day Care Facilities	8,642
Facility Type S 24-Hour	**Number of Facilities**
Child Placement Agency	108
Child Placement Group Center	23
Child Placement Group Home	17
Day Treatment Center	53
Family Foster Home	8
Residential Child Care Center	103
Secure Residential Treatment Center	7
Specialized Group Center	6
Specialized Group Home	21
Subtotal 24-hour Facilities	346
Total S All Facilities	8,988

Source: Office of the State Auditor analysis of Child Care Division data, August 1998.

Risk-Based Inspections of Licensed Facilities

Chapter 1

Background

In our 1995 performance audit of the Child Care Division, we found that the Division had not carried out all its regulatory functions because it was understaffed for its workload. As a result, the Division had been unable to inspect child care facilities every two years as required. It had not inspected many facilities for up to four years. We recommended that the Division evaluate several options for regulatory oversight of child care facilities to fit its existing resources. The alternatives ranged from eliminating licensing to reducing oversight for some types of facilities. (These alternatives are summarized in Appendix A.) The Division selected the risk-based inspection alternative and presented its proposal to the General Assembly in October 1995.

The General Assembly passed House Bill 96-1006, which allowed the Division to use a risk-based approach for inspections. Because the Division has limited resources, the General Assembly directed it to concentrate its efforts on high-risk facilities. The legislative declaration of House Bill 96-1006 states:

> . . . In balancing the needs of children and their families with the needs of the child care industry, the general assembly also recognizes the financial demands with which the department of human services is faced in its attempt to ensure a safe and sanitary environment for those children of the state of Colorado who are in child care facilities. In an effort to reduce the risk to children outside their homes while recognizing the financial constraints placed upon the department, it is the intent of the general assembly that the limited resources available be focused primarily on those child care facilities that have demonstrated that children in their care may be at higher risk. . . .

The revised statute also requires that inspections focus on facilities that:

> . . . have been found to be the subject of complaints or to be out of compliance with the standards . . . and the rules of the department or that otherwise appear to be placing children at risk.

Thus, under the risk-based inspection alternative, the Division is supposed to prioritize inspections to work first with facilities with a poor compliance history to help them meet standards. These types of facilities are to be inspected more frequently than those in full compliance with statutes and regulations.

The Division Has Made Progress in Implementing the Risk-Based Model

We reviewed the Division's progress in implementing the risk-based inspection model. We found that the Division has made progress in implementing the risk-based approach. For example, the Division has:

- **Identified critical indicators for inspections.** Working with the Child Care Licensing Advisory Committee, the Division chose indicators that it believes distinguish between providers who typically comply with rules and those who have difficulty following standards. For example, one critical indicator under "Discipline" is "corporal or other harsh punishment is not allowed." A provider who follows standards would ensure that physical punishment was never used, while a problem provider might resort to physical punishment.

- **Developed critical indicator checklists**. The Division drafted initial risk-based inspection checklists for day care facilities in July 1996. The checklists were revised several times before the final versions were completed on February 1, 1998. Licensing specialists use critical indicator checklists to evaluate facilities during inspections.

- **Assigned risk factors to 8,230 facilities as of July 31, 1998**. In conjunction with the Child Care Licensing Advisory Committee, the Division developed criteria for assigning facilities to one of seven risk categories. Assignment criteria include the length of time that a facility has been open, the number and seriousness of substantiated complaint investigations, and the number and seriousness of licensing violations documented during inspections.

  The Division began assigning risk factors in the spring of 1996 and refined the assessments during the remainder of that year. The Division initially used the risk-based criteria for assignment of risk factors to less-than-24-hour (day care) facilities. Because the 24-hour facilities were inspected annually, the

Division assigned them a risk factor equivalent to a one-year inspection. The Division has decided to include the 24-hour facilities in the model and intends to change the risk factors as inspections are completed over the next year.

The following table shows the risk factors, review periods, and the number of facilities for each factor.

Facilities Risk Factor Assignment		
Risk Factor	**Review Period**	**Number of Facilities**
A	Monthly	15
B	Every 6 months	194
C	Every 12 months	786
D	Every 18 months	163
E	Every 24 months	5,548
F	Every 30 months	677
G	Every 36 months	847
Total		8,230

Source: **Office of the State Auditor analysis of Child Care Division data, as of August 1998.**
Note: **309 of the facilities are 24-hour centers (e.g., residential treatment centers); the other 7,921 are day care facilities. Appendix B summarizes the breakdown by facility type.**

- **Developed a "tickler report" to help licensing staff schedule visits.** The automated licensing database system generates a monthly report to notify licensing staff which facilities need to be inspected within the next 30 days and which facilities are past due for an inspection.

The risk-based approach for inspections is a dynamic model for regulation of child care facilities. As such, it requires continual evaluation and refinement. For example, risk factors need to be reviewed periodically to determine if they are reasonable predictors of problem facilities. Additionally, inspections need to be matched to available staff resources. Through our review we identified the following areas in which improvements to the current risk-based approach are needed. Specifically, the Division needs to improve its:

- Identification of risk factors.
- Assignment of risk factors to facilities.
- Focus on high-risk facilities.
- Process used to adjust risk factors and inspection schedules.

Improvements Are Needed in the Identification of Risk Factors

According to Section 26-6-107(1)(b), C.R.S., **the Division is to focus its inspections on those licensed facilities that "have been found to be the subject of complaints or to be out of compliance with the standards . . . and the rules of the department or that otherwise appear to be placing children at risk."** However, as shown in the table below, two ("B" and "C") of the Division's three highest risk factors primarily reflect the length of time facilities have been licensed. Although some facilities assigned a risk factor of "B" may have received complaints, most are new facilities that have not yet met all required standards (e.g., fences). Categories B and C require inspections every 6 or 12 months, or more frequently than those required for facilities that have been open 1 to 5 years and have had complaints.

Frequency of Inspections Based on Assigned Risk Factors and License Type

Type of License	Type of Provider	Risk Factor Assigned	Frequency of Inspections
Probationary	Used for negative licensing actions.	A	Monthly
Provisional	Used for new facilities who still have areas to bring into compliance (such as fencing the play area).	B	6 months
Permanent	Used for facilities under one year of licensure.	C	12 months
Permanent	Used for facilities open 1 to 5 years with some complaints.	D	18 months
Permanent	Used for facilities open 1 to 5 years with minor, unsubstantiated, or old complaints.	E	24 months
Permanent	Used for facilities open 5 to 10 years with minor, unsubstantiated, or old complaints.	F	30 months
Permanent	Used for facilities open 10 years or more with no complaints or facilities that are nationally accredited.	G	36 months

Source: Office of the State Auditor analysis of Child Care Division data, March 1998.

The Division Should Reevaluate Its Risk-Factor Criteria

According to management, the Division assigns risk factors to facilities based on criteria that include the length of time the provider has been licensed and the number, frequency, and seriousness of:

- Founded and unfounded complaints.
- Violations identified during on-site inspections.
- Substantiated and unsubstantiated allegations of abuse and neglect.

The Division has not analyzed data gathered through inspections to identify which types of complaints, violations, and allegations of abuse and neglect present the greatest risks. Division management told us that new facilities are given a high-risk factor as a preventive measure to help ensure that any problems are caught early. However, the Division has not analyzed data on new facilities to determine if they have more problems than facilities that have been licensed for over a year.

The Division should evaluate the risk-factor criteria to ensure that staff resources are being allocated to facilities that have high risk of noncompliance with minimum health and safety standards. It should also determine if facilities that have been licensed for less than one year are at higher risk than those that have been licensed longer. Risk factors assigned to new facilities could be based on the number and seriousness of licensing violations found during the first licensing visit, rather than just on the fact that they are new facilities.

Recommendation No. 1:

The Child Care Division should improve the effectiveness and accuracy of the risk-based approach by

a. Evaluating its current criteria for assignment of risk factors to facilities.

b. Identifying and assessing the risks for facilities that have been licensed less than one year.

c. Assigning the highest risk factors based on complaints and problems identified through on-site visits.

Child Care Division's Response:

Agree. The Division will reevaluate its current criteria for assignment of risk factors and identify and assess the risks for first-year facilities. Until the State's Children, Youth, and Families (CYF) system is operational, the Division has no method of generating statistically accurate historical reports about the risk-based system that are not labor-intensive. However, it has included in its requirements for CYF that this function be available. The Division currently assigns risk factors based on complaints and problems identified through on-site visits.

The draft of the criteria for the risk-based system was completed in June 1995. The risk-based system was implemented in June 1996 following extensive review and ongoing revisions and approval by the Child Care Licensing Advisory Committee.

Oversight by Other Regulators Should Be Included as Criteria

From our sample of 5,924 facilities, we identified 1,107 (19 percent) that currently have risk factors requiring inspections every 18 months to 30 months and that also may have oversight from other regulators. However, the Division has not formally included oversight by other regulatory agencies as part of its risk-factor criteria. Agencies providing additional oversight include:

- Department of Education (DOE) for the Colorado Preschool Program and some child care centers. DOE reviews the educational programs and ensures that teachers are certified. In addition, the preschool program has ratio and room size requirements. DOE and Child Care Licensing have cross-trained staff so that DOE staff are aware of licensing issues.

- Division of Youth Corrections for Secure Residential Treatment Centers. The Division of Youth Corrections performs annual inspections of facilities which include the following areas:

  - Program/policy development

  - Educational services

  - Adequate documentation

- Medical/psychiatric services
- Facility and maintenance
- Food services

Division staff told us that when they are behind on inspections, they will delay an inspection for a provider that has oversight from another agency. Staff believe that although the other regulatory agencies do not conduct identical types of inspections, the additional oversight reduces the risk of noncompliance and provides an additional way that potential problems can be identified.

Recommendation No. 2:

The Child Care Division should improve the efficiency of the risk-based approach by using oversight by another regulatory agency as a criterion in assigning risk factors.

Child Care Division's Response:

Agree. The Division currently considers oversight by other regulatory agencies in its assignment of risk factors. It will develop an action plan and protocols for this component of the risk-based system.

Some Facilities Have Not Been Assigned Risk Factors

Our analysis of the Division's data shows that there are 758 facilities that do not have a risk factor assigned. The Division has agreed to investigate the data. The Division was not aware that these facilities did not have a risk factor assigned and was unable to explain the reasons for this large discrepancy. One possible explanation is that these are pending applications.

For the most part, the Division has limited its risk-based approach for inspections to family day care homes, child care centers, and school-age child care centers. As discussed previously, the Division did not initially include the 24-hour facilities in the risk-based model. Although it has made preliminary risk-factor assignments to 309 of the 346 facilities, it has not developed standardized checklists for inspecting these facilities. Currently it inspects each of the 24-hour facilities annually.

In May 1998, Division management reported that it expects that all 24-hour facilities will be assigned a risk factor as inspections are completed over the course of the next 12 months. However, because the Division has not developed critical indicator checklists for the 24-hour facilities, it cannot be assured that the inspections are sufficient or consistent among licensing staff. The Division needs to take steps to improve the effectiveness, efficiency, and consistency of its inspections of 24-hour facilities.

The Division should develop controls to ensure that all facilities are assigned risk factors at the time of licensure. In addition, the Division should expand the use of critical indicator checklists to 24-hour facilities.

Recommendation No. 3:

The Child Care Division should improve the effectiveness and consistency of inspections and ensure that all facilities are inspected according to the risk-based approach by:

a. Developing a process to identify applications that are pending and identifying the 758 facilities that have not been assigned a risk factor to determine if they are pending applications or licensed facilities that should be assigned a risk factor.

b. Implementing controls to ensure that all facilities are assigned a risk factor at the time of licensure.

c. Developing core indicator checklists for the 24-hour facilities.

Child Care Division's Response:

Agree. The Division will develop an initial version of core indicator checklists for 24-hour facilities. The development of such checklists is a complex process, as different types of facilities require different indicators and these need to be validated, reviewed, and revised.

The Division will identify the facilities that have not been assigned a risk factor to determine if they are pending applications or licensed facilities that should be assigned a risk factor. It will also implement controls to ensure that all facilities are assigned a risk factor at the time of licensure.

The Division Should Improve Its Collection and Analysis of Data

The Division does not track the number of completed inspections by risk factor. The Division's lack of data regarding the number of inspections by risk factor and the fact that some facilities may not have been assigned a risk factor indicate significant problems with its implementation of a risk-based approach. These issues have prevented the Division from realizing one of the major benefits of a risk-based approach S reallocation of staff resources to oversight of high-risk facilities to increase compliance with the State's child care facility standards.

In our 1995 audit we recommended that the Division develop a system to collect, analyze, and use data from the core indicator checklists to evaluate the effectiveness of the risk-based approach for inspections. The Division has not yet done so. As a result, it does not know if the checklists are useful in identifying high-risk facilities.

The Division needs to take immediate action to improve its implementation of the risk-based approach. It should identify the number of inspections it does annually by risk factor and report the results to the Joint Budget Committee through the performance narrative of the budget request by October 1999. It should also design a system to evaluate the predictive value of the core indicator checklists.

Recommendation No. 4:

The Child Care Division should improve implementation of the risk-based approach for facility monitoring by:

a. Identifying and tracking the number of inspections it does by risk factor and reporting the results to the Joint Budget Committee through the performance narrative of the budget request by October 1999.

b. Designing and implementing an approach to evaluate the predictive value of the core indicator checklists in identifying high-risk facilities.

Child Care Division's Response:

Agree. The Division will develop a system to identify and track by risk factor the number of inspections it does and to collect, analyze, and use information gathered from the core indicator checklists. Currently the Division does not collect such data because it is operating with a number of outdated systems

that do not interface with each other. The functions currently tracked by these separate systems will be integrated into the CYF system, which will provide accurate and consistent statistics. However, the Division will manually track the number of inspections by risk factor and report the results to the Joint Budget Committee through the performance narrative of the budget request by October 1, 1999.

Inspections Have Not Been Timely for Some High-Risk Facilities

Although the Division has made progress in implementing a risk-based approach, it has not been able to completely focus its staff resources on those facilities with poor compliance records. As discussed previously, the Division was unable to provide information showing the number of inspections done in 1997 by category of license and risk factor assigned. Thus, management has not been able to tell if the Division's resources are concentrating on the high-risk facilities as required by statute.

Our analysis of inspections for our sample of 5,924 of the facilities that had been assigned a risk factor showed that 1,288 facilities were at least one month past due for an inspection. Under the risk-based approach, inspections for the facilities assigned the highest-risk factors (A through C) should be current. However, we found that 239 (33 percent) of the 721 facilities assigned to the highest-risk categories were at least one month past due for an inspection. Furthermore, 187 of these 239 high-risk facilities were at least three months past due for an inspection. On average, inspections were between 10 and 19 months past due for these 187 facilities. The following table shows the number of facilities by each risk category that are past due for an inspection.

Facilities by Risk Factor Past Due for Inspection					
Risk Factor	**Review Period**	**1 Month Past Due**	**2 Months Past Due**	**3 Months Past Due**	**Totals**
A	Monthly	6	3	5	14
B	6 Months	5	2	10	17
C	12 Months	22	14	172	208
D	18 Months	1	2	16	19
E	24 Months	74	28	704	806
F	30 Months	10	10	100	120
G	36 Months	6	5	93	104
Totals		124	64	1,100	1,288

Source: **Office of the State Auditor analysis of Child Care Division inspection data, March 1998.**
Note: **The timeliness of inspections was based on the last inspection date, regardless of whether the inspection occurred before or after the assignment of a risk factor.**

If inspections are not completed timely, neither the Division nor the public has assurance that child care facilities are in compliance with state requirements. The Division has no other way to determine whether a facility's performance has slipped below levels that are safe for children.

Frequent monitoring and inspection of child care facilities help ensure compliance with state standards. The Children's Defense Fund, a nationally recognized child advocacy organization, reports that if child care regulations are to help protect children, it is essential that state licensing inspectors periodically visit child care programs to ensure the programs are complying with state requirements and to detect any real or potential problems.

Improvements Could Allow the Division to Prioritize High-Risk Facilities

As discussed in Recommendation No. 4, the Division has not collected or analyzed data needed to evaluate the effectiveness of the risk-based approach. The Division could better focus on high-risk providers by analyzing the providers in each risk category. The Division has placed 14 percent of facilities in risk categories requiring inspections more frequently than every two years. About 19 percent of the facilities

are to be inspected at intervals greater than two years. The majority of facilities, 67 percent, are still on a two-year inspection schedule. The risk-based model has not moved many facilities to a longer inspection interval. Providers in low-risk categories should not be assigned factors that require frequent inspections. The Division should also consider adopting a risk factor that allows for inspections every four years for very low-risk providers (as the Division suggested in its October 1995 proposal to the General Assembly for the risk-based model); develop guidelines for staff to use to ensure inspections are prioritized and completed according to risk; and ensure that staff are fully trained on the risk-based model. By taking these actions, the Division can concentrate on high-risk facilities as envisioned by the General Assembly.

Recommendation No. 5:

The Child Care Division should improve the timeliness of inspections and concentrate on high-risk providers by:

a. Analyzing the providers in each risk category and assigning only those with high risks to the categories needing frequent inspections.

b. Considering expanding the risk-based model to include four-year inspection schedules for very low-risk providers based on available resources.

c. Developing guidelines for staff to use to ensure that priority is given to high-risk facilities.

d. Providing additional training on risk factors and criteria to licensing staff.

Child Care Division's Response:

Agree. The Division will continue to assign only those with high risks to the categories needing frequent inspections and will develop protocol for monitoring staff to ensure that priority is given to high-risk facilities. It will provide licensing specialists with additional training on risk factors and criteria. This will be completed by June 1, 1999.

Six months following full implementation of the CYF system, which will provide statistical data on risk-based codes, the Division will analyze providers in each risk category and following analysis of caseloads, resources, and numbers of facilities in each risk category, consider expanding the risk-based model to include four-year inspection schedules for very low-risk providers.

Inspections Are Not Always Scheduled According to the Risk-Based Model

We found that the Division's automated licensing database system does not always notify licensing specialists when inspections should be done. The Division's system requires that data be entered into the risk factor and last inspection date fields. Our tests showed that the system requires that these fields be entered in specified formats. However, we found that 24 in our sample of 5,924 facilities did not have a last inspection date in the system. Additionally, we identified another six facilities in the database that did not have a risk factor assigned. The Division recognizes that this is a computer error and does not know how it occurred. Without these data the system will not notify licensing specialists when the next inspection should be scheduled.

The Division needs to improve its processing controls to ensure that the system produces accurate information. It should investigate the reasons for the missing data fields and correct the problem. It should ensure that risk factors and last inspection dates are present on the system for all facilities.

Recommendation No. 6:

The Child Care Division should improve controls over the risk-based approach by investigating the cause of the missing data fields for the 30 facilities and implementing controls to ensure that all facilities have complete records for inspection scheduling.

Child Care Division's Response:

Agree. The Division will investigate the cause of the missing data fields for the 30 facilities and will implement controls to ensure that facilities have complete records for inspection scheduling. Missing inspection or risk-factor data were reported on 30 facilities out of a sample of 5,924. This number represents .005 of the sample.

A Process for Adjusting Risk Factors and Inspection Schedules Is Needed

The Division is unable to track changes made by licensing staff to facility risk factors or to inspection dates within its current Child Welfare Eligibility and Services Tracking system (CWEST). Licensing specialists can make these types of changes without supervisory approval. The automated system does not track changes made to either of these fields. Supervisors do not review the changes, and licensing specialists are not required to document why changes to the risk factors were made. Therefore, we could not determine the number of risk factors that had been changed, what the changes were, or if the changes were based on the Division's criteria.

We compared the last inspection date from CWEST with inspection reports in facility files for 30 providers in the imaging system (LOLA). The Division developed LOLA in 1996 to provide easy, on-line access to licensee information by parents, other members of the public, and its staff. The information in LOLA has, for the most part, replaced all hard-copy licensee files. We found discrepancies between CWEST and provider files for half of those reviewed; specifically:

- Inspection reports for the date listed on CWEST were not on file for 15 of the 30 providers.

- No inspection reports were on file for 10 of these 15 providers, 4 had an inspection report in file that was older than the last date of inspection, and 1 had a report of inspection that was more recent than the inspection date on CWEST.

Division management could not locate documentation for the missing ten reports or explain why the reports were missing and dates were inconsistent. As a result of the incorrect data, the public, especially parents, cannot rely on the data in LOLA to provide complete and accurate information regarding inspections of facilities. Parents may make decisions regarding potential child care providers based on inaccurate and incomplete information. Division management cannot be sure that inspections are being completed as reported. Additionally, the Division's risk-based criteria require a licensing specialist to review the number and seriousness of licensing violations found during on-site inspections. If this information is not on file, the licensing specialist will make an assessment of the risk-factor assignment based on incomplete or outdated information.

The Division needs to ensure that inspections are completed as reported. The Division should improve the information provided to the public by ensuring that the

new Children, Youth, and Family system, currently being developed, includes controls to track changes made to the risk-factor and last inspection date fields, by including regular monitoring of risk-factor changes, and by requiring an appropriate level of documentation in provider files.

Recommendation No. 7:

The Child Care Division should improve tracking of provider histories and information provided to the public by:

a. Requiring that the new Children, Youth, and Families system include historical tracking of the risk factors and inspection dates, including when changes are made and who made the changes.

b. Requiring regular monitoring of risk-factor changes.

c. Specifying that changes to risk factors be documented, including reasons for changes.

Child Care Division's Response:

Agree. The Division has already included in its requirements for the new CYF system that it include historical tracking of risk factors and inspection dates, including why and when changes are made and who made the changes. The Division will establish monitoring requirements and a review process to improve tracking of provider histories and protocol for including this information in the file.

Complaints and Investigations

Chapter 2

Background

In addition to regular inspections, an important part of the Division's regulatory oversight includes following up on complaints and investigating licensing issues related to allegations of institutional abuse and neglect. We found that the Division needs to make improvements in these areas.

Complaint Handling Needs Improvement

The Division receives complaints on child care facilities from a variety of sources, including parents, facility staff, county social services offices, and the public. Complaints are made about various problems, including inappropriate ratios (number of adults to children), harsh treatment of children, lack of supervision of children, and other health and safety issues. In Calendar Year 1997 the Division received 773 complaints and completed investigations on 688 of them. As of May 1998, the Division's automated complaint system did not have a closure date for 85 of these 773 complaints. The Division could not determine if investigations of these complaints had been completed. Due to problems with the Division's previous complaint system, comparative data on complaints for years prior to 1997 are unavailable.

When a complaint is reported to the Division, an intake worker enters the information into the Complaint Tracking System and assigns a severity level. Severity levels range from "Very Serious" (Level 1) to "Very Mild" (Level 5). After the severity level is assigned, the complaint is forwarded to a licensing specialist who investigates the allegations. The investigation must be started within the time limits established for the severity level assigned to the complaint as shown in the following table.

Severity Levels for Complaints	
Severity Level	**Time Limits for Investigation**
1 - Very Serious	Report to police or Protective Services within 24 hours
2 - Serious	0 - 5 business days
3 - Moderate	0 - 15 business days
4 - Mild	0 - 20 business days
5 - Very Mild	Next reasonable visit
Source: ***Complaint Investigation Guidelines for Child Care Facilities*****, Child Care Division.**	

The licensing specialist documents the results of the inspection. Depending on the seriousness of the violations found, the licensing specialist may require the facility to make corrections or recommend that the Division take negative licensing action, as discussed in Chapter 3. The provider must sign the inspection report and agree to make any required corrections within the time specified by the licensing specialist. Verification of corrective actions can be done by reinspection or by allowing the provider to send a letter indicating that all corrections have been made. Follow-up with providers is also discussed in Chapter 3. The inspection report becomes part of the permanent licensee file. Licensing specialists are supposed to use the number and seriousness of the violations to determine if the risk factor is appropriate or should be changed.

After the investigation has been completed, the licensing specialist also fills out a complaint investigation form which details the steps taken and whether the complaint was founded or other violations were discovered. These forms are then given to the Division's data entry staff to be entered into the Complaint Tracking System.

We reviewed the Division's complaint handling. We found the Division does not assign some complaints appropriate severity levels, staff do not investigate all complaints within mandated time requirements, and management does not hold staff accountable for complying with the complaint guidelines. In addition, the Division has not fully addressed the issue of providers using alcohol when children are present. Finally, information is not always correctly entered into the Division's Complaint Tracking System. These problems are discussed below.

Some Complaints Are Assigned Incorrect Severity Levels

As discussed above, a complaint is assigned a severity level based on the seriousness and type of allegation made. We found that 5 of the complaints in our sample of 25 were assigned severity levels lower than they should have been. Specifically:

- Four should have been assigned a "Serious" level but were assigned a "Moderate" level. For example, one complaint was about an unlicensed provider who was caring for more small children than the regulations allow, and there were allegations of abuse. Division management agrees with our assessment that all four of these complaints would warrant assigning a severity level of "Serious."

- The other complaint was assigned a "Mild" severity level but should have been assigned a "Moderate" level. The complaint alleged a baby was found with a pebble in its mouth, the facility had inadequate number of staff and unsanitary equipment, and staff did not attend to crying children. According to Division criteria, these allegations would warrant assigning a severity level of "Moderate." However, Division management believes that this problem should not have been handled as a complaint but as an investigation of licensing issues related to abuse or neglect. After receiving the complaint, the Division learned that the county was conducting a child abuse investigation on this complaint. The Division does not assign complaint severity levels to allegations of abuse or neglect.

An incorrect severity level for a complaint may result in a delayed investigation. The more serious the allegations, the sooner the investigation should be started. Children may be at greater risk if a complaint is assigned a severity level lower than it should be.

Severity Level Descriptions Should Be Improved

The Division's severity level descriptions in its *Complaint Guidelines* are ambiguous and overlap. The Division's complaint intake workers use the guidelines to assign a severity level to new complaints. In some situations, particularly for staff-to-children ratio violations, the intake workers may have difficulty determining of which level a particular complaint should be classified. The problems generally exist between "Serious," "Moderate," and "Mild" severity levels as described in the following table.

Description of Complaint Severity Levels	
Severity Level	**Description**
2 - Serious	1. Gross violation of ratios (double the number of children for what ratio should be) 2. Children abandoned, left or wandering away from the facility 3. Serious physical injury 4. Caring for infants or toddlers without a license 5. Negative licensing in process for similar allegations 6. Unlicensed care with other allegations that would indicate a threat to the safety of the children (children unsupervised, large numbers of children, filthy conditions) 7. Failing to obtain emergency medical care for a child
3 - Moderate	1. Ratio violations 2. Inadequate numbers of staff 3. Unqualified staff 4. Inappropriate discipline, including rough handling or yelling at children 5. Inadequate or unsafe equipment 6. Facility dirty or unsanitary to the level of being a health hazard 7. Unsafe transportation of children; too many children in a vehicle 8. Over-enrollment
4 - Mild	1. Children not getting enough or adequate food 2. Children not getting an adequate rest period 3. Crying child(ren) not attended to 4. Parents not notified of injury to child 5. Staff checks bouncing 6. Unlicensed care
Source:	***Complaint Investigation Guidelines for Child Care Facilities,* Child Care Division.**

During the course of this audit, Division management indicated it is aware that the *Complaint Guidelines* need improvement and is currently in the process of revising them. As part of this improvement effort, the Division should redefine the severity level descriptions to eliminate the overlap and ambiguities and to ensure the descriptions are appropriate. The Division should also provide more examples to the complaint intake workers of the types of problems that should be included under each level. It should also provide additional training to the intake workers on how to assign the severity levels.

Recommendation No. 8:

The Child Care Division should improve its accuracy in assigning severity levels by:

a. Evaluating the severity level descriptions in the *Complaint Investigation Guidelines for Child Care Facilities* and identifying overlaps and ambiguities and making adjustments where necessary.

b. Developing a more detailed description of each severity level and providing staff with examples of complaints that would fall under each category.

c. Providing additional training to the complaint intake workers on how to assign the severity levels.

Child Care Division's Response:

Agree. The Division will evaluate the severity level descriptions in the *Complaint Investigation Guidelines for Child Care Facilities,* identify overlaps and ambiguities, and make adjustments where necessary. It will develop a more detailed description of each severity level and provide staff with examples of complaints that would fall under each category. The Division will provide additional training to the complaint intake workers on how to assign the severity levels.

The Division Should Improve the Timeliness of Complaint Investigations

As discussed above, the Division's complaint investigation guidelines specify the number of business days required to begin investigating a complaint. All complaints, except those designated as "Very Mild," must have an investigation started within a maximum of 20 business days. The Division does not have criteria specifying time frames for finishing investigations and submitting documentation.

We found that 10 of the 25 complaints in our sample were not investigated within the Division's own mandated time requirements. Delays ranged from 1 to 161 days more than the mandated time requirements for starting investigations. As shown in the following table, all 10 involved risks to the health and safety of children.

Complaints in Sample That Were Not Investigated Timely

	Complaint	Severity Level	Mandated Time Frame for Investigation (business days)	Actual Time to Investigate (business days)	Results of Investigation
1	Ratio: not specified	Moderate	0 - 15	22	Founded; center voluntarily closed.
2	Ratio: 19 - 25 toddlers with one staff	Serious	0 - 5	17	Unfounded.
3	Parents not notified of three injuries to child	Moderate	0 - 15	29	Founded; provider did not notify the Division of any corrections being made.
4	Ratio: 15-20 four-year-olds with two teenage staff	Moderate	0 - 15	176	Unfounded.
5	Provider did not have proper forms; child transported in automobile without a car seat.	Moderate	0 - 15	16	Founded; provider responded eight months later that corrective actions had been taken.
6	Ratio: Ten toddlers with one teacher	Moderate	0 - 15	21	Founded; provider was already on probation. Division took negative licensing action by issuing a second probationary license.
7	Kitchen had maggots and dead rodents; teacher bit toddlers.	Moderate	0 - 15	16	Unfounded but licensing specialist found other problems, such as ratio violations, documentation not complete, electrical outlet covers not used.
8	Teacher yelled at children and used physical discipline (grabbing and spanking)	Moderate	0 - 15	23	Unfounded.
9	Provider did not give authorized medications to child with disabilities	Moderate	0 - 15	30	Founded; provider responded with corrective action.
10	Child was bruised on hands and face	Moderate	0 - 15	31	Unfounded.

Source: Office of the State Auditor analysis of Child Care Division complaints.

Division Licensing Staff Are Not Held Accountable for Complying With Complaint Guidelines

Currently the Division does not hold either the licensing specialists or the licensing supervisors accountable for compliance with the complaint investigation guidelines. Management has not fully complied with the state law that requires that all staff receive annual performance evaluations. As a part of our audit work on complaint investigations, we reviewed performance evaluations for the Division's 37 licensing staff. We found that 11 of the 37 staff had not been evaluated in 1997. Additionally, six staff evaluations could not be located. Management could not provide documentation that evaluations had been done for these six individuals.

State law requires that all classified employees receive an evaluation at least once a year. According to Section 24-50-118(3), C.R.S., supervisors who do not evaluate their staff annually are subject to penalties:

> (a) A supervisor . . . who does not evaluate his or her subordinate employees as provided in this section, on at least an annual basis, shall be suspended from work without pay for a period of not less than one workweek.
>
> (b) The head of each principal department . . . shall determine annually on May 1 whether each supervisor has completed the mandatory performance evaluation required for each of his subordinate employees during the preceding twelve months. If any evaluations have still not been completed by July 1, the supervisor may be subject to demotion or termination. If a supervisor has not timely completed annual performance evaluations for two consecutive years, he shall be demoted to a non-supervisory position.

Performance evaluations are important to ensure that staff are adequately performing their assignments and duties. The Department needs to take immediate action to ensure that performance evaluations are completed for all Child Care Division staff. Supervisors who have not completed evaluations for their staff for over one year should be disciplined according to statute.

Recommendation No. 9:

The Department of Human Services should improve its oversight of the Child Care Division by immediately:

a. Requiring that performance evaluations be completed for all staff who were not reviewed in 1997.

b. Taking the appropriate disciplinary actions as required by statute for those supervisors who have not evaluated subordinate staff in over one year.

Department of Human Services' Response:

Agree. The Division will complete evaluations for all staff. The Division holds its staff accountable for complying with complaint guidelines in a number of ways and is monitoring compliance through several monthly complaints reports. It has also assigned a complaint coordinator to produce monthly complaint reports and to monitor complaint compliance.

As noted in the 1995 audit report, the Division of Child Care has some of the highest caseloads in the nation. In the past five years it has also initiated a number of substantial and labor-intensive projects to streamline and improve the licensing process—including designing and implementing an optical imaging system, an automated complaint system, a risk-based licensing system, and a self-assessment tool. In the past several years the Division has focused its attention on the implementation of these major projects. The Division acknowledges the importance of formal, written staff evaluations, and will complete all staff evaluations by January 1, 1999.

The Division Should Propose Regulations Regarding the Use of Alcohol by Providers

Over a four-year period, the Division reports receiving 13 complaints about alcohol abuse by providers. Six of the complaints were not founded, five were substantiated, and two providers closed before the investigations were completed. The five substantiated complaints involved:

- A neighbor telephoned local law enforcement about a provider drinking while caring for five infants. During the investigation, the police officer believed the children were in danger. He observed the provider pick up and almost drop an infant. The Division took action three days later by summarily suspending the provider's license under an emergency motion. The Division later denied the provider's request for reinstatement.

- A provider was arrested for Driving Under the Influence. Her Blood Alcohol Content was 0.236, and she had an infant in the car with her. The Division took a negative licensing action by downgrading her child care license to probationary. After the licensee completed court-ordered counseling and a year of probation, her permanent child care license was restored.

- After receiving a complaint from a parent that a provider was "stumbling drunk" while children were present, a county department of social services requested that local law enforcement investigate. The officer assigned confirmed through a nystagmus test that the provider had been drinking. She had been arrested for Driving Under the Influence the year before. On the basis of the investigation and other previous violations, the Division took negative licensing action by downgrading the license to probationary.

- At a child care facility staff complained that another staff member was impaired by drinking while at work. The staff member denied drinking. The Division's investigation substantiated the complaint. Because the facility fired the staff member, the Division did not take any negative licensing actions.

- A parent complained that a provider was drinking during lunch while children were present. The provider admitted to the Division that she drank one beer. The Division did not take any negative licensing action because the licensing specialist did not believe the provider was impaired.

Currently neither the Child Care Licensing Act nor the Division's regulations prohibit the use of alcohol by providers when children are present. In our 1995 audit we recommended that the Division improve its oversight of providers in the area of alcohol abuse and illegal drug use by:

- Analyzing its actions in cases where illegal drugs are being used and/or alcohol is being abused by a provider.

- Investigating whether it is able to propose standards under the "character, suitability, and qualification" guidelines of the Child Care Licensing Act to eliminate indirect risk to children.

- Evaluating the need for statutory changes to remove the restrictions from the Child Care Licensing Act concerning convictions due to abuse of drugs and/or alcohol and proposing statutory changes if needed.

In 1996 the General Assembly adopted statutory changes allowing the Division to deny a license or take negative licensing actions if a licensee, employee, or person residing with a licensee was convicted of unlawful use, distribution, manufacturing,

dispensing, sale, or possession of illegal drugs. However, the Division did not propose statutory changes or adopt regulations on the use of alcohol by providers.

The Division has issued regulations that restrict other provider behavior. For example, one regulation prohibits smoking in child care facilities during business hours in all areas where children are present and when transporting children. We found that 4 of the 13 states we contacted about complaint investigations have strict regulations prohibiting the use of alcohol during child care hours of operation. Furthermore, the Colorado Association of School Boards encourages school districts to adopt its model employment rules prohibiting teachers and other staff from using alcohol on school grounds. Regulation of alcohol use is important. The Division should propose statutory changes to restrict alcohol use during child care hours.

Recommendation No. 10:

The Child Care Division should propose statutory changes to strengthen the Child Care Licensing Act by restricting alcohol use during child care hours and allowing it to take negative licensing action if alcohol is used during child care hours.

Child Care Division's Response:

Agree. The Division will propose statutory changes to strengthen the Child Care Licensing Act that would restrict alcohol use during child care hours and allow the Division to take negative licensing actions if alcohol is used during child care hours. While the Division agrees that substance abuse is a widespread problem in society and that the issue should continue to be analyzed as it relates to the child care industry, it has not been shown to be a prevalent problem among licensed child care providers. In the past four years, the Division has received only 13 complaints alleging abuse of alcohol by a child care provider.

Improvements Are Needed for Investigations of Abuse and Neglect

In our 1995 audit we found that the State did not have a coordinated approach for providing oversight of investigations of allegations of institutional abuse and neglect. Institutional abuse and neglect includes mistreatment of a child in a public or private facility that provides out-of-the-home child care. By statutory definition, institutional

abuse and neglect does not include mistreatment that occurs in any public, private, or parochial school system except where extended day care services are provided.

Various agencies within the state, county, and local governments are involved in institutional abuse and neglect investigations. Each agency has assigned responsibilities, although investigative efforts may overlap at times:

- **The Division of Child Welfare** prepares the Department's rules for investigating institutional abuse and neglect complaints, trains county staff, and maintains the Central Registry of confirmed incidents.

- **County departments of social services** investigate child abuse and neglect allegations. The county department in which the child care facility is located is responsible for the investigation. Department of Human Services' rules require that the counties notify the Child Care Division within 24 hours of an initial report of institutional abuse or neglect and submit a "Stage I" report of the results of their investigation within 60 days of the initial complaint. Counties are also required to report confirmed abuse or neglect within 60 days to the Central Registry.

- **Local law enforcement agencies** investigate violations of the law related to institutional abuse and neglect. These investigations may result in criminal charges and/or arrests.

- **The Child Care Division** investigates licensing issues related to institutional abuse and neglect complaints. These investigations are called Stage II investigations and are conducted to determine whether program or licensing violations created circumstances which resulted in the child abuse. Stage II investigations focus on the administration of child care facilities and the policies and procedures under which the facilities operate. The Division's informal guidelines for Stage II investigations suggest that licensing staff begin an investigation within 30 business days of receiving a county's Stage I report. As a response to a recommendation in our 1995 audit, the Division appointed a staff person to coordinate and track all Stage II investigations.

Timeliness of Investigations Should Be Improved

We reviewed 50 of the 119 allegations of institutional abuse and neglect reported for child care centers and homes in Calendar Year 1997. The Division found there were licensing violations for 23 of these allegations and recommended negative licensing action for 12. Allegations ranged from neglect to physical and sexual abuse of children. Our review of the investigations showed that:

- **Thirty-eight percent of the Stage II files reviewed were incomplete**. The Division could not locate required investigation documentation for 19 of the 50 investigations. As a result, we could not determine timeliness and appropriateness of investigations of the Division's investigations of these 19 allegations. Division management could not explain why the required documentation was missing for these 19 files.

- **The Division does not have formal time requirements for investigations.** As discussed previously, the Division's informal guidelines suggest that a licensing specialist start an investigation within 30 business days of receiving a Stage I report from a county. We found that the Division did not investigate 4 of the 31 allegations within this time frame. The Division substantiated licensing issues with two of these four. These two involved:

  - **Inappropriate discipline of a child**. The Division did not begin its investigation until 37 business days after the county's Stage I report confirmed that the provider had hit a three-year-old in her care.

  - **Sexual abuse of a child**. The Division did not begin its investigation until 40 business days after the county's Stage I report was completed. The Stage I report confirmed the provider's teenage son had inappropriately touched a three-year-old several times.

Delayed Investigations Increase Risks

A child care facility may continue to operate and children in that facility may be at risk until allegations are investigated and appropriate actions are taken. The Division cannot determine if negative licensing action is needed until it completes an investigation.

The Division should take immediate action needed to ensure that all abuse and neglect allegations are followed up promptly. The Division should develop formal time standards to use in completing investigations. In addition, the Division needs to ensure that files contain required documentation of abuse and neglect reports. Furthermore, the Division should train its licensing staff on investigation standards and regularly review provider files that are the subject of investigation to ensure all required documentation is present.

Recommendation No. 11:

The Child Care Division should improve the timeliness of Stage II investigations by:

a. Developing time standards for completion of Stage II investigations.

b. Incorporating those standards in the follow-up procedures of the Stage II Coordinator.

c. Ensuring that all licensee files contain required reports on county abuse and neglect investigations and the Division's Stage II investigations by regularly monitoring the files.

d. Training Division staff on the standards.

Child Care Division's Response:

Agree. The Division will develop time standards for completion of Stage II investigations, incorporate those standards into the follow-up procedures of the Stage II Coordinator, design a process for ensuring that abuse and neglect information is scanned into the LOLA imaging system, provide training for staff on the Stage II standards, and establish a monitoring system to ensure that documentation on Stage II investigations is complete.

Improvement in County Oversight Is Needed

In 1995 we found the Department of Human Services did not provide appropriate oversight of the counties' investigations of institutional abuse and neglect. We found similar problems during this audit. As a result, counties often do not meet time requirements for reporting abuse and neglect allegations to the Child Care Division. For example, the counties did not notify the Division of abuse or neglect allegations within 24 hours in 13 of 50 cases we reviewed. Additionally, the counties did not send the Stage I reports within 60 days of the investigation for 23 of the 50 cases reviewed.

As discussed previously, the Division of Child Welfare is responsible for writing the rules and training counties on institutional abuse and neglect issues. However, it has not implemented our 1995 recommendation to work with the counties on the roles and responsibilities of the State and the counties in investigating institutional abuse and neglect for day care facilities. Additionally, the Child Care Division does not

routinely evaluate or monitor the information provided by counties to determine issues or to identify training needs for the Division of Child Welfare to address with the counties. Abuse and neglect allegations represent the highest risk to children.

Recommendation No. 12:

The Division of Child Welfare should improve its oversight of county investigations of institutional abuse and neglect by working with the Child Care Division to identify issues and training needs for the counties and then providing regular training to the counties regarding abuse and neglect investigations for less-than-24-hour facilities.

Division of Child Welfare's Response:

Agree. The Division of Child Welfare will work with the Division of Child Care to identify problem areas in the counties' investigations of less-than-24-hour-care facilities and plan for how these can best be addressed. Training needs will be identified by both divisions so that these can be addressed in future training plans. Where role confusion exists, it will be addressed.

Some Data in the Complaint Tracking System Are Inaccurate

In response to a recommendation in our 1995 audit, the Division developed the Complaint Tracking System (CTS) which is used to track its investigations of all types of complaints. We found that some data in CTS were not complete or accurate. Specifically, we found that information on the complaint investigation forms for 6 of the 25 complaints were different than data in CTS. For example, two investigation forms indicated the complaints were founded and an inspection report had been issued. However, the Complaint Tracking System reflected that no reports of inspection were issued. Division management indicated that the licensing specialists do not always complete the forms before sending them to data entry. Data entry staff sometimes try to complete the information without verification.

If investigation information in CTS is incorrect, the reports generated by the system are also wrong. Users cannot rely on the system to make informed decisions. The Division needs to ensure investigation information is accurately entered into the Complaint Tracking System. The Division should require supervisory review to compare the information entered by data entry staff with the investigation forms.

Division management should also require licensing specialists to complete investigation forms. Incomplete forms should be returned to licensing specialists.

Recommendation No. 13:

The Child Care Division should improve the accuracy of data in the Complaint Tracking System by:

a. Requiring supervisory review of data entry.

b. Requiring licensing staff to complete investigation forms and data entry staff to return incomplete investigation forms to licensing specialists.

Child Care Division's Response:

Agree. The Division will implement procedures for monitoring accuracy of complaint data and for data entry staff to return investigation forms to licensing specialists.

Enforcement of Child Care Standards

Chapter 3

Background

The Division can take action against a provider's license to enforce compliance with child care licensing standards and regulations. Negative licensing actions include denial of an original application, downgrading of a license to probationary, suspension, or revocation. A probationary license is issued for a specific time period (e.g., up to two years). During that time the Division is supposed to inspect the child care facility regularly to ensure the facility complies with regulations. When a license is suspended, the Division temporarily takes the license away from a provider. During the time of suspension the provider cannot care for children. The final type of action that the Division can take is license revocation.

The Child Care Licensing Act also authorizes the Division to assess fines. According to Section 26-6-114, C.R.S.:

> In addition to any other penalty otherwise provided by law, any person violating any provision of this part 1 or intentionally making any false statement or report to the department to any agency delegated by the department to make an investigation or inspection under the provisions of this part 1 may be assessed a civil penalty of not more than one hundred dollars a day to a maximum of ten thousand dollars.

We found that the Division needs to improve many aspects of its enforcement activities. It needs to make sure that the licensing staff follow up on all founded violations and take negative licensing action when needed. It should also increase the use of civil penalties (fines) as an intermediate sanction.

The Division Cannot Confirm Appropriate Follow-Up Action Is Taken

The Division may take negative licensing action if a provider continuously violates licensing standards or if there is a serious threat to the health and safety of children. For less serious violations, the Division is supposed to work with the provider to make sure problems are corrected. However, we found that the Division does not regularly determine if violations identified through complaint investigations and/or routine inspections are corrected.

We found that 58 facilities in a sample of 105 had licensing violations that were found during inspections and investigations. We reviewed the Division's follow-up actions for the violations at these facilities and found the Division did not appear to have followed up on violations at 29 of the 58. The Division's records do not reflect that these 29 facilities have made the necessary corrections. Thus, half of the facilities with confirmed violations in our sample do not appear to have had any follow-up at all. These 29 cases contain serious licensing violations, including:

- **Ten complaints of physical/sexual abuse or improper discipline**. For example, a provider spanked a toddler during toilet training. The spanking left bruises. Another provider had many complaints that she was abusive to children.

- **Eight complaints of neglect or lack of supervision**. For example, a provider left an infant with a bottle in a crib, thus putting the baby at risk of choking. Another provider did not adequately supervise small children. These children found and ingested blood pressure medications. As a result, their stomachs had to be pumped.

- **Eight complaints of safety violations at facilities**. For example, a provider's play yard was not fenced. Another provider did not have any smoke detectors.

- **Two complaints of staff-to-children ratio violations**. For example, because a center was understaffed, toddlers were subjected to "roughhousing" by older children.

- **One complaint of an unlicensed provider.** The Division was unable to provide documentation that a cease and desist notification was sent to the provider.

Once it has identified that a provider has violated licensing standards, the Division must either ensure that corrections are made or take negative licensing actions. We recommend that the Division immediately follow up on the violations at these 29 facilities.

The Division Should Develop Policies and Procedures to Ensure Appropriate Follow-Up

The Division has not developed written policies and procedures to ensure that staff appropriately follow up on violations. In addition, the Division has not designated any time limits for providers to correct problems. Although licensing specialists generally allow providers 30 days to correct violations, we found these limits are not typically enforced. For example, two providers in our sample did not respond to the Division that the problems had been corrected until at least seven months after the violations were identified. Both of the founded violations were for serious problems affecting the health and safety of children:

- A provider transported a child without a car seat or permission from the parent.

- A provider left sleeping children alone on another floor of the facility.

The Division should establish written policies and procedures that define appropriate follow-up of founded violations. The Division should require that licensing staff adhere to the standards and appropriately follow up on all founded violations.

Recommendation No. 14:

The Division should improve its follow-up of licensing violations by:

a. Establishing written policies, procedures and time frames for appropriate follow-up for both Division staff and child care providers.

b. Ensuring that licensing staff follow up on all founded violations.

Child Care Division's Response:

Agree. The Division will establish written policies, procedures, and time frames for follow-up on licensing violations and for monitoring follow-up of founded violations.

The Division Does Not Always Take Appropriate Negative Licensing Actions

In addition to lack of follow-up, we question the appropriateness of some of the Division's actions. As discussed in Chapter 2, we reviewed the Division's investigation of licensing issues related to 50 complaints of institutional abuse or neglect. We found that the Division does not always take appropriate negative licensing actions on substantiated problems related to these serious allegations. In addition, the Division does not have information on the number and types of negative licensing actions it has taken.

The Division found that there were licensing violations related to the abuse and neglect allegations for 23 (46 percent) of these 50 allegations. Licensing specialists recommended the Division take negative licensing actions on 12 of these 23 founded allegations. Another five did not require negative licensing, because the centers closed. The licensing specialists did not recommend negative licensing action for six of these founded allegations. We agree with the Division's assessment for four of these six cases. There was no evidence of major problems, or the facilities were in the process of correcting the violations. However, we do not agree with the Division's decision not to recommend negative licensing actions for two others:

- **Sexual abuse of a child by a teenager.** As discussed previously, a provider's teenage son sexually abused a young child. The District Attorney prosecuted the individual, who was convicted and received probation. Although the Division's policy, as outlined in its training materials, requires that a license be summarily suspended if there is a confirmed incident of sexual abuse by the licensee, employee, or a person residing with the licensee, this was not done, because, according to the Division, the son was going into the armed service. We have since determined that this person did not go into the service. Division management agrees with our assessment regarding negative licensing action and told us that the license should have been summarily suspended. The incident occurred February 25, 1997, and the Division completed its investigation on April 23, 1997. As a result of our inquiry, the Division started negative licensing action in July 1998.

- **Sexual abuse of a child by another child**. A provider's six-year-old grandson sexually abused another young child. The Division licensing specialist confirmed that the provider did not properly supervise the children in her care. The provider should have been held accountable for improperly supervising children in her care. Division management agrees with our assessment and told us that the license should have been either revoked or downgraded to probationary. The Division has indicated that although the licensing specialist recommended negative licensing action prior to her

retirement, the supervisor never received the recommendation and action was not taken. The incident occurred May 28, 1997, and the Division completed its investigation on July 7, 1997. As a result of our inquiry, the Division started negative licensing action in July 1998.

Additionally, we found that the Division's licensing contractor's assessment of licensing issues related to abuse and neglect allegations was incorrect for another case. Although our evaluation suggests that it could have substantiated licensing violations, it did not initially do so:

- **Physical abuse to a child**. The county Stage I investigation confirmed a child's arm was pulled out of the socket by a child care staff. This injury was not reported to the parents until two to three hours after it happened. The county reported that the child care worker had been involved in a similar incident the year before. The Division's licensing contractor performed a Stage II investigation at the same time the Stage I was performed and disagreed with the county's findings. Division management agrees that it "dropped the ball" on this case. The incident occurred April 7, 1997, and the Division's contractor completed its investigation April 10, 1997. As a result of our inquiry, the Division started negative licensing procedures in July 1998.

Stage II Reports Should Be Reviewed

Division management told us that licensing supervisors do not routinely review Stage II reports and thus cannot evaluate the need for negative licensing actions. Supervisors typically are more experienced in licensing enforcement than are the licensing specialists. By reviewing the Stage II reports, supervisors should be able to identify the need for negative licensing actions. Additionally, the Division has not developed comprehensive staff guidelines for conducting Stage II investigations and recommending negative licensing actions. In a 1988 audit of Child Care Licensing we found that the Division did not have written guidelines for its licensing staff. Although the Division has developed some training materials and issued policy memoranda, these are not comprehensive. They do not provide direction to staff on how to conduct Stage II investigations.

The Division needs to take immediate action to improve its oversight of investigations of licensing issues related to institutional abuse and neglect complaints. It should develop comprehensive guidelines. Licensing supervisors should regularly oversee the decisions made on Stage II investigations, including the decisions made by licensing specialists not to conduct a Stage II investigation. On the basis of our identification of substantial problems within our sample, the Division should immediately review the Stage II investigations that were not included in our audit sample for the past year.

Recommendation No. 15:

The Division should improve its oversight of investigations of licensing issues related to institutional abuse and neglect complaints by:

a. Developing comprehensive guidelines for staff to use on how to conduct Stage II investigations.

b. Establishing procedures to review decisions not to conduct Stage II investigations and final Stage II reports.

c. Reviewing the Stage II reports for the last year that were not included in our sample to identify cases requiring additional action.

Child Care Division's Response:

Agree. The Division will develop comprehensive guidelines for conducting Stage II investigations and for ongoing reviews of Stage II investigations. The Division will review all Stage II investigations for the past year.

The Division Does Not Typically Assess Fines for Violations by Licensees

As discussed previously, Section 26-6-114, C.R.S., allows the Division to assess a civil penalty of up to $100 per day, not to exceed $10,000, on:

> . . . any person violating any provision of [the Child Care Licensing Act] . . . or intentionally making any false statement or report to the department or to any agency delegated by the department to make an investigation or inspection under the provisions of [the Child Care Licensing Act].

Management told us that it believes the Act does not allow the Division to assess fines for violations of child care licensing standards. According to management, it is very difficult to prove that a licensed provider has violated the Act or made a false statement to Division staff.

Although we requested information on all penalty fines assessed for the past five years, the Division was able to identify only five cases. The Division assessed fines of about $7,000 against five unlicensed child care providers in Calendar Year 1997.

Although the Division told us that it does not have the statutory authority to assess fines against current licensees, management also said it recently assessed a fine of $500 against a provider who had a dog that had bitten a small child. According to management, this fine was part of an April 1998 settlement agreement with the licensee.

Other States Assess Fines as an Intermediate Sanction

Seven of the nine states with similar regulatory environments that we contacted regarding their enforcement policies told us that they can fine licensees who violate child care licensing laws, rules, or standards. As the following chart illustrates, the dollar amount of the fines ranges from $5 to $5,000/day per violation.

Fines as a Penalty Used by Other States	
State	**Dollar Ranges for Fines**
California	$50-$150/day per violation
Connecticut	Developing regulations
Florida	up to $500/day per violation
Minnesota	$100-$1000/day per violation
Mississippi	$5-$100 per violation
Utah	up to $5,000/day per violation
Wisconsin	up to $1,000/day per violation
Source: Office of the State Auditor analysis of other state information.	

In general, managers in these other states told us they believe fining allows them to have an intermediate enforcement option. In other words, these states can fine a licensee before taking a negative licensing action. For example, California fines a facility that has a second offense within a 12-month period $150 for the offense and $50 per day until it is corrected. Although none of the states has evaluated the results of fining, all believe it is a tool that will potentially encourage high-risk providers to improve and comply with state standards.

Although the fining process is different in each of the states, all can assess fines on violations such as improper staff to child ratios, excessive discipline, and improper transportation of children. Additionally, the amount of fines assessed typically varies with the seriousness of the violation. For example, violations that involve risks to the health and safety of children result in higher fines.

The Division Should Consider Using Fines as Intermediate Sanctions

By assessing fines on providers that fail to comply with state licensing standards, the Division would have a regulatory option that would be less severe than negative licensing. The Division should evaluate the use of its fining authority as one more enforcement tool. It should propose statutory changes it believes are needed.

Recommendation No. 16:

The Division should improve its enforcement of child care licensing standards by either issuing and implementing regulations regarding violations and fines or proposing statutory change.

Child Care Division's Response:

Agree. The Division currently has statutory authority to impose fines for false statements made to the Department and for violations of the Child Care Act. The Division will investigate the possibility of proposing a statutory change to allow the Department to fine licensed providers for willful, deliberate, and consistent violations of licensing regulations.

Because of the need for child care in the State, the Division is concerned that fining for individual violations might become a disincentive to becoming licensed.

Licensing Issues

Chapter 4

Background

Licensing is an important part of child care regulation. Licensing activities include screening potential providers, assessing fees, and setting standards. The Division screens child care licensee applicants to determine suitability. Licensees must meet certain requirements, such as minimum age. Licensees also pay annual fees. Standards specify the minimum level of care that licensees must provide.

We reviewed the Division's licensing activities and found that improvements are needed. Specifically, the Division should enhance its criminal background screening process and improve its financial management.

Criminal Background Checks Are Used to Screen Potential Providers

Although criminal background checks can be an important part of screening of potential child care providers, we found the criminal records screening process conducted by the Colorado Bureau of Investigation (CBI) does not provide the Division information on all applicants or providers who have been convicted of serious crimes.

Statutes Require Criminal Background Checks

The Colorado Child Care Licensing Act requires that the criminal histories of applicants be reviewed. According to Section 26-6-107(1)(a)(I), C.R.S.:

> . . . the department shall require each applicant, owner, employee, new hired employee, licensee, and any adult who resides in the licensed facility to obtain a criminal record check by reviewing any record that shall be used to assist the department in ascertaining whether the person being investigated has been convicted of any of the following: Child abuse, as specified in section 18-6-401, C.R.S.; an unlawful sexual offense, as defined in section 18-3-411(1), C.R.S., or a felony. The state board of human services shall promulgate rules that define

> and identify what the criminal background check shall entail, including but not limited to, identifying those circumstances in which fingerprinting shall be required. As part of said investigation, the state central registry of child protection shall be accessed to determine whether the owner, applicant, employee, newly hired employee, licensee, or individual who resides in the licensed facility being investigated is the subject of a report of known or suspected child abuse. Any change in ownership of a licensed facility or the addition of a new resident adult or newly hired employee to the licensed facility shall require a new investigation. . . .

The State Board of Human Services has promulgated rules requiring criminal record checks through CBI for all types of individuals specified in the Act. Fingerprint cards for applicants are submitted to CBI. CBI checks the fingerprints against its Automated Fingerprint Identification System (AFIS). AFIS contains records of fingerprints of individuals who have been arrested in Colorado. Each month CBI sends the Division a report listing applicants who have a fingerprint match and a copy of their criminal records. CBI also developed a flagging system for child care background checks. This system will flag an arrest of anyone who has previously been processed as a child care applicant. CBI notifies the Division of these subsequent arrests. The Division follows up with investigations of applicants who have been arrested for child abuse, drug offenses, and felonies. Because the CBI database does not include information on convictions, the Division must determine if the arrest resulted in a conviction. An individual identified as having an arrest for a serious crime is required to submit documentation on the outcome (e.g., conviction, plea bargain, acquittal). If the individual has been convicted of one of the statutory offenses, the Division may deny the application or take a negative licensing action.

The Division Should Obtain More Complete Criminal History Data

We matched records of individuals who had been processed for child care by the CBI from 1994 through 1997 with conviction records in the Judicial Department's Integrated Colorado On-line Network (ICON) system. We found that the CBI had not notified the Division about 20 individuals who had been convicted of serious crimes, including misdemeanor child abuse, domestic violence, driving with ability impaired, drug offenses, and 14 felonies, ranging from forgery to murder. CBI does not have any record of arrests for these 20 individuals for these offenses.

As we reported in 1995, the CBI database does not include all arrests. Some local law enforcement agencies do not report arrests to CBI. Additionally, individuals who have been convicted of a serious crime may not have been arrested. In some cases individuals are issued a summons instead of being arrested. According to the Judicial

Department, this happens even with serious crimes, such as child abuse. A district attorney may request a court to issue a summons for an individual to appear at court on a certain day to answer charges. The individual is not arrested. Although Colorado statutes require the individual responding to a summons for a serious crime to be fingerprinted, this is not always done. In these cases the CBI would have no record of the offense for which the individual was issued a summons. The Judicial Department was not able to estimate the number of these types of cases.

According to the Division, if it had received information on these cases, it would have investigated these convictions for the 20 individuals we identified and may have taken negative licensing actions. The individuals could be child care providers, employees of child care centers, or adults residing in a licensed facility.

In May 1998 the State implemented a Criminal Justice Information System (CJIS) to link criminal justice systems for the Judicial, Corrections, and Public Safety Departments, the Division of Youth Corrections, and the District Attorney Council. The Department of Human Services plans to link its new Children, Youth, and Families system to CJIS. CJIS will allow its users to access complete criminal history data, including arrests and convictions.

The Division needs to work with the Judicial and Public Safety Departments to develop procedures to ensure it receives complete criminal histories. When the new CJIS system is fully implemented, the Division should access it to obtain criminal history information. The Division also needs to take immediate action to determine the current employment status of these 20 individuals and take negative licensing action if appropriate.

Recommendation No. 17:

The Child Care Division should improve its access to criminal history information of child care applicants and providers by:

a. Working with the Judicial and Public Safety Departments to ensure that it is receiving complete information on individuals who have been convicted of serious crimes.

b. Accessing the new CJIS system when it is fully implemented to obtain criminal history information on applicants and periodically for all child care providers.

c. Following up on the 20 individuals already identified as convicted of serious crimes.

Child Care Division's Response:

Agree. The Division will work with the Judicial and Public Safety Departments to ensure that it is receiving complete information on convicted felons.

The Judicial Department's CJIS system is to be linked to the CYF automated system, and the Division will investigate the possibility of obtaining dispositions of arrests directly through CYF. Also, CBI is currently implementing an electronic clearance system for criminal background checks. The first component for name and birth date checks is already in place; when the second component, for fingerprint checks, is implemented, the Division will investigate the possibility of being linked to the CBI system.

The Division will follow up on the 20 individuals already identified as convicted of serious crimes.

The Division Needs to Improve Its Management of Fees

The Division does not analyze its licensing fees annually as required by the Child Care Licensing Act. In our 1995 audit we found that the Division did not have a systematic process for revising its child care licensing fees, nor had it tracked all indirect and direct costs associated with licensing activities. The General Assembly subsequently passed House Bill 96-1006, which required the Division to monitor fees. According to Section 26-6-105(1)(c), C.R.S.:

> . . . The division involved in licensing child care facilities shall develop and implement an objective and systematic approach for setting, monitoring, and revising child care licensing fees by developing and using an ongoing method to track all direct and indirect costs associated with child care inspection licensing, developing a methodology to assess the relationship between licensing costs and fees, and annually reassessing costs and fees and reporting the results to the state board.

The Act also requires the Division to consider the size of facilities, the time needed to license facilities, and the ability of facilities to pay license fees in developing a fee schedule. The Board of Human Services last revised fees in 1995. Currently licensed family child care homes pay annual fees of $16 for 1 to 6 children and $24 for 7 to 12

children. Fees for licensed child care centers vary according to facility size and times of operation as shown in the following table.

Annual Licensing Fees for Child Care Centers				
Number of Children	**Full Day Full Year**	**Part Day Full Year**	**Full Day Part Year**	**Part Day Part Year**
5-20	$35	$18	$18	$14
21-50	$86	$43	$43	$34
51-100	$138	$69	$69	$52
101-150	$190	$95	$95	$72
151-250	$242	$121	$121	$91
251 +	$294	$147	$147	$110
Source: Department of Human Services, General Rules for Child Care Facilities.				

The Division also charges fees for child placement agencies licensed for foster care and adoption. The child placement agency fees range from $50 to $350 based on the number of certified foster homes supervised and $150 to $350 based on the number of finalized adoptions during the previous year.

According to the Child Care Licensing Act, the Division may assess fees up to all of the direct and indirect costs incurred for child care licensing. The fees are to be used for expenditures incurred by the Department in its performance of its duties for child care licensing.

The Division should comply with the Child Care Licensing Act. It should develop and implement an objective and systematic approach for setting, monitoring, and revising child care licensing fees, track all direct and indirect costs associated with child care inspections, and report to the State Board of Human Services on its annual reassessment of fees.

Recommendation No. 18:

The Child Care Division should improve its management of licensing fees by complying with Section 26-6-105(1)(c), C.R.S., of the Child Care Licensing Act. Specifically the Division should:

a. Develop and implement an objective and systematic approach for setting, monitoring, and revising child care licensing fees.

b. Use an ongoing method to track all direct and indirect costs associated with child care inspection and fees.

c. Reassess costs and fees annually.

d. Report the results to the State Board of Human Services annually.

Child Care Division's Response:

Agree. The Division will develop and implement an objective and systematic approach for setting, monitoring, and revising child care licensing fees. It will track direct and indirect costs associated with child care inspection and fees by applying the Department's cost-allocation formula. The Division will annually reassess costs and fees.

Management Issues

Chapter 5

The Department Needs to Strengthen Its Management and Oversight of Child Care Facility Regulation

Several issues have affected the Division and its ability to fulfill its statutory responsibilities related to regulation of child care facilities in Colorado.

- Welfare reform has required the Division to concentrate on increasing child care capacity in the State.

- The Division has been involved in implementing the new LOLA imaging system and developing the Children, Youth, and Family system (to be implemented in 1999).

- The Division has changed the way it regulates through the risk-based approach for inspections.

Although we recognize that these issues have impacted the Division, we have found that there are several areas that continue to be problems for the Division. In 1988 and 1995 we conducted performance audits of the Division. (Appendix C summarizes our evaluation of the Division's implementation of the recommendations from our 1995 audit.) **The problems we identified in the 1988 and 1995 audits are still major issues today, including:**

- **Backlogs of inspections**. The Division has not been able to inspect child care homes and centers as frequently as its standards require. As discussed earlier, in response to a recommendation in our 1995 audit, the Division adopted a risk-based approach for inspections in 1996 as a way to focus its resources on those facilities in which the health and safety of children may be at risk. However, we found that the Division is not consistently focusing its efforts on the high-risk facilities.

- **Handling of complaint investigations**. The Division is slow in investigating some complaints and does not always follow its own investigative standards. Additionally, it does not routinely follow up to ensure violations are corrected as required. In some serious cases it had not taken action when it found that a provider's behavior put children at serious risk of neglect or abuse but is now in the process of taking action.

- **Oversight of counties**. The Department of Human Services has not ensured that the counties have received adequate training and oversight in their investigations of institutional abuse and neglect complaints for the less-than-24-hour facilities. As a result, counties do not always provide the Division with timely reports of these serious allegations. Thus, the Division cannot promptly investigate licensing issues related to these complaints.

- **Criminal background checks**. The Division has needed to improve its process for checking criminal history records of child care license applicants for nine years. Additionally, the Division does not currently obtain information on criminal histories from all sources, including the Judicial Department. For example, we found that CBI did not notify the Division of 20 individuals we identified who were providing child care and who had been convicted of serious crimes, including child abuse, drug offenses, forgery, and murder.

- **Data tracking and analysis**. The Division has not identified all types of data it needs for management decisions. For example, the Division has not developed a system to collect and analyze data from core indicator checklists. This is basic information that is needed for management purposes. Without tracking and analysis, the Division does not know what impact various processes have on its workload and its ability to effectively meet all of its oversight functions.

- **Incomplete licensee files**. Some of the Division's licensee files are not organized or up to date. Although it went to an on-line imaging system for its files in 1996, we found some information was not consistently well organized, and often important documents (either the images or hard copies) could not be located. The missing documents included reports of the Division's investigations of licensing issues related to allegations of abuse and neglect. These reports are public information. It is important that parents have access to this information in order to make informed decisions regarding child care.

- **Financial management** The Division does not analyze its fees annually as required by the Child Care Licensing Act. It does not track direct and indirect costs associated with these fees or fines that are assessed as a civil penalty.

- **Staff procedures**. The Division has not developed a comprehensive procedures manual for its licensing staff to use in carrying out their regulatory duties as was recommended in our 1995 audit. The Division provides direction to staff through memorandums.

In addition to the problems described above that were identified in the 1988, 1995, and 1998 audits, we also identified serious management issues in this audit, including:

- **Supervisory review**. As described in Chapter 3, licensing supervisors do not routinely monitor staff reports on institutional abuse and neglect allegations. As a result, the Division does not always take negative licensing actions against providers with founded violations when such action is warranted. Thus, the health and safety of children are at risk. For example, in one case we discussed previously, a child's arm was pulled out of the socket by a child care staff. The county investigated and determined that the allegation was founded. The Division's contractor disagreed and did not pursue negative licensing action. Additionally, supervisors do not review changes made by staff to facility risk factors. As a result, the Division cannot be sure that the changes are appropriate.

- **Lack of performance evaluations**. As described in Chapter 2, the Division does not comply with Colorado statutes that require all classified staff be evaluated at least once a year. We found that about 30 percent of the Division staff have not been evaluated in the past year. Eleven staff have not received a performance evaluation for up to six years.

The Department Needs to Develop an Implementation Plan for Improvements

Management told us that the Division has been unable to address many of the problems because of the need to continually "put out fires." The nature of the Division's overall management style is crisis-driven and it, therefore, has difficulty prioritizing. However, the problems we identified are serious and raise concerns about the overall effectiveness of the Division's regulatory oversight.

The Division needs to take immediate action to begin solving key regulatory issues. Specifically, it should develop an implementation plan which ensures that problems

identified in this report are addressed. The plan should include key review dates and identify staff accountable for ensuring that improvements are made.

Recommendation No. 19:

The Department of Human Services should improve regulation of child care in Colorado by ensuring that the Child Care Division develops a comprehensive plan to address implementation of the recommendations in this report.

Department of Human Services' Response:

Agree. The Division will develop a comprehensive plan that addresses the implementation of the recommendations in the 1998 audit report.

Appendix A

Alternatives for Child Care Regulation
As Presented in the 1995 Office of the State Auditor Report

In our 1995 performance audit of the Child Care Licensing Division we found that the Division had not been able to carry out its regulatory responsibilities. Through our research, we identified six alternatives for child care regulation. These options ranged from no regulation to strict regulation. We recommended that the Division evaluate the alternatives:

- **No licensing**. The State would not license child care facilities. There would be no costs. No one in the State would set standards, license providers, monitor compliance, or enforce regulations. There would be no assurance of the health and safety of children.

- **Voluntary registration**. Child care centers and homes would be encouraged to register with a central agency. The central agency could be either state-run or privatized. This agency would maintain a list of registered providers, develop and publish child care guidelines, and screen providers for criminal convictions. There would be few inspections, and enforcement would come through investigation of complaints. There would be little assurance of the health and safety of children.

- **Mandatory registration**. This alternative would be the same as voluntary registration except that all facilities would be required to register.

- **Voluntary licensing**. Child care centers and homes would be encouraged to become licensed. The State would provide standards for licensure. The State's regulatory unit would provide full regulatory services for licensed facilities.

- **Mandatory licensing (using a risk-based inspection approach)**. Child care facilities would be required to be licensed. However, inspections would be done on a risk-based schedule. Those facilities having problems would be inspected more frequently than those in compliance with statutes and regulations.

- **Mandatory licensing (using mandatory inspection approach)**. All child care facilities would be required to be licensed and would be inspected at least once every two years.

Appendix B
Facilities by Type

Facility Type	Total Number of Facilities	Number of facilities with risk factors	Difference
Less-than-24-hour Facilities:			
Day Care Center	1,160	1,057	103
Day Care Home	5,870	5,416	454
Infant Toddler Home	114	77	37
Large Day Care Home	75	71	4
Pre-School	563	502	61
Resident Camp	121	114	7
School-Age Child Care Center	739	684	55
Subtotal	8,642	7,921	721
24-hour Facilities:			
Child Placement Agency	108	94	14
Child Placement Group Center	23	23	0
Child Placement Group Home	17	14	3
Day Treatment Center	53	40	13
Family Foster Home	8	6	2
Residential Child Care Center	103	103	0
Secure Residential Treatment Center	7	2	5
Specialized Group Center	6	6	0
Specialized Group Home	21	21	0
Subtotal	346	309	37
Total	8,988	8,230	758

Source: Office of the State Auditor analysis of Child Care Division data, as of August 1998.

Appendix C

Implementation of Prior Audit Recommendations

Background

The Office of the State Auditor conducted a performance audit of the Child Care Division in 1995. This audit was a follow-up to the 1988 performance audit of the Division. The 1995 report contained 13 recommendations relating to child care regulation activities. We found at that time that the Division did not:

- Provide adequate oversight of child care licensing.
- Carry out all of its child care regulatory duties.
- Adequately monitor and track child care activities, which includes inspections, investigations of licensing issues related to abuse and neglect allegations, and follow-up on complaints.
- Follow its own guidelines on complaint investigations to ensure timeliness.
- Have a systematic method for setting and revising child care licensing fees.
- Have an efficient criminal background check process.
- Adequately oversee licensing issues related to provider alcohol abuse and illegal drug use.
- Maintain organized provider files that were easily accessible by the public.
- Have meaningful performance measures that evaluated the efficiency and effectiveness of its programs and if it is achieving its goals and objectives.
- Have adequate rules for educating parents on child care licensing rules and violations.

Follow-Up Results

Since the 1995 audit, the Division has made improvements in many of the problem areas identified in the prior audit report recommendations. The Division has implemented a new optical imaging system for provider files, a complaint tracking system, and the risk-based system to inspections. However, during the course of this audit we found that problems continue to exist. We believe that these problems affect the Division's ability to fulfill its child care regulatory duties, and we have made additional recommendations in this current audit report. These issues include the Division's risk-based

licensing model for inspections, handling of complaints and investigations of licensing issues related to allegations of abuse and neglect, and enforcement of standards.

The Division's implementation actions for each recommendation from the 1995 audit are summarized below.

Child Care Licensing Oversight

In the 1995 audit we found that for its workload and organizational arrangement, the Division was understaffed and underfunded. As a result, the Division was unable to carry out all of its regulatory duties, including monitoring child care facilities every two years and investigating unlicensed providers proactively. We estimated the Division would need to double its licensing specialist staff from 22.25 to 47 FTE to carry out all of its responsibilities.

1995 Recommendation No. 1:

We recommended that the Child Care Division determine what it needed to do to improve its oversight of child care licensing oversight by:

a. Analyzing its workload to determine the number of FTE needed.

b. Requesting additional FTE if needed.

Department's 1995 Response to Recommendation No. 1:

Agree. The Child Care Division is currently analyzing the workload of the entire licensing and information and support units as a result of the January 1, 1995, implementation of SB 94-101, which created a new permanent child care license with accompanying self-declaration and supervisory inspection visits. The workload analysis will be incorporated into the review of licensing functions (see Recommendation No. 2), which will be accomplished by October 15, 1995. With an expected decrease in federal funds and reduction in the Department of Human Services' funding, it is anticipated that no new FTE will be requested. Efficiencies will be achieved by continuing to streamline the licensing system, including the development and implementation of a risk-based approach to monitoring and inspection (see Recommendation No. 3).

Office of the State Auditor's Follow-Up Results:

The Division has developed various reports to help it manage the current workload. These reports identify the child care providers that are past due for an inspection and the percentage of visits that were conducted on time. However, the Division does not have reports that help

it to identify changes in workload requirements or the number of FTE needed, and a formal analysis has not been conducted. The Division has not requested additional FTE.

Division's Role in Child Care Regulation

In the 1995 audit we found that if additional resources could not be obtained, the Division needed to evaluate options for regulatory oversight of child care that fit into its existing resources. The options ranged from eliminating licensing to reducing oversight for some types of facilities.

1995 Recommendation No. 2:

We recommended that the Child Care Division evaluate the State's role in regulation of child care by:

a. Assessing the alternatives for child care regulation.

b. Developing a reasonable model for Colorado's regulatory oversight given current funding and future limitations.

c. Presenting its recommendations to state policymakers by October 15, 1995.

Department's 1995 Response to Recommendation No. 2:

Agree. The Child Care Division will convene an internal Department workgroup to make recommendations to Departmental Executive Management on alternatives for licensing in Colorado. After review and approval, the selected model will be presented to child care stakeholders throughout the State in a series of focus groups that will be conducted during the summer of 1995.

This will also fulfill the current state statutory requirement to review the child care licensing process and regulations every three years through consultation with "parents and consumers of child care, child care providers, the department of health, experts in the child care field, and other interested parties throughout the state." The final report of recommendations will be presented to the State Board of Human Services, the Advisory Committee on the Licensing of Child Care Facilities, and the General Assembly by October 15, 1995.

Since the Child Care Act will need to be revised in order to adopt a different licensing model, the Department will work with the Legislature to draft a total cleanup and rewrite of the child care licensing statute to be introduced in the 1996 General Assembly.

Office of the State Auditor's Follow-Up Results:

The Division assessed alternatives for child care regulation. The risk-based model was chosen after the Division conducted its own analysis and received public input. In October 1995 the Division submitted its proposal to the General Assembly for approval. The General Assembly passed House Bill 96-1006 establishing the risk-based approach for inspections.

Division's Monitoring Activities

In the 1995 audit we found that the Division was not able to conduct inspections of child care homes or centers every two years as recommended by standards and implied by statute. The Division had a backlog of child care facilities that needed to be inspected. Some facilities had not been inspected in four years.

1995 Recommendation No. 3:

We recommended that the Child Care Division continue its efforts to develop and implement a comprehensive risk-based approach for inspecting all child care facilities by:

a. Identifying critical indicators to assess child care quality in homes and in centers.

b. Collecting and analyzing data on the critical indicators.

c. Establishing a schedule to inspect all facilities based on the need identified by the critical indicators but no less than once every three years.

Department's 1995 Response to Recommendation No. 3:

Agree. The Division began its development of a risk-based approach for inspections in its work to implement SB 94-101. This approach, along with the design of a critical-indicator checklist and provider self-assessment process, has already been discussed with the State Board of Human Services and numerous provider groups. The new system will be fully adopted and integrated into the licensing process by January 1, 1996.

Office of the State Auditor's Follow-Up Results:

The Division has developed a risk-based model for inspections, and 8,230 day care facilities have been assigned a risk factor. The risk factors determine the frequency of the inspection schedule. However, the Division has <u>some</u> problems with its risk-based inspections as detailed in Chapter 1.

System for Tracking Licensing Activities

In the 1995 audit we found that the Division's Licensing Data Management System (LDMS) contained inaccurate, incomplete, and unreliable data. For example, we reviewed 22 files with complaints and 18 of the files contained complaints that were not listed in the LDMS report. The Division could not use the data to support and evaluate its operations.

1995 Recommendation No. 4:

We recommended that the Child Care Division improve its tracking of complaints, inspections, and other licensing activities by:

a. Identifying its information requirements.

b. Modifying the Licensing Data Management System so that it can be used to track all facility contacts and complaints by type, category, and facility and produce histories of facilities.

c. Identifying controls needed to ensure the modified system produces information that is complete, reliable, and accurate.

d. Providing training to staff on the use of the modified system.

Department's Response to Recommendation No. 4:

Agree. In February and March of 1995 the Division's Management Team worked with the Office of Information Technology Services to develop a written plan for accomplishing the development of a comprehensive management information system that includes modification to the current licensing data management system as well as all of the Division's information needs. Short-term improvements in the current licensing data management system will be made by September 1, 1995. A plan for the more comprehensive system will be presented to Executive Management by February 1, 1996.

Office of the State Auditor's Follow-Up Results:

The Division replaced LDMS with a new automated complaint tracking system in January 1997. The new system tracks facility contacts and complaints by category and facility. The Division trained staff on the use of the system. However, as discussed in Chapter 2, we found that some investigation information in the system is inaccurate. Additionally, the Division does not track the number of inspections by risk factor.

Institutional Abuse and Neglect Investigations

In the 1995 audit we found that the State did not have a coordinated approach for providing oversight of investigations of allegations of institutional abuse and neglect at child care centers and homes. For example, many of the abuse and neglect cases we reviewed did not have a follow-up investigation by the Division to identify licensing concerns because the counties did not report the information to the Division as required. Recommendations 5 and 6 relate to this issue.

1995 Recommendation No. 5:

We recommended that the Child Care Division improve the day care institutional abuse and neglect investigations by:

a. Designating immediately a staffing structure to coordinate all aspects of institutional abuse oversight and investigations. This includes receiving all initial reports on institutional abuse and communicating to the counties on how and to whom reports should be submitted.

b. Formalizing an agreement with the Central Registry unit to ensure it receives copies of all institutional abuse and neglect incidents that are reported to the Registry monthly.

Department's 1995 Response to Recommendation No. 5:

Agree. In March 1995 the Division designated the five licensing supervisors to be responsible for total oversight of the licensing aspects of institutional abuse investigations in less-than-24-hour child care facilities in each of their assigned supervisory territories. In 1994 the total number of such cases was 36.

The Divisions of Child Care and Child Welfare developed a written policy to ensure that the Child Care Division receives all institutional abuse and neglect Central Registry incident reports monthly, effective April 1, 1995.

Office of the State Auditor's Follow-Up Results:

The Division designated a coordinator for its investigations of licensing issues related to abuse and neglect allegations. However, during the course of this audit we found that some problems still exist with investigations.

1995 Recommendation No. 6:

We recommended that the Division of Child Welfare improve the day care institutional abuse and neglect investigations by:

a. Working with the counties to clarify the roles and responsibilities of the state and the counties in investigating institutional abuse and neglect and communicating the results to all participants.

b. Evaluating the costs and benefits of expanding the proposal for a statewide institutional abuse investigation team to include investigations of day care institutional abuse.

Department's 1995 Response to Recommendation No. 6:

Agree. The Divisions of Child Welfare and Child Care will issue an agency letter to all county departments of social services to provide further clarification and guidance on the Department's rules regarding the investigation of institutional abuse and neglect. A follow-up teleconference will be conducted with all counties by October 1, 1995, to provide additional technical assistance.

The Division of Child Welfare will work with the Child Care Division to conduct a cost-and-benefit analysis of a possible statewide institutional abuse investigation team that includes less-than-24-hour child care facilities. This analysis will be presented to the Department's Executive Management by July 1, 1995, for consideration as a possible budget initiative during the 1996 budget process.

Office of the State Auditor's Follow-Up Results:

We found that the roles and responsibilities of the counties and the State in investigating institutional abuse and neglect allegations still need to be clarified.

Handling of Complaint Investigations

In the 1995 audit we found that the Division did not follow its guidelines for investigating complaints. For example, on average, the Division took longer to investigate complaints than its guidelines allowed. We believed that when the Division does not investigate complaints in a timely manner, there are potential risks to the health and safety of children.

1995 Recommendation No. 7:

We recommended that the Child Care Division develop management controls to ensure that all complaints are investigated within the Division's timeliness standards. Specifically, the Division should ensure that:

a. Licensing specialists follow guidelines on timely completion of complaint investigations.

b. Staff complete all aspects of the form fully and categorize all complaints appropriately on the form at the time of receipt. Compliance with the Division's complaint policy should be a factor included in staff performance evaluations.

c. Adequate and appropriate training is provided to staff who receive complaints and complete the complaint forms.

Department's 1995 Response to Recommendation No. 7:

Agree. By March 1, 1995, the Division had already tightened its policies on complaint investigation and provided additional training to all staff that process complaints. Further management controls will be built into the modified licensing data management system.

Office of the State Auditor's Follow-Up Results:

The Division has assigned a staff member to be the complaint coordinator. The complaint coordinator tracks the timeliness of complaint investigations and follows up on complaints that have not been investigated within the Division's established time frames. The complaint coordinator also trains staff who receive complaints, on what information is needed when taking a complaint and how to enter the information in the Complaint Tracking System. However, we found that 10 of 25 complaints in our sample were not investigated within Division time lines. We also found that the complaint intake workers did not assign appropriate severity levels to some complaints and the criteria for the severity levels need clarification.

Child Care Licensing Fees

In the 1995 audit we found that the Division did not have a systematic method for setting and revising child care license fees. The Division did not determine all the direct and indirect costs of child care licensing activities when it established its fees. As a result, the Division's fees did not generate sufficient funds to cover its cash-fund appropriation.

1995 Recommendation No. 8:

We recommended that the Child Care Division develop and implement a systematic process to set and revise child care licensing fees by:

a. Developing and using an ongoing method to track all direct and indirect costs associated with child care licensing.

b. Developing a methodology to assess the relationship between licensing costs and fees.

c. Annually reassessing costs and fees and reporting the results to the Board of Human Services.

Department's 1995 Response to Recommendation No. 8:

Agree. The Division will design and implement a systematic process for setting and revising fees that will be reported to the State Board of Human Services each year beginning in SFY 95-96.

Office of the State Auditor's Follow-Up Results:

The Division has not instituted a process to set and revise fees. It has not developed a method to track all direct and indirect costs associated with child care licensing and it has not assessed the relationship between licensing costs and fees. Additionally, the Division does not annually reassess its fees and costs as required by Section 26-6-105(1)(c), C.R.S.

Criminal Background Checks

In the 1995 audit we found that the criminal background check process was slow and cumbersome. The Colorado Bureau of Investigation (CBI) had a large backlog of background checks to process.

1995 Recommendation No. 9:

We recommended that the Child Care Division and the Colorado Bureau of Investigation work together to improve and streamline the criminal background check process.

Department's 1995 Response to Recommendation No. 9:

Agree. In February 1995 the Division began meeting monthly with representatives from the Colorado Bureau of Investigation to identify and resolve problem areas in the short term. The two agencies are now developing a plan that will streamline the process for the Division, CBI, and providers. This plan will be incorporated into the licensing model review process (see Recommendation No. 2) with recommended improvements becoming a part of the rewrite of the Child Care Act.

Colorado Bureau of Investigation's 1995 Response to Recommendation No. 9:

Agree. We have been meeting monthly with the Division to critique and to improve the process. We are working to turn all screening requests around within three working days. Toward that end we have taken the following steps to address the noted concerns:

Completeness of Records at the CBI. We have reallocated personnel to ensure seven-day, twenty-four-hour processing of information requests received from the Division; have employed temporary help to eliminate a backlog of work that has accumulated during the past year; and have applied for federal assistance to automate historical arrest records of persons whose records have yet to be requested.

Quality Control & Completeness of Reporting by Local Law Enforcement Agencies. The CBI conducts local law enforcement agency audits to identify agencies that fail to report felony and child abuse arrests to the CBI as required by law. One hundred percent reporting is our goal and is required by law.

Timely Reporting. The CBI continues to encourage agencies to submit arrest and applicant prints as soon as possible, not to save prints until there are hundreds or thousands to send it at once. When we detect a violation of this procedure, we notify management at the contributing agency.

Final Disposition Reporting. The State Court Administrator is planning to report 95 percent of all final district court dispositions to the CBI by July 1995, and 100 percent by January 1996.

Office of the State Auditor's Follow-Up Results:

The Division and CBI formalized a plan to improve and streamline the criminal background check process but the plan has not been fully implemented. However, there have been improvements. The backlogs have decreased. Also, CBI implemented an automated clearance system that will allow the Division to connect to CBI by modem and obtain name and birth date checks. The Division cannot pursue this option until the system is fully operational.

Enforcement of Licensing Requirements

In the 1995 audit we found that the Division did not take action when the character of a provider was in question due to alcohol abuse or illegal drug use outside of the direct care of the children. We believed that the existence of a provider's alcohol/drug problems contributed to an environment of indirect potential harm to children in care.

1995 Recommendation No. 10:

We recommended that the Child Care Division improve oversight in the area of provider alcohol abuse and illegal drug use by:

a. Analyzing its actions in cases where illegal drugs are being used and/or alcohol is being abused by the provider.

b. Investigating whether it is able to propose standards under the "character, suitability, and qualification" guidelines to eliminate indirect risk to children.

c. Evaluating the need for statutory changes to remove the restrictions from the Child Care Act concerning convictions due to abuse of drugs and/or alcohol and proposing statutory changes, if needed.

Department's 1995 Response to Recommendation No. 10:

Agree. The Division will work with the Attorney General's Office to review past decisions where alcohol and/or illegal drugs were used by providers when children were not present. If changes to the child care licensing rules and/or statute are deemed necessary, these changes will be a part of the licensing model review process (see Recommendation No. 2).

Office of the State Auditor's Follow-Up Results:

The Division has analyzed cases where illegal drugs are being used and alcohol is being abused by the provider. The Division also investigated whether it is able to propose standards under the "character, suitability, and qualification" guidelines. However, it did not propose standards under these guidelines. Instead, the Division proposed statutory changes, which gave the Division more latitude in taking negative licensing actions for convictions due to illegal drug use. These statutory changes were enacted and incorporated into the Child Care Licensing Act. No such changes were made for alcohol abuse.

Public Information

In the 1995 audit we found that the Division needed to improve its process for maintaining child care licensing files. We found that the licensing files were disorganized and not "user-friendly." As a result, parents reviewing these files did not have the facts needed to make informed child care decisions.

1995 Recommendation No. 11:

We recommended that the Child Care Division improve how it provides child care licensing information to the public by:

a. Reevaluating the content of the child care licensing files to determine how to organize the information in the files better.

b. Considering the information that should be contained in or removed from the files.

c. Developing and using an action report form that summarizes the results of an investigation for inclusion in the files.

Department's 1995 Response to Recommendation No. 11:

Agree. In March 1995 the Division finalized a plan to purge all unnecessary information from the nearly 10,000 active child care facility licensing files by September 1, 1995. Work with the

Attorney General's Office on what information should and should not remain in the licensing files for public review will be completed by September 1, 1995. An action report will be developed based on the results of this consultation.

Office of the State Auditor's Follow-Up Results:

The Division evaluated the contents of the child care licensing files. In doing so, it determined how to organize the files better and what information needed to be contained in the files, and what information should be removed. However, we have found issues with the accuracy of the information currently contained in the provider files. The Division has recently developed an action report form that summarizes the results of investigations and is to be included in provider files. This form is not yet consistently used by licensing specialists.

Parental Education

In the 1995 audit we found that the Division needed to require that facilities provide additional information for parents. We believed that the education of parents was important because parents could help monitor standards at child care facilities and could alert the Division of potential problems.

1995 Recommendation No. 12:

We recommended that the Child Care Division improve parent education by adopting rules that require day care center facilities post information on results of inspections and the ratio of children to staff for each room.

Department's 1995 Response to Recommendation No. 12:

Agree. The Division will work closely with the Advisory Committee on the Licensing of Child Care Facilities to draft rules that expand the requirements for the posting of licensing information by providers and will present them to the State Board of Human Services for public hearing in October 1995.

Office of the State Auditor's Follow-Up Results:

The Division worked with the Advisory Committee on the Licensing of Child Care Facilities to draft rules that expand the requirements for the posting of licensing information by providers. These rules were adopted and providers are now required to post the results of their most recent inspection and the ratio of children to staff for each room.

Performance Measures

In the 1995 audit we found that the Division needed to improve its performance measures by making the indicators more meaningful for internal management and policymakers. From our review, we found that none of the Division's measures indicated program effectiveness or the impact of the services provided. We believed that better performance measures could help the Division evaluate use of its resources and accomplishment of its goals, including improving the quality of child care.

1995 Recommendation No. 13:

We recommended that the Child Care Division develop, track, and report performance measures that indicate the efficiency and effectiveness of its programs and whether the Division is achieving its goals and objectives.

Department's 1995 Response to Recommendation No. 13:

Agree. The Division will work with the Department's Budget Office to develop efficiency and effectiveness performance measures as a part of the submission of the SFY 96-97 Departmental budget request. The tracking and reporting of the performance results will be incorporated into the new management information system described under Recommendation No. 4.

Office of the State Auditor's Follow-Up Results:

We reviewed the Division's performance measures and found that the Division developed measures that could indicate the efficiency and effectiveness of its programs and whether it is achieving its goals and objectives if the Division had the appropriate data. As we discuss throughout this report, we found the Division does not have the data needed to monitor and manage its activities. Additionally, the Division does not track certain activities, including the number of inspections by risk factor.

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