MASSACHUSETTS
Department of
Early Education and Care

COVID-19 Child Care Playbook

Implementing the Minimum Requirements for Health and Safety

AUGUST 28, 2020

A Note to Child Care Providers

Dear early education and care colleagues,

The evolving health landscape that we are currently navigating requires flexibility, adaptability, and perseverance. We see the strength and dedication of the early education and care field every every day. The work you do is essential to our communities, our recovery, and EEC is committed to supporting you every way we can.

On June 1st, EEC released the Minimum Requirements for Health and Safety, which programs have been implementing since reopening began. Now, with several months of experience with child care during COVID-19 and emerging scientific research as our guides, we are revising the Minimum Requirements to continue to keep children and educators safe and healthy. And because the school day and year will look very different this year, we know you need solutions that did not previously exist.

Beginning September 1st, early education and care programs will be expected to implement the revised Minimum Requirements for Health and Safety. This document combines the Minimum Requirements for Health and Safety with operational guidance and best practices to help you welcome families into high-quality, safe care that is joyful and engaging.

If you have any questions, please do not hesitate to contact your EEC licensor or get in touch with us by emailing office.commissioners@mass.gov.

Thank you again for your work to care for the children and support the families of the Commonwealth.

The MA Department of Early Education and Care

The requirements in this document are specific to COVID-19 and the declared state of emergency. Regulations have been temporarily modified to align with the Minimum Requirements and can be found here: https://eeclead.force.com/resource/1598028195000/EEC_InterimRegulations

This guidance document is being issued on August 28, 2020 and is subject to updates as necessary.

Table of Contents

Updates **4**

1. Preparedness and Planning **5**

2. Screening and Monitoring of Children and Staff **11**

3. Responding to Illness **14**

4. Strategies to Reduce the Risk of Transmission **16**

5. Cleaning, Sanitizing, and Disinfecting **22**

6. Transportation **25**

7. Considerations for Special Populations **28**

8. Expanded Child Care Options for Remote Learning **30**

9. Supplements **34**

Family Child Care 34

Group and School-Age Care 35

Links and Resources **36**

COVID-19 Scenario Response Planning 37

Early Childhood Mental Health Consultation 41

Professional Development Centers 42

Background Record Check Information 43

Subsidy Policy Information 45

Educator Qualifications 48

Definitions **53**

Fliers and Forms **54**

This playbook will be updated as neceesary. All updates will be indicated by this icon. Please go directly to page 4 for a list of changes since the last iteration.

How to use this Playbook

On the left hand side of pages 5-29 you will find the Minimum Requirements for Health and Safety. On the right hand side you will find suggestions, best practices, and clarifications for how to implement the Minimum Requirements in your program.

Updates

The following updates have been made since the June 12th version of the ***Massachusetts Child and Youth Serving Programs Reopen Approach: Minimum Requirements for Health and Safety***.

1. All child care programs may return to pre-COVID licensed ratios.

2. All child care programs may return to pre-COVID-19 licensed maximum group size provided that for GSA programs, 42 sq ft of licensed space per child can be achieved.

3. Early educators and child care providers are now required to wear face masks at all times when at child care unless outside and maintaining 6 feet of physical distance (p 19). Face masks use for children continues to be encouraged.

4. Programs must now report all positive COVID-19 cases directly to the Department of Public Health via an online reporting form (p 15). Please note, this does not replace filing an incident report before a positive test result if symptoms or a possible exposure are reported.

5. During the COVID-19 emergency, only children up to the age of 8 who live in an FCC home and are present in the child care space will be considered to be 'in the care of educators' for the purposes of determining capacity. Children who are enrolled in school and older than 8 may be in the child care space without counting towards licensed capacity as long as 35 square feet per child can be maintained. (pg 30)

6. Limited in-person support services are now allowed when the service can't be effectively provided via telehealth. All providers must follow proper health and safety protocols including completing a health attestation and screen at entry, wearing appropriate PPE, and not moving between groups. (pg 28)

7. Field trips are allowable with a plan to maintain discrete groups, physical distancing, face masks, and frequent handwashing (pg 17)

1. Preparedness and Planning

A. PLANNING

Programs must develop and submit plans prior to reopening (and maintain them once reopened) that address how the program will meet the COVID-19 specific health and safety requirements. Elements of this planning address how the program will safely reopen during the COVID-19 pandemic and must include the following:

1. Program Operations Plan

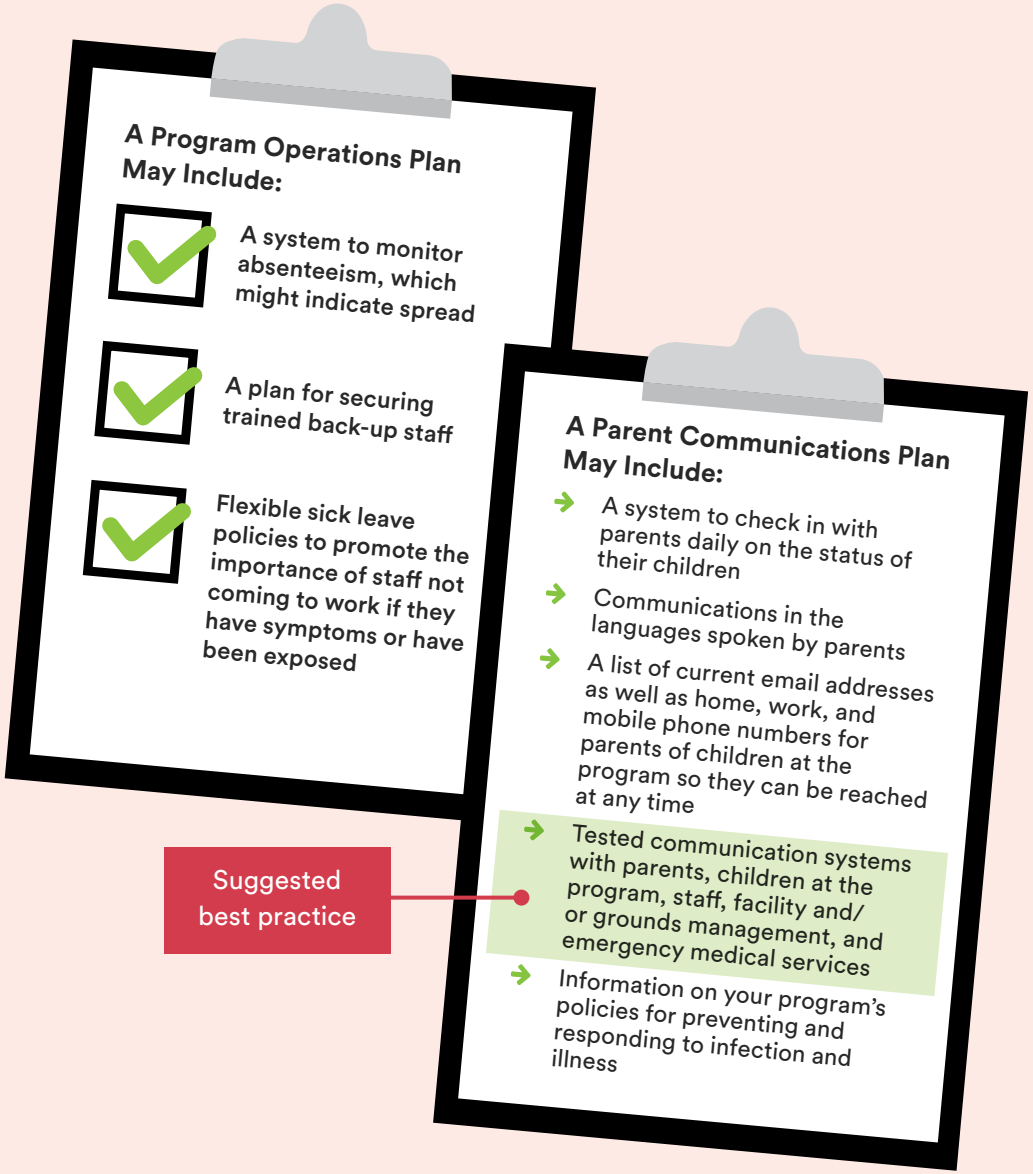
a. Program Administration: A plan to ensure that strategies are in place to minimize contact and promote physical distancing.

b. Parent Communications: A plan to ensure that reasonable measures are in place to communicate with families and ensure family support of infection control practices.

c. Support Services: A plan for how the program will coordinate space and facilitate virtual or limited in-person support services for children, including when identified on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

2. Cleaning Plan

A plan that identifies what items must be cleaned, sanitized, or disinfected and with what frequency, as well as how cleaning supplies will be stored and prepared safely and away from children.



For plan templates, visit https://sforce.co/2Xy7HSw

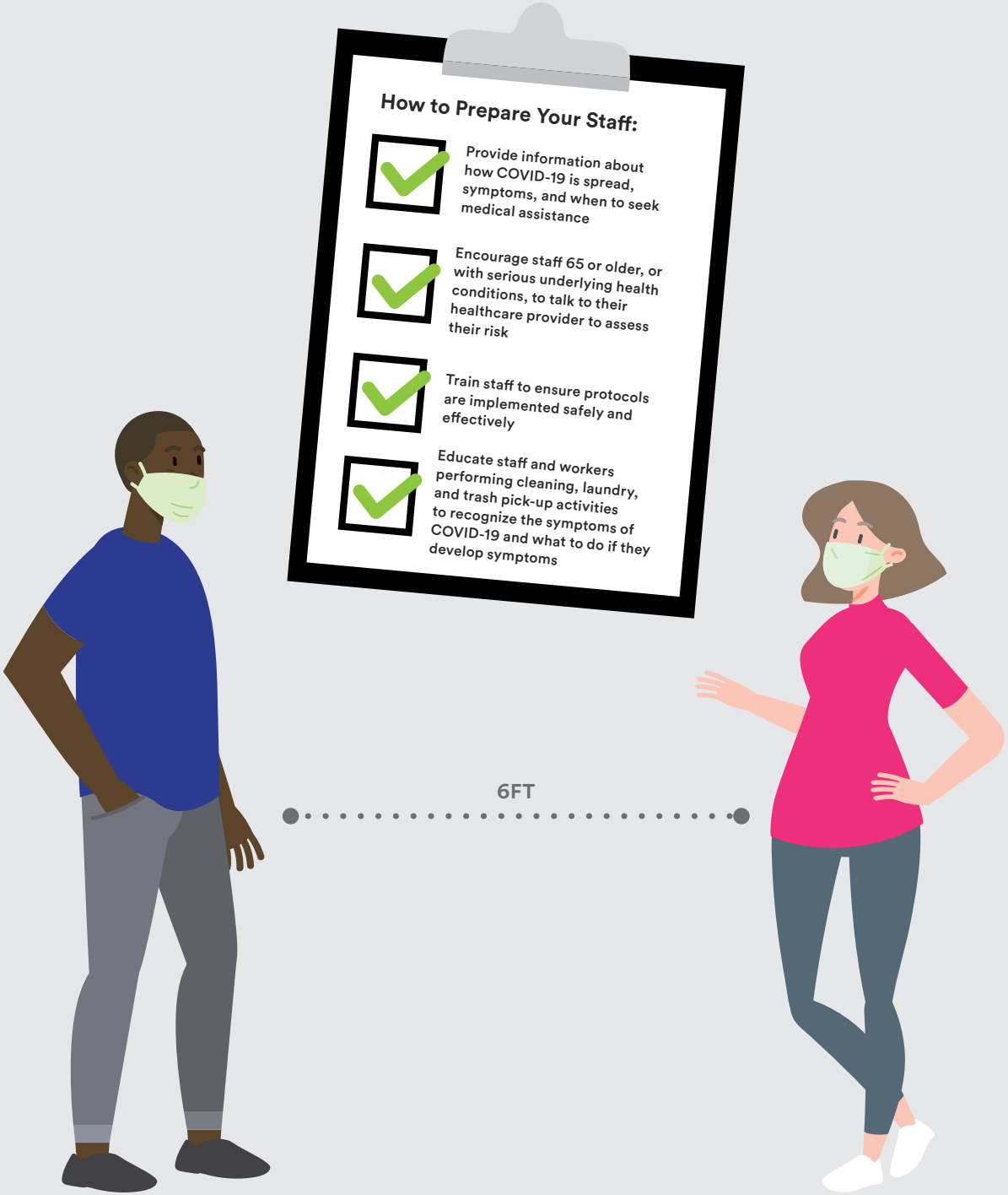
3. Monitoring and Response Plan

a. **Screening:** A plan to identify sick, symptomatic, and exposed children and staff that includes but is not limited to daily screening checks, location of screening activities, staff responsible for screening, and barriers for screening.

b. **Isolation and Discharge:** A plan for the isolation and discharge of sick, symptomatic, and exposed children or staff, including: procedures for contacting parents immediately; criteria for seeking medical assistance; transportation of children or staff who have developed symptoms related to COVID-19 mid-day and who rely on program transportation; mitigation of transmission until a sick individual can safely leave the program.

c. **Board of Health Engagement:** A plan to work with your local and state health departments to ensure appropriate local protocols and guidelines are followed, such as updated/additional guidance for cleaning and disinfection and instructions and availability of COVID-19 testing.

d. **Program Closing and Absences:** A plan for handling program closings, staff absences, and gaps in child attendance. The plan must include procedures to alert local health officials about large increases in child and staff absences or substantial increases in respiratory illnesses (like the common cold or the "flu," which have symptoms similar to symptoms of COVID-19). Programs must determine how the facility will communicate with staff and parents and identify who will be responsible for informing the funding agency, local board of health, and other appropriate audiences.



4. Medication Administration Plan

A plan for the administration of medication including a plan for the treatment of children with asthma and other chronic illness.

5. Transportation Plan

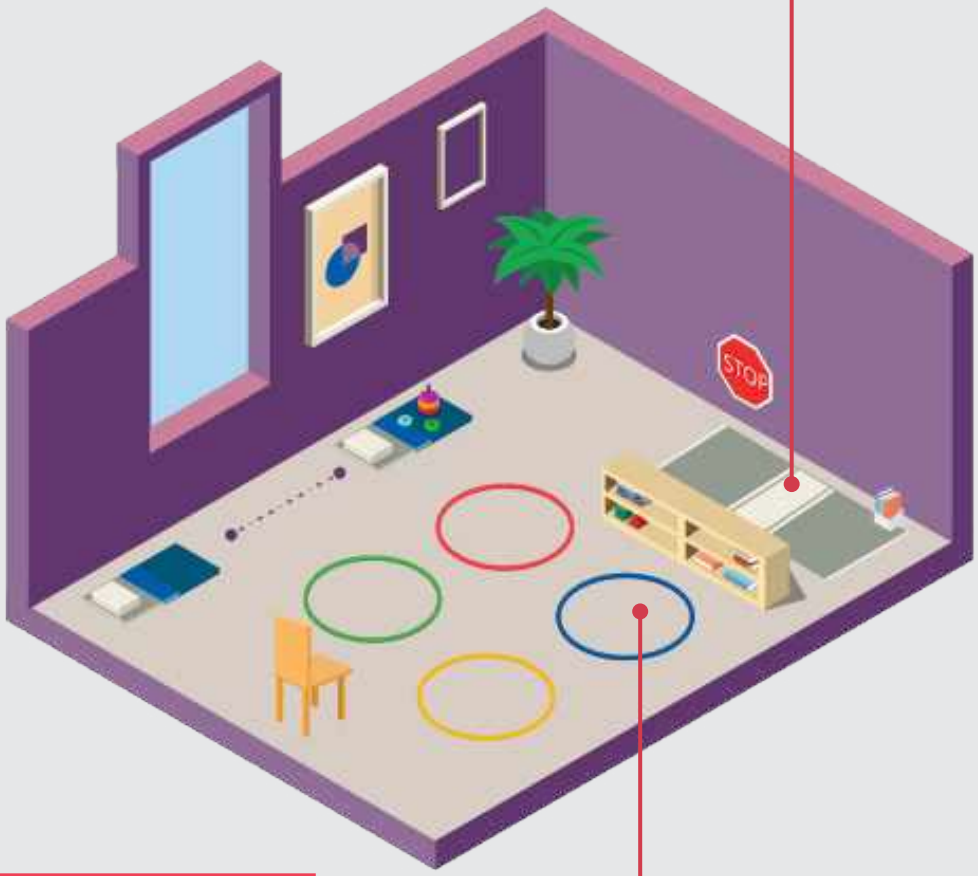
If applicable, a plan that includes how to implement infection control strategies during transportation, including during boarding and disembarking, and a plan to maintain physical distancing and hand hygiene practices before, during, and after transport.

PREPARING THE PHYSICAL SPACE

All spaces used for child care must be large enough to accommodate the number of children present and arranged in a way that promotes the Minimum Requirements in this document.

1. Arrange the physical space to promote physical distancing
   a. For Group and School-Age Programs: A minimum of 42 square feet per child in attendance is required in the program space.
   b. Programs with large, open spaces used by more than one discrete group at the same time must create a barrier that defines the separate spaces and ensures a minimum of 6 feet between the groups.

2. Designate a space for isolation of sick or symptomatic individuals
   a. A separate space must be pre-identified for the child or adult to remain in until he or she can be picked up.
   b. Designated isolation space must allow for both physical separation from other children and continued supervision until the child can be picked up.



If possible, designate a separate exit for those being discharged due to suspected COVID-19 infection.

Decisions about how to organize your space should be guided by your **ability to implement consistent physical distancing.**

Best Practice

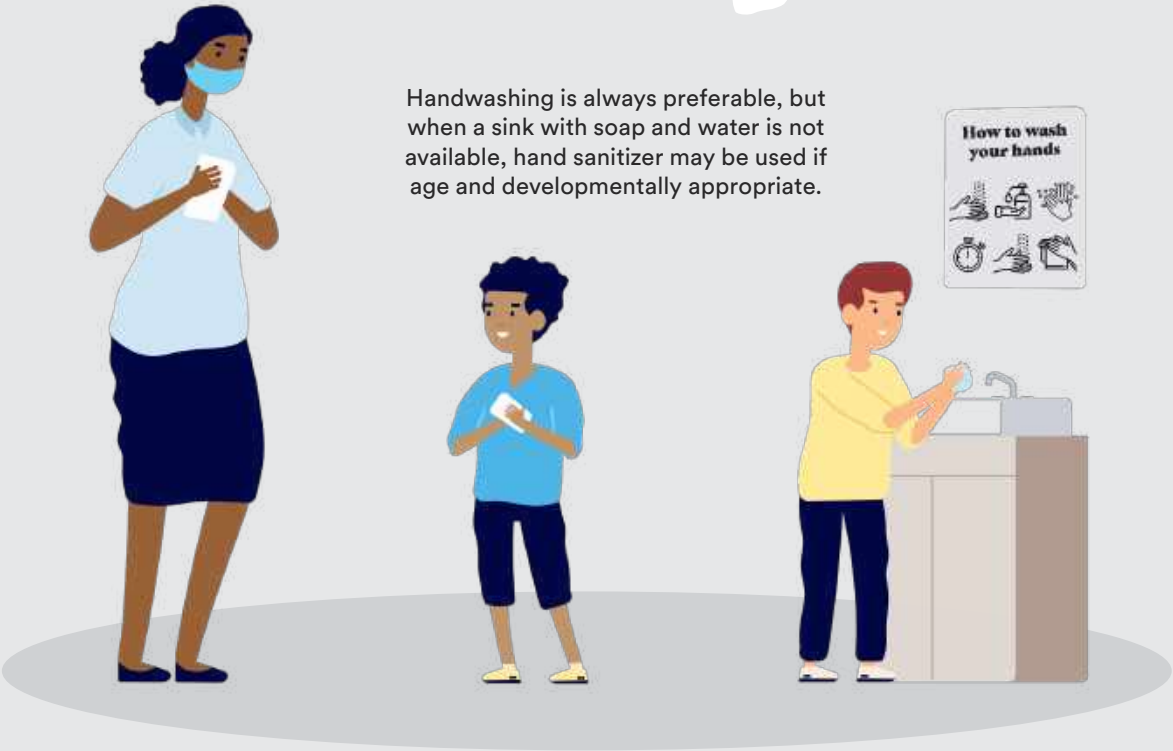
Ensure adequate supplies to minimize sharing of high touch materials like art supplies, or limit use of supplies and equipment to one group of children at a time, then clean and disinfect between uses.

3. Eliminate materials that increase the likelihood of transmission
   a. Remove soft, porous toys and items that cannot be easily cleaned between uses (e.g., stuffed animals, pillows).
   b. Remove any shared items that cannot be cleaned or disinfected at all (e.g., playdough).
   c. Remove all communal water, sand, and sensory tables.
   d. Store child and adult personal belongings in a manner where they do not touch.
   e. Close drinking fountains that require contact for use.

4. Promote frequent hand hygiene
   a. Provide adequately supplied handwashing facilities with soap, water, and disposable paper towels that are readily accessible to all children and staff.
   b. Set up hand hygiene stations at the designated entrance of the premises, so that children and staff can clean their hands before they enter.
   c. Handwashing instructions must be posted near every handwashing station where they can easily be seen by children and staff.

If you allow children to bring in items from home, have a plan in place to ensure the cleanliness of these items and carefully monitor use to ensure that these objects are not shared between children.

Handwashing is always preferable, but when a sink with soap and water is not available, hand sanitizer may be used if age and developmentally appropriate.



Best Practice

If possible, assign an individual sensory bin to each child daily to reduce shared materials and limit needed cleaning and sanitizing or disinfecting to the end of the day.

5. Facilitate cleaning, sanitizing, and disinfecting routines

   a. Establish safe storage of all cleaning, sanitizing, and disinfecting solutions that is separate from food items, accessible to staff in each area of the program, and out of reach of children.

   b. Label all sanitizing and disinfecting solutions to identify the contents. Do not store sanitizing and disinfecting solutions in beverage containers.

6. Confirm safe operations, including the safety of water and ventilation systems

   a. Test and confirm that ventilation systems operate properly prior to reopening for child care services and ensure that regular maintenance is carried out, including changing filters, where applicable.

   b. Test and confirm that all water systems and features (e.g., cooling systems) are safe to use to minimize the risk of Legionnaires' disease and other diseases associated with water, excess moisture, or mold.

Increase ventilation and circulation of outdoor air as much as possible by opening windows and doors when safe to do so.

Cabinets that store cleaning products must be able to be locked and must remain out of reach of children at all times.

2. Screening and Monitoring of Children and Staff

A. DAILY SCREENING

Programs must screen all individuals, including staff, children, service providers, and maintenance professionals, for symptoms of COVID-19 before they are permitted to enter the child care space.

1. Establish a single point of entry to the program to ensure that no individual is allowed to enter the immediate child care space until they are screened and are confirmed to have none of the symptoms in 2C.

2. Establish a designated screening area that is close to the point of entry and allows for physical distancing during screening activities.

3. Designate specific program staff to conduct all screening activities. The designated staff must obtain information necessary to complete the daily screening either by direct observation of the child, by asking the parent/guardian, or through conversation with the child, as appropriate and reliable.

4. Record and maintain on file all health check responses (i.e. signed daily health attestation forms) collected through daily screening.

5. Prohibit entry to any individuals who decline to complete the required daily screening or attestation.

Establish a single point of entry, to ensure that no one is allowed to enter until they are visually screened.

Drop off and pick up protocols and space should **promote physical distancing for parents/guardians.**

Post signs at the designated entrance reminding children, families, and staff of the symptoms of COVID-19 and not to enter child care if they have noticed any of those symptoms.

If possible, place sign-in stations outside the child care space to encourage physical distance. If pens are used, they must be disinfected between uses.

Web-based health attestation, or having parents complete the health attestation prior to arrival are also acceptable procedures.

All staff, parents, children, and anyone seeking entry into the program space must self-screen at home prior to coming in.

→ **Self-screening:** checking for symptoms such as fever, cough, shortness of breath, gastrointestinal symptoms, new loss of taste/smell, muscle aches, or any other symptoms that feel like a cold. Anyone with a fever of 100.0F or above or any other signs of illness must not be permitted to enter the program.

B.

HEALTH ATTESTATION

All parents or guardians must complete a health attestation for each child every day prior to arriving at childcare. Health attestations must include:

1. A check for new symptoms listed in section 2C observed in the child, staff, or household members within the past 24 hours;

2. A check for close contact with a known COVID-19 positive individual within the last 14 days; and

3. A statement that individuals with a fever or other new or unexpected symptoms consistent with COVID-19 and those who have had close contact with a COVID-19 positive individual must not be permitted into the child care space.

Health Attestation:

- Fever, feverish, had chills
- Cough
- Sore throat
- Difficulty breathing
- Gastrointestinal distress
- Fatigue
- Headache
- New loss of taste or smell
- New muscle aches
- Any other signs of illness

Both a health attestation by the parent or guardian AND a visual symptom screen by a staff member or educator must be completed before a child may attend child care.

Remind parents through regular communications that if a child is exhibiting any of the symptoms at home, they should not be brought to care

C.

SYMPTOM LIST

1. The following symptoms, if observed in a child or staff member are cause for immediate isolation and exclusion from child care:
   a. Fever (100.0° and higher), feverish, had chills
   b. Cough
   c. Sore throat
   d. Difficulty breathing
   e. Gastrointestinal distress (Nausea, vomiting, or diarrhea)
   f. New loss of taste or smell
   g. New muscle aches

2. The following symptoms, if observed in combination with symptoms from 2C(1), are cause for immediate isolation and exclusion from child care:
   a. Fatigue
   b. Headache
   c. Runny nose or congestion
   d. Any other signs of illness

D.

REGULAR MONITORING

Staff must actively visually monitor children throughout the day for symptoms included in section 2C. Programs must have a non-contact or temporal thermometer on site to check temperatures if a child is suspected of having a fever. Special care must be taken to disinfect the thermometer after each use, in accordance with CDC guidance.

3. Responding to Illness

A. ISOLATE AND DISCHARGE

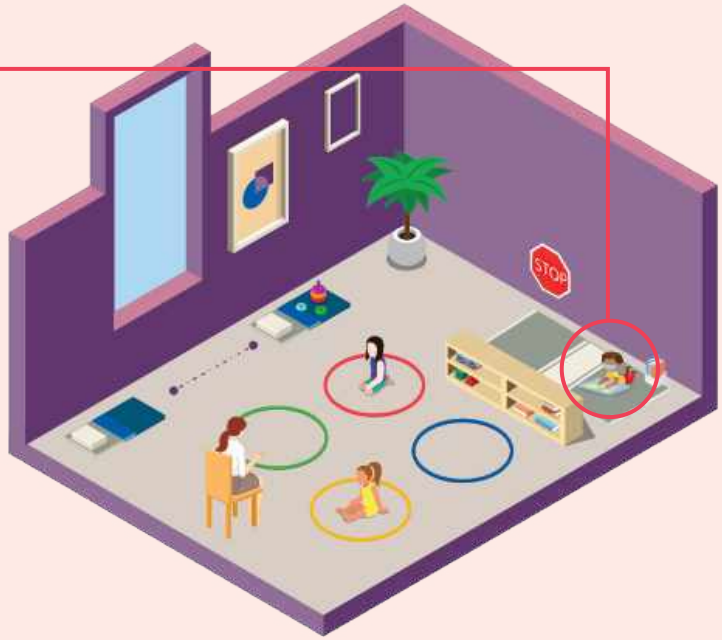
1. In the event that a child becomes symptomatic while in care:
   a. Immediately isolate the child to the previously identified isolation area to minimize further exposure to other children and staff;
   b. Have the child wear a face mask if appropriate based on the criteria in 4C(4); and
   c. Contact the child's parents or emergency contact on file to arrange for immediate pick-up.

2. In the event that an adult becomes symptomatic while at a child care program:
   a. Immediately cease all child care duties; and
   b. Isolate from the child care space to minimize further exposure to other staff and children until he or she can leave the premises.

If a child begins showing symptoms while already at care, **they should be isolated as quickly as possible** until they can be picked up.

Have an emergency back-up plan for staff coverage in case a child or staff member becomes sick.

Have masks and other cloth face coverings available for use by children and staff who become symptomatic.



If a child or staff member appears to have severe symptoms, call emergency services immediately. Notify the transfer team if the individual is suspected to have COVID-19.

Severe symptoms include:

- Extreme difficulty breathing (i.e. not being able to speak without gasping for air)
- Bluish lips or face
- Persistent pain or pressure in the chest
- Severe persistent dizziness or lightheadedness
- New confusion or inability to rouse someone
- New seizure or seizures that won't stop

B.

REPORT CONFIRMED CASES

In the event that you are informed of a COVID-19-positive individual in your program, or a COVID-19-positive individual that shares a home with someone in your program, you must:

1. **REPORT** the positive case to the Department of Public Health using the COVID-19 Positive Reporting Form (a link to this form can be found in LEAD).

2. **CONNECT** with an epidemiologist from the Department of Public Health to discuss next steps. The epidemiologist will call the program contact as listed in the reporting form after the COVID-19 Positive Reporting Form is submitted.

3. **IMPLEMENT** a communication plan that maintains the privacy of the infected individual and addresses next steps with impacted families as discussed with the epidemiologist.

4. **SUBMIT** an incident report in LEAD in the same manner as any other infectious disease.

C.

RETURNING TO CARE OR WORK

1. After a confirmed exposure to COVID-19 or a COVID-19 positive test, return to care or work at a child care center is based on the end dates of quarantine or isolation established by the local board of health or state health department.

2. Return to care or work after exclusion and a diagnosis or isolation for a non-COVID-19-related illness should be in line with a provider's existing exclusion policies as stated in their health care policy and in consultation with families. If the non-COVID-19-related illness is a reportable infectious disease other than COVID-19, and is not already addressed in the health care policy, consultation with the local board of health or state health department may still be necessary to establish a return to care or work.

If a child, staff member, educator, or household member of anyone in the program tests positive for COVID-19, follow these 4 steps:

1. REPORT

Immediately report to the Department of Public Health using the short COVID-19 Positive Reporting Form.

Link to reporting form is available in LEAD.

2. CONNECT

A Public Health representative will call to ask follow-up questions to help you determine a plan that may include enhanced monitoring, enhanced cleaning, or closure of a grouping or program.

3. IMPLEMENT

Share only pertinent information and instructions with families while maintaining the confidentiality of individuals.

4. SUBMIT

Within 48 hours, submit an incident report in the LEAD system, just as you would with any other infectious disease.

If, for any reason, you have not been able to get in touch with Public Health, please notify your licensor for assistance.

Incident reports should still be completed in a manner consistent with pre-COVID-19 protocols prior to a positive test result.

For questions in advance of a positive test result, programs may also send an email to DPH epidemiologists at childcare.covid19@mass.gov or call 617-983-6800 and follow the prompts.

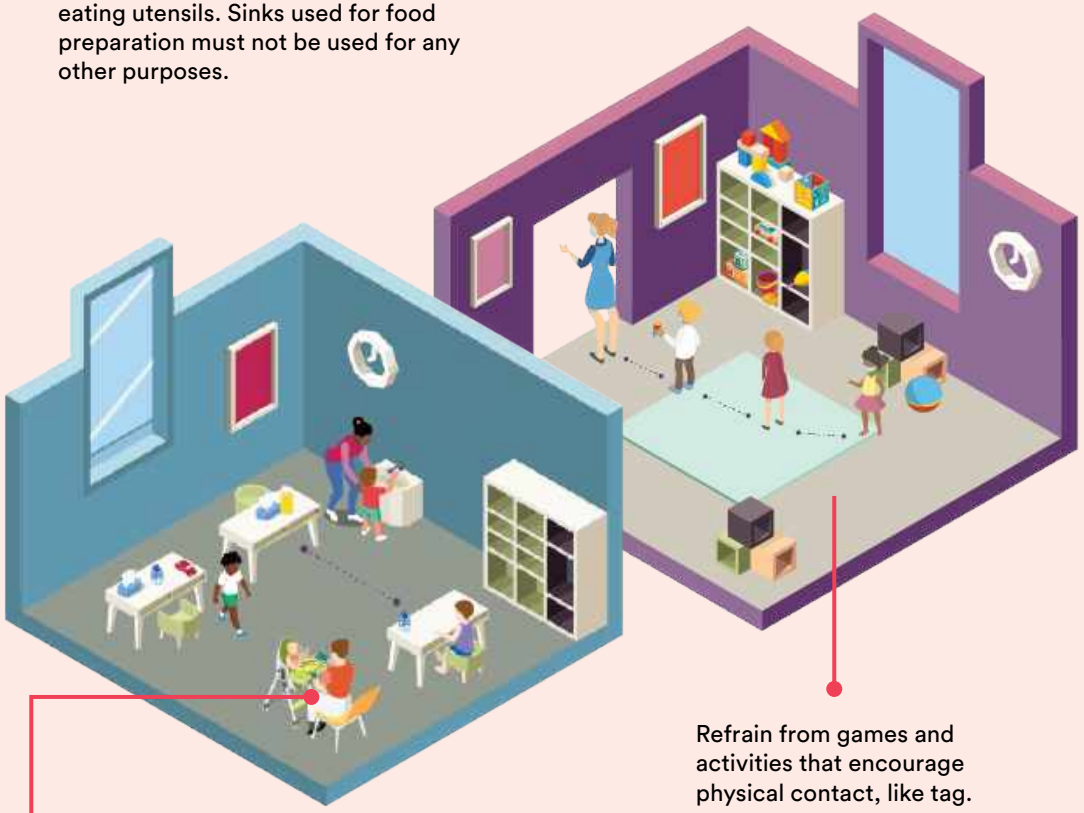
4. Strategies to Reduce the Risk of Transmission

A. PHYSICAL DISTANCING

Programs must implement routines and create spaces that promote 6 feet of physical distancing at all times.

1. Children and staff must physically distance at all times, including but not limited to:
   - During transitions (e.g., moving from inside to outside spaces);
   - During meal times;
   - During all indoor and outdoor activities;
   - During sleep, rest, or quiet play time; and
   - While on transportation.

If group-style dining is typically used, serve meals in classrooms instead. All food should be ready to serve in individual portions or pre-packaged to minimize handling. Every child must have their own drinking cup and eating utensils. Sinks used for food preparation must not be used for any other purposes.



Refrain from games and activities that encourage physical contact, like tag.

Tables, chairs, high chairs, and high chair trays used for meals need to be cleaned and sanitized before and after use.

Best Practice

Use a social story to explain how germs can spread through sharing food and drink.

DISCRETE GROUPINGS

Children must remain with the same group of children and staff each day and at all times during the day while in care.

1. Discrete groups of children and staff must not be combined with other groups during the day including:
   a. During drop-off;
   b. During pick-up;
   c. During transition times;
   d. During, before or after care; and
   e. During all activities.
2. The same staff must be assigned to the same group of children each day.
3. Toys, materials, and equipment must not be shared between groups unless they are properly and thoroughly cleaned and disinfected or sanitized before being shared from one group to another.
4. All non-essential visitors must be prohibited from entering the child care space including interns, volunteers, coaches and consultants. Exceptions include:
   a. Employees specifically assigned to the site on a daily basis;
   b. Contracted service providers who cannot deliver services remotely; and
   c. Program staff needed for supervision or coverage due to an emergency.

Limit field trips to only those venues where physical distancing can be achieved, discrete groupings can be maintained, and that have plans in place to enforce COVID-19 specific health and safety practices.

When all other options have been exhausted, **an adult not regularly assigned to a stable group, like a director, may provide coverage for a primary educator** when children are engaged in activities that require less adult involvement provided they take all health and safety precautions including wearing a mask at all times, and limiting prolonged close interactions.

Best Practice

Written parent permission must be obtained for all off-site trips as previously required and a plan should be in place to ensure that handwashing occurs immediately upon return.

HAND HYGIENE

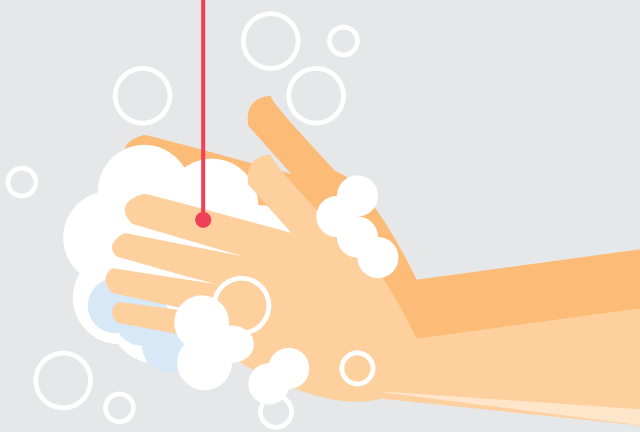
Children must be encouraged to wear face masks during the program day whenever 6 feet of physical distance is not possible. Adults must be required to wear a face mask at all times unless outside and maintaining physical distance.

1. Adults and children must regularly wash their hands throughout the day, including but not limited to
   a. Upon entry into and exit from program space;
   b. When coming into the program space from outside activities;
   c. Before and after eating;
   d. After sneezing, coughing or nose blowing;
   e. After toileting and diapering;
   f. Before handling food;
   g. After touching or cleaning surfaces that may be contaminated;
   h. After using any shared equipment like toys, computer keyboards, mouse, climbing walls;
   i. After assisting children with handwashing;
   j. Before and after administration of medication;
   k. Before entering vehicles used for transportation of children;
   l. After cleaning, sanitizing, disinfecting, and handling refuse;
   m. After contact with face mask or cloth face covering; and
   n. Before and after changes of gloves.

2. If handwashing is not available, hand sanitizer with at least 60 percent ethanol or at least 70 percent isopropanol may be utilized as appropriate to the ages of children and only with written parent permission to use.[1]
   a. Hand sanitizer must be stored securely and used only under supervision of staff.
   b. Staff must make sure children do not put hands wet with sanitizer in their mouth and must supervise children during and after use.

1. While hand sanitizer may be used by children over 2 years of age with parental permission, handwashing is the preferred and safer method.

Ask parents and caregivers to wash their own hands and assist in washing the hands of their children before dropping off, prior to coming for pick-up, and when they get home.



Supervise children when they use hand sanitizer to make sure they rub their hands until completely dry, so they do not get sanitizer in their eyes or mouth. Due to its high alcohol content, ingesting hand sanitizer can be toxic for a child.

Best Practice

Post visual steps of appropriate handwashing to assist children or cue them to **sing the "Happy Birthday" song TWICE** (approx. 20 seconds) as the length of time they need to wash their hands.

FACE MASKS

Programs must promote the wearing of face masks or transparent face masks during the program day for children and require the wearing of face masks for adults at all times.

1. Face masks must cover the nose and mouth, fit snugly against the sides of the face, and be secured behind the ears or head.

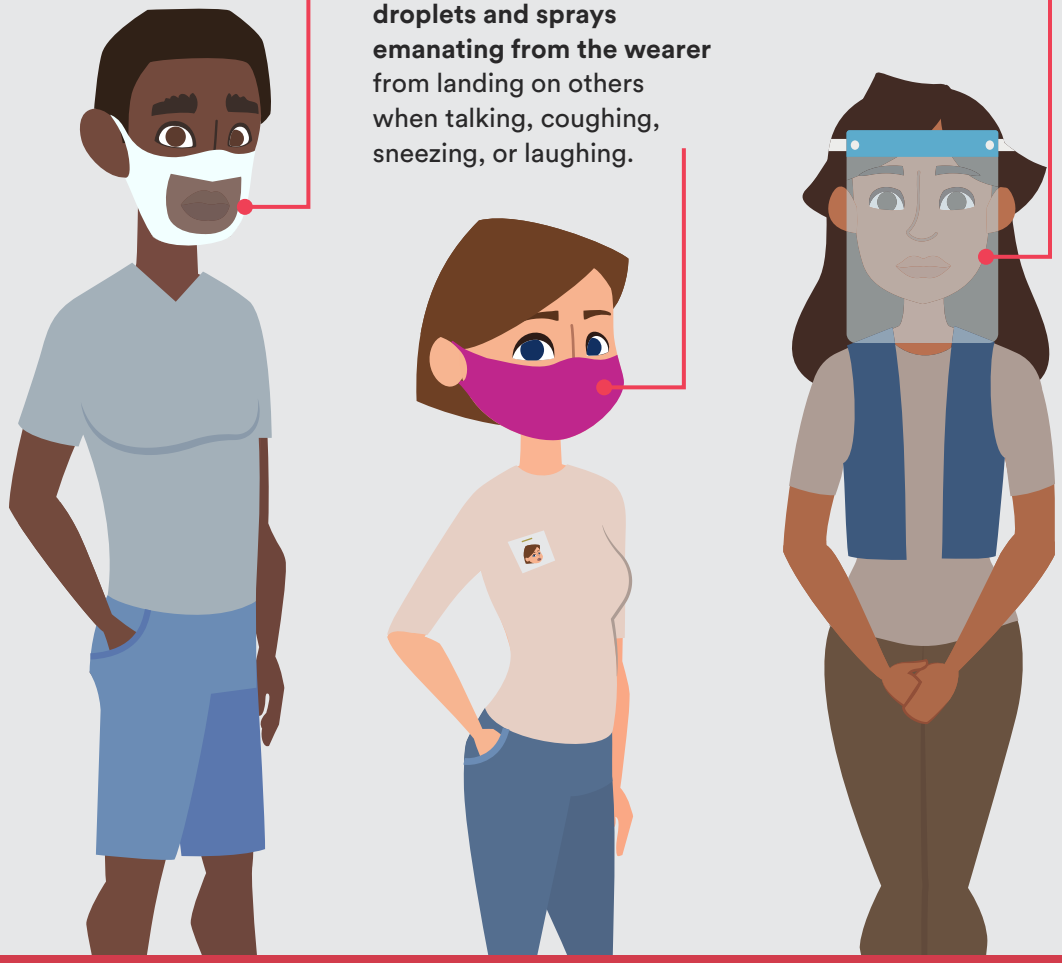
2. Programs must require face mask use by all people in the program space, including parents or guardians during drop-off and pick-up, facilities maintenance professionals performing upkeep and maintenance duties, and any adults providing services to children in the program space (i.e. 1-1 aides).

3. When 6 feet of distance is not possible, face mask use requirements for children are as follows:
   a. Children age 7 and older must wear a face mask.
   b. Children age 2-6 who can safely and appropriately wear, remove, and handle face masks must be encouraged to wear face masks and must be supervised at all times while wearing a face mask.
   c. Children under the age of 2 years must not wear face masks or face coverings of any kind.

A *transparent face mask* or covering is a face mask that has an integrated transparent panel so the wearer's mouth can be seen.

A *face shield* is a clear plastic guard that is usually secured at the forehead, but open around the face. It blocks splashes, sprays, and spatter from others from landing on the face of the wearer. **If a face shield is worn, a mask must be worn underneath.**

All *face masks* prevent droplets and sprays emanating from the wearer from landing on others when talking, coughing, sneezing, or laughing.



Best Practice

Using a transparent face mask allows facial expressions to be read by children. When a traditional face mask must be worn, an educator can pin a fun photo of him or herself to their clothing to help ease a child's fear or anxiety.

4. Exceptions to the use of face masks:

a. Children of any age who cannot safely and appropriately wear, remove, and handle masks;

b. Children while eating, drinking, sleeping, or napping;

c. Individuals who have difficulty breathing with the face covering or who are unconscious, incapacitated, or otherwise unable to remove the cover without assistance;

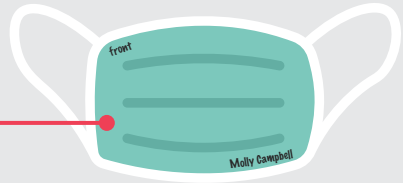
d. Children with severe cognitive or respiratory impairments that may have a hard time tolerating a face mask;

e. Children for whom the only option for a face covering presents a potential choking or strangulation hazard;

f. Individuals who cannot breathe safely with a face covering, including those who require supplemental oxygen to breathe; and

g. Individuals who, due to a behavioral health diagnosis or an intellectual impairment, are unable to wear a face covering safely.

Families should clearly mark masks with their child's name and distinguish which side of the covering should be worn facing outwards so they are worn properly.

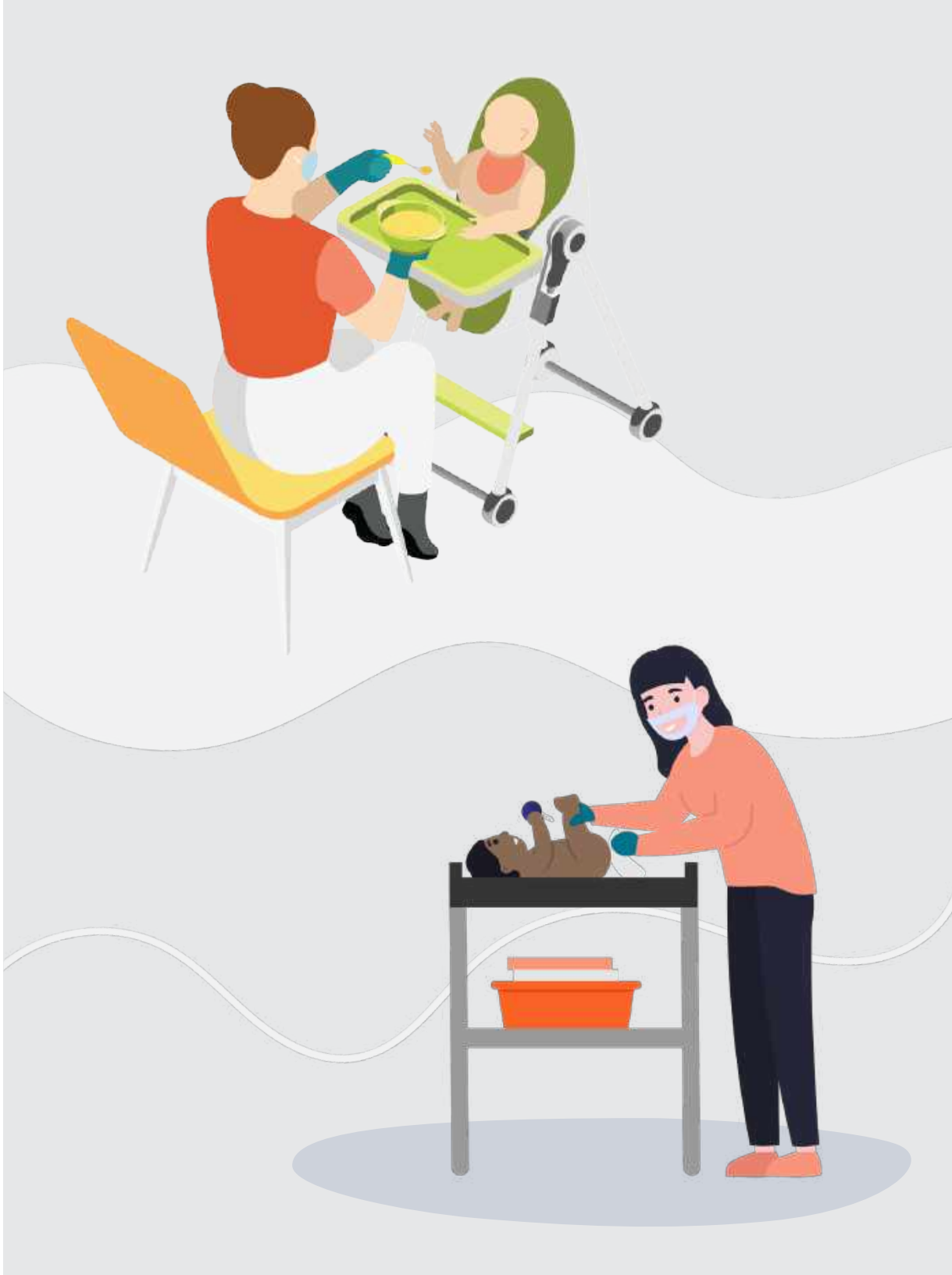


Encourage everyone to adhere to the CDC's recommendations for wearing a mask or cloth face covering whenever going out in public and/or around other people.

E.

USE OF GLOVES

1. Gloves must be worn at all times during the following activities:
   a. Diapering and toileting;
   b. Administering medication;
   c. Food preparation; and
   d. Screening activities requiring contact.
2. Gloves must always be removed and discarded after each use and in the following instances:
   a. Visible soiling or contamination with blood, respiratory or nasal secretions, or other body fluids occurs;
   b. Any signs of damage (e.g., holes, rips, tearing) or degradation are observed; and
   c. Maximum of four hours of continuous use.
3. Programs must consult with a child's medical records and identify any allergies when determining type of gloves to use.
4. Handwashing or use of an alcohol-based hand sanitizer before and after the preceding activities and instances is always required, whether or not gloves are used.



5. Cleaning, Sanitizing and Disinfecting[2]

A. RESOURCES AND SUPPLIES

1. Programs must use EPA-registered disinfectants and sanitizers against COVID-19, whenever possible. Before using any product, staff must read and follow directions on the label, including ensuring that the disinfectant or sanitizer is not expired and that the product is approved for use on that type of surface (such as food-contact surfaces). If the directions for use for viruses/viricidal activity list different contact times or dilutions, staff must use the longest contact time or most concentrated solution appropriate to safely clean, sanitize, or disinfect.
2. When EPA-approved disinfectants or sanitizers are not available, a bleach and water solution[3] must be used as follows:
   a. To disinfect, add 1/3 cup of household bleach to 1 gallon of water OR 4 teaspoons of bleach per quart of water with a contact time of at least 2 minutes. Alternatively, a 70% alcohol can be applied.
   b. To sanitize, add one teaspoon bleach to one gallon of water OR 1/4 teaspoon bleach to one quart of water with a contact time of at least 1 minute or 30 seconds if immersing the object.
3. All bleach and water dilutions must be freshly mixed every 24 hours. Label and date all bleach solutions and discard unused mixtures 24 hours after preparation.
4. Programs must not prepare cleaning solutions in close proximity to children.
5. Only single-use, disposable paper towels must be used for cleaning, sanitizing, and disinfecting. Sponges must not be used.

2. Refer to CDC guidance for more information about proper cleaning, sanitizing, and disinfecting.
3. This is based on concentrated household bleach containing 8.25% sodium hypochlorite.

Books and paper-based materials are not considered high-risk and do not need additional cleaning or disinfecting. They should be regularly inspected and disposed of when heavily soiled or damaged.

Some bleaches, such as those designed for safe use on colored clothing or for whitening may not be suitable for disinfection.

Avoid aerosols, because they contain propellants that can affect breathing. Pump or trigger sprays are preferred.

Best Practice

When preparing sanitizing or disinfecting dilutions always add bleach to water to avoid splashes.

PROPER USAGE

Proper guidelines must be followed when cleaning, sanitizing, and disinfecting.

1. All sanitizing and disinfecting solutions must be used in areas with adequate ventilation and never in close proximity to children so as to not trigger acute symptoms in children with asthma or other respiratory conditions. Do not spray chemicals around children.

2. All surfaces must be cleaned with soap and water first, then disinfected or sanitized using a diluted bleach solution, alcohol solution with at least 70% alcohol, or an EPA-approved disinfectant for use against the virus that causes COVID-19.

3. Use all cleaning products according to the directions on the label. Follow the manufacturer's instructions for concentration, application method, and contact time for all cleaning and disinfection products.

4. Surfaces and equipment must air dry after sanitizing or disinfecting. Do not wipe dry unless it is a product instruction. Supervise children carefully to ensure that children are not able to touch the wet surface until it is completely dry.

5. Do not mix chemicals.

6. When disinfecting for coronavirus, EPA recommends following the product label use directions for enveloped viruses, as indicated by the approved emerging viral pathogen claim on the master label. If the directions for use for viruses/viricidal activity list different contact times or dilutions, use the longest contact time or most concentrated solution. Be sure to follow the label directions for FOOD CONTACT SURFACES when using the chemical near or on utensils and food contact surfaces.

Staff members designated exclusively for cleaning and sanitizing routines who do not come in contact with children are not counted in child care ratios.

Cleaning first will allow the disinfectant product to work as intended to **destroy germs on the surface.**

Disinfecting hard, nonporous surfaces is one of the most reliable ways to help lower the risk of spreading germs and should be done as often as possible.

D.

CLEANING, SANITIZING, AND DISINFECTING AFTER A POTENTIAL EXPOSURE IN DAY PROGRAMS:

If a COVID-19 positive individual has been in the program space, cleaning and disinfecting must be conducted as follows and with guidance from the Department of Public Health.

1. Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area. Wait 24 hours or as long as practical before beginning cleaning and disinfection. Programs must plan for availability of alternative space while areas are out of use.

2. Cleaning staff must clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment (e.g., tablets, touch screens, keyboards) used by the ill persons, focusing especially on frequently-touched surfaces.

Routine cleaning, sanitizing, and disinfecting practices must be intensified, paying extra attention to frequently-touched objects and surfaces, including doorknobs, bathrooms and sinks, keyboards, and banisters.

	Clean	Disinfect	Sanitize	Frequency
Frequently-touched objects and surfaces like doorknobs, bathrooms and sinks, keyboards and bannister	✓	✓		At least daily
Toys that touch a child's mouth	✓		✓	Before and after every use
Plastic toys and figurines	✓	✓		After every use or as much as possible
Wood toys building blocks and puzzles	✓	✓		After every use or as much as possible
Vinyl materials like climbing blocks and chairs	✓	✓		After every use or as much as possible
Art supplies	✓	✓		After every use or as much as possible
Sinks and handles	✓	✓		After every use or as much as possible
Bathrooms	✓			After every use or as much as possible
Cubbies	✓	✓		At least daily
Bibs and non-disposable towels	✓		✓	Before every use
Tables for mealtime	✓		✓	Before and after every use

6. Transportation

A. PRECAUTIONS DURING GROUP TRANSPORTATION:

Programs intending to provide transportation services must follow the guidance below.

1. Physical distancing of at least 6 feet must be maintained to the greatest extent possible while in transit.

2. Hand washing (hand sanitizer where appropriate) must be required upon arrival to the program after exiting the bus, van, or vehicle and prior to departure before boarding the bus, van, or vehicle. Drivers and monitors must have adequate supplies of tissues, hand sanitizers, face masks, cleaning supplies, and garbage bags inside the vehicle.

3. Transportation personnel must verify that each child has a signed daily health attestation form before the child boards group transportation each day.

    a. Children will not be allowed to board transportation without a completed health screen OR if they have any of the symptoms included in the health screen.

4. Program staff must perform a visual wellness check and symptom screen on all children arriving to the program via group transportation and collect all health attestations.

Stagger drop-offs/pick-ups. Encourage families to have the same person do drop-offs/ pick-ups each day.

Vehicles should off-load and load one vehicle at a time, unless a location allows for enough distance between vehicles.

Best Practice

Programs can provide printed copies of the daily health attestation for parents and guardians to complete before their child boards transportation. Educators can collect the health attestation when the child arrives at the program while they are completing the visual screening.

5. Drivers and monitors must wear face masks at all times.

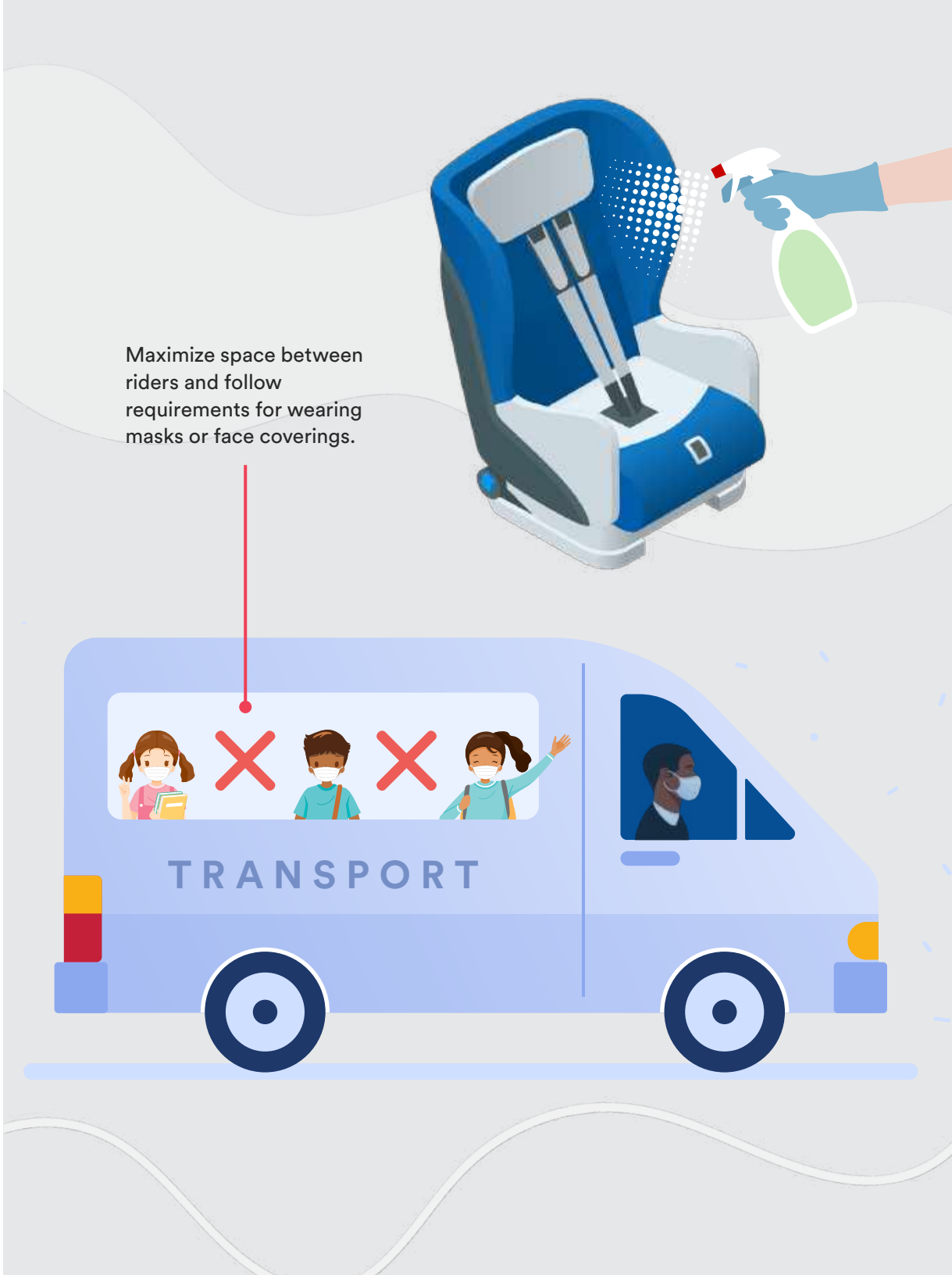
6. Riders over the age of 2 must wear face masks in compliance with section 4C of the Minimum Requirements.

7. Windows must be kept open, where safe to do so.

8. Do not recirculate conditioned air.

9. Require monitors and drivers to stay home if sick or symptomatic.

10. Vehicles must be wiped down with an appropriate cleaner between use by different groups of children.



B. ROUTINE CLEANING OF VEHICLES

The interior of each vehicle must be cleaned and either swept or vacuumed thoroughly after each route and disinfected at least once each day including using an EPA-Registered Product for Use Against Novel Coronavirus SARS-CoV-2 (the cause of COVID-19) to clean high-touch surfaces, including buttons, handholds, pull cords, rails, steering wheels, door handles, shift knobs, dashboard controls, and stanchions.

If soft or porous surfaces (e.g., fabric seats, upholstery, carpets) are visibly dirty, they must be cleaned using appropriate cleaners and then disinfected using EPA Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2.

Routinely clean and disinfect frequently-touched surfaces

Staff should be trained to use disinfectants in a safe and effective manner and to clean up potentially infectious materials and body fluid spills.

Best Practice

Ensure every vehicle has adequate supplies of soap, paper towels, tissues, hand sanitizers, face masks, cleaning supplies, and garbage bags.

7. Considerations For Special Populations

A. CHILDREN WITH SPECIAL NEEDS

Programs must ensure that children with special needs are provided appropriate care:

1. Ensure adequate staffing to accommodate each child's needs, including those required to maintain COVID-19-related infection control practices.
2. Ensure continued delivery of specialized services that cannot be effectively provided via telehealth.
3. Ensure staff are trained and prepared to support children with the necessary provisions of health care such as administration of medication needed throughout the day, tube feedings, blood sugar checks, and allergies to certain foods.
4. Provide staff with the appropriate PPE including:
   a. Transparent face masks for adults working with children who are deaf or hard of hearing to facilitate the reading of lips and facial expressions.
   b. Face masks and eye protection (face shields or goggles) for adults working in close proximity to children who are unable to wear a face mask due to intellectual, behavioral, or sensory differences.
5. **For Group and School-Age Programs Only:** Offer families the option of limited in-person delivery of specialized services that cannot be provided effectively via telehealth due to the developmental appropriateness or a child's ability to engage sufficiently in the telehealth model.
   a. All service providers providing limited in-person services must enter through the designated entrance, complete a health attestation, pass a visual screen, and wear appropriate PPE.

Infants and toddlers aren't able to tell us when they don't feel well, so staff must be attentive to any changes in a very young child's behavior. If a child starts to look lethargic and is not eating as well, notify the parent to determine whether the child's pediatrician should be contacted.

Reach out to families of children receiving EI, IEP, or other specialized services to **discuss how to meet the needs of the child and balance the health and safety of all individuals in the program.**

Early Childhood mental and behavioral health consultants are ready to respond and provide immediate support to programs that are working with children who are showing signs of emotional distress or behavioral disregulation. Please contact your region-specific ECMHC if you need help with an urgent behavioral issue. Contacts can be found in the resource section of this document on page 40.

STAFF CARING FOR SPECIAL POPULATIONS INCLUDING INFANTS AND TODDLERS

To protect themselves, staff who care for children requiring hands-on assistance for routine care activities, including toileting, diapering, feeding, washing, or dressing, and other direct contact activities must take precautions including:

1. Wearing a gown or other body covering (e.g., an oversized button-down, long sleeved shirt, etc.) and eye protection where available during washing and feeding activities;
2. Tying long hair back so it is off the collar and away from the reach of the child;
3. Washing with soap and water any area of the skin that has been touched by a child's bodily fluids; and
4. Changing clothes when contaminated by a child's bodily fluids.

For more invasive procedures, **staff should protect themselves by wearing a gown or other body covering, eye protection, and mask.**

To protect themselves, staff who care for infants, toddlers and children with special needs should have multiple changes of clothes on hand.

Nebulizers are allowed when absolutely necessary.

The program should have a plan in place to administer nebulizer treatment in a manner that is safe for the child and staff, including a separate space, ideally with a door that can be closed, and PPE, including mask, eye protection, gloves, and gown or additional outer garment.

Best Practice

Infants, toddlers, and children with special needs will require unique supports that may make it less possible to practice consistent physical distancing. Appropriate PPE and frequent hand washing are the best way to prevent the spread of COVID-19 when working with these individuals.

8. Care Options for Remote Learning

A. OVERVIEW

Families in communities returning to school with hybrid or fully remote learning models face increased need for supplemental childcare for school age children. Therefore, The Department of Early Education and Care (EEC) and the Department of Elementary and Secondary Education (DESE) have collaborated to provide policies to support expanded access to childcare.

Governor Baker recently issued COVID-19 Executive Order No. 49 which provides three paths for communities to expand safe, in-person supervision and supplemental care options for families with children enrolled in hybrid or remote learning during the school day.

Care Options for Hybrid and Remote Learning: Joint Guidance from EEC and DESE seeks to provide families, educators, communities, and childcare providers with complete information on:

- Expanding the capacity of EEC licensed providers serving school aged children
- Applying for a ***Remote Learning Enrichment Programs*** license exemption
- Remote Learning Parent Cooperatives
- Collaboration between districts, schools, and childcare providers

EXPANDING THE CAPACITY OF EEC LICENSED PROVIDERS SERVING SCHOOL AGED CHILDREN

EEC licensed providers are ordinarily not permitted to serve school-aged children during the hours of the school day per Massachusetts statute. However, in response to the hybrid and remote instructional models adopted by many districts, COVID-19 Executive Order No. 49 permits EEC licensed providers to operate during the school day and with increased capacity to meet the needs of families with children engaged in remote learning arrangements.

- An expedited EEC approval process for additional space (new space or converting existing space into classroom space) will occur for EEC licensed programs seeking to serve more school age children during the school day during this time.
- EEC licensed programs should speak with their licensor and apply through their LEAD portal.

IMPLEMENTING THE NEW REMOTE LEARNING ENRICHMENT PROGRAMS EXEMPTION

COVID-19 Executive Order No. 49 has established a new category of license exemption: *Remote Learning Enrichment Programs*.

- This license-exemption can apply to entities that are not already licensed by EEC and that seek to provide supervision, care, and educational support to school age children during school hours only.
- Programs that would like to serve children during before school or after school hours must apply to be licensed by EEC.

Remote Learning Enrichment Programs must:

- Adhere to EEC or DESE Health and Safety Standards with respect to the use of face masks, maintaining discrete groups, promoting physical distancing, and other strategies to reduce the risk of transmission
- Maintain a staff:child ratio of 1:13 with a maximum group size of 26 in accordance with EEC regulations
- Have completed Background Record checks for each staff member
- Have up to date fire, lead paint, and applicable building inspections

Collaborating with licensed providers to expand existing programs is the fastest path for communities to increase support to families during remote learning.

Existing programs are accustomed to health and safety standards and are prepared to create safe environments for students.

Entities interested in the Remote Learning Enrichment Programs exemption must first be approved by a **municipal authority (for example, a school district, local board of health, etc)**, which is also required to monitor the program, and may then apply for the exemption from EEC.

Municipality endorsement:
Municipalities will establish their own processes to work with interested entities, verify their eligibility, and monitor their programs on an on-going basis.

REMOTE LEARNING PARENT COOPERATIVES

Some families may seek to set up **remote learning parent cooperative** where multiple sets of parents or guardians share supervision of remote learning activities for their children throughout the school week. These are automatically exempted from EEC licensure if:

- There are no more than 5 families involved in the arrangement;
- All of the children participating are in kindergarten or above, and enrolled in school;
- A parent or guardian is acting in a supervisory role on site at all times.
- No parent is directly compensated for the time spent caring for children or supporting their education. Any exchange of funds must be directly related to materials, food, or supplies needed to support the informal cooperative arrangement.

If an informal cooperative arrangement does not abide by the above conditions, it is subject to regulation by EEC or may require advance approval of the local school district.

Families pursuing an **remote learning parent cooperative** should consider creating a plan for the time they are together including

- how supervision responsibilities will be divided among the families
- what health and safety precautions will be taken each day (Will there be a symptom screen? Will adults or children be expected to wear masks?)
- an action plan in case a child begins to show symptoms during the day
- expectations for remote learning support and engagement by the on-site parent.

An remote learning parent cooperative of families may hire an individual, such as a tutor or other instructor, to support remote instruction without requiring EEC licensure if all of the criteria are met AND the paid tutor or instructor is working only during the hours of the school day.

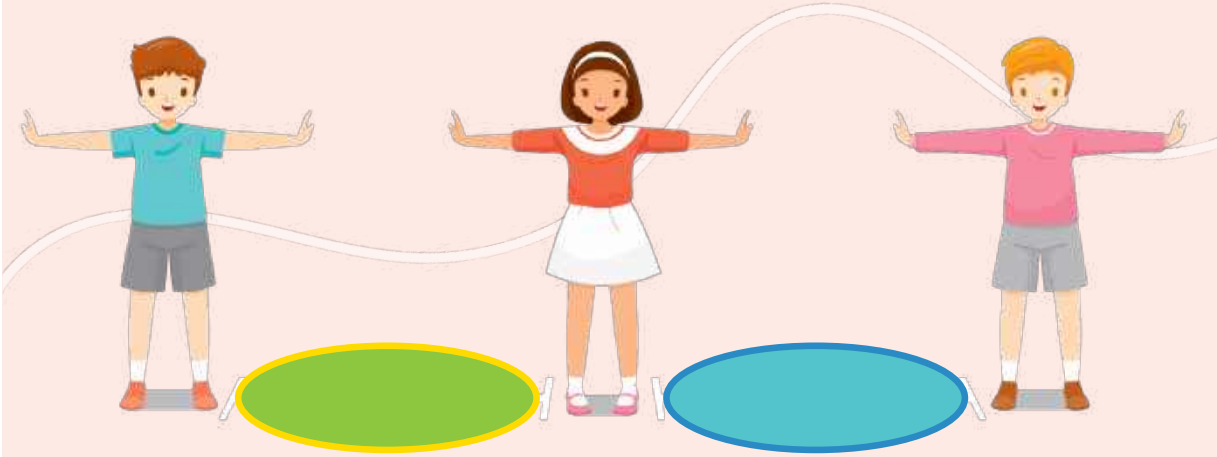
B. BALANCING HEALTH AND SAFETY WITH CHILD DEVELOPMENT AND SOCIAL EMOTIONAL LEARNING IN CHILDREN AGES 3-8

Education and care in a time of physical distancing does not have to mean that children are denied rich learning experiences, interactions with peers and spontaneous fun, or joyful play. For more ideas on the following topics, please read Child Care Options for Hybrid and Remote Learning: Joint Guidance from EEC and DESE.

- **Supporting playful learning in new ways**: Designing individual play experiences might feel strange at first, but with practice, they can help foster self direction, confidence and competency building.
- **Comforting children:** There will always be times when educators will need to tend to children and provide comfort and aid in the form of hugs and other close contact. Physical distancing protocols should not prevent an educator from providing the attention and care a child needs in a time of distress. There may be times when educators will need to tend to children and provide comfort and aid. Physical distancing protocols should not prevent an educator from providing the attention and care a child needs in times of distress - but verbal comfort or a favorite toy may also be used to help.
- **Arranging the Learning and Care Environment**: Opportunities for more tailored and custom activity centers and bins abound in this new environment, and when paired with presentation, questioning, and prompting for child-led discovery, new depths of relationship and engagement may emerge.

Have children **decorate or label their individual materials bins** so they have ownership of their items, and can locate them easily.

Use arrows or brightly colored signs on the floor to help children move around the space in a specific direction, or space out at an appropriate distance while waiting to go outside, or wash hands.



9. Supplements

Family Child Care

EEC is creating flexibility for FCC educators who have their own school age children participating in hybrid or virtual learning by temporarily lowering the age of children living in an FCC educator's home who count in an FCC's capacity. During the COVID-19 emergency, only children up to the age of 8 who live in the FCC home and are present in the child care space will be considered to be 'in the care of educators' for the purposes of determining capacity.

- Children who are enrolled in school and older than 8 may be in the FCC child care space without counting towards licensed capacity as long as 35 square feet per child can be maintained.
- Please note: Friends of household members up to the age of 13 who are in the home during child care hours still count in FCC capacity.

In an attempt to provide maximum flexibility for FCCs and families, **FCC educators may care for children for more than 12 hours within a 24-hour period.**

- FCCs must state that they are using this flexible protocol in their plan.
- EEC highly recommends that FCC educators create schedules of care that allow for significant breaks between groups of children in order to follow cleaning and disinfecting/sanitizing protocols and to ensure the educator has enough time for his or her own personal needs to be met.

1.B. When it is possible, FCC educators are encouraged to designate specific areas of the home as accessible only to enrolled children.

- Defined child care space will make the required cleaning protocols more manageable and will minimize impact to the space used by household members in the case of an exposure.

2.A. All household members must self-screen before coming into the Family Child Care space.

2.A. Visual screening protocol: If the FCC educator does not have an assistant to complete the visual screen before a child enters the child care space, the educator may follow the protocol below:

1. Post instructions at the designated entrance instructing parents/guardians to complete and sign the health attestation, and with a reminder that children with symptoms must not enter the child care space.
2. When the parent/guardian and child have completed the screening and signed in, they may continue into the child care space where the educator should complete the visual screen of the child for signs of illness.
3. If symptoms are observed, the child may not attend child care and must return home immediately.

3.A. In an FCC setting, symptomatic children must be isolated from the group while remaining visible to the educator for proper supervision.

4.A. All household members not involved in the care of enrolled children should maintain physical distance from all enrolled children throughout the day and, to the extent possible, should not share the same spaces, even at different times.

4.B. Part-time enrollment is allowed. FCC educators should strive to maintain stable groups as much as possible.

4.B. FCC educators are encouraged to maintain separate collections of toys for each group to the extent possible, or to limit the toys taken out on any given day to minimize the risk of transmission and to reduce the number of items that require cleaning, sanitizing, disinfecting at the end of each day.

Supplements Cont.

Group and School-Age Care

1.A. Identify a specific person who is responsible for sharing information with parents if a COVID-19 positive case occurs and establish a process for how that information will be communicated.

4.A&B. Limit playground access to one discrete group at a time unless groups can be kept separate on the playground and still have room to maintain 6 feet of physical distance.

4.B. If a program has large communal spaces used by multiple discrete groups:

- Use barriers like permanent walls, movable walls, or other stable partitions like cubbies to create separate areas for discrete groups in the space at the same time;
- Repurpose communal space (if license appropriate) for a non-communal purpose;
- Schedule time between uses for cleaning and disinfecting the common space.

7.A. Designate a space or spaces for the delivery of limited in-person services for students with special needs and for administering regular medical procedures as identified in a child's plan.

- The space should maintain a child's privacy, be large enough to accommodate the services while maintaining physical distance (when appropriate), and be appropriately decorated for use by a child.
- The space must be cleaned after each use.

Links and Resources

HEALTH AND SAFETY

- For additional questions related to stemming the spread of COVID-19 in child care settings, please contact Department of Public Health epidemiologists at childcare.covid19@mass.gov
- The Commonwealth's Community Tracing Collaborative is helping to stop the spread of COVID-19. Learn about contact tracing and answer the call if it comes!
- EEC will supply gloves, masks, and hand sanitizer through reopening for all licensed programs to ease the burden and cost of meeting the new requirements so programs can safely serve children and families. Please contact your Regional Office for more details.

EEC RESOURCES

- EEC COVID-19 Information website
- EEC Strong Start training 'Guidance for Reopening Childcare'
- Coordinated Family and Community Engagement Network
- Family Child Care systems
- Strong Start Professional Development Centers
- Child Care Resource & Referral

ADDITIONAL LINKS

- Reopening Massachusetts
- COVID-19 Updates and Information
- Massachusetts Department of Public Health
- MA Office of the Child Advocate
- MA Association for Infant Mental Health
- Shared Services of Massachusetts
- Centers for Disease Control Guidance for Child Care
- Center for Early Childhood Mental Health Consultation
- NAEYC Cleaning, Sanitizing and Disinfection Frequency Table

Links and Resources Cont.

COVID-19 Scenario Response Planning

SCENARIO 1: A STAFF MEMBER OR CHILD TESTS POSITIVE FOR COVID-19...

Reporting:

Complete the online reporting form found in your LEAD account to alert the Massachusetts Department of Public Health (DPH) and receive guidance for follow-up.

Impact on the individual:

If the individual is in the program when the test result is returned, isolate the individual immediately, ask them to wear a mask (if age and developmentally appropriate) and schedule prompt pick up.
The COVID-19 positive individual will be required by Public Health to isolate at home until they have met the criteria to discontinue isolation as established by the Local Board of Health or DPH. Isolation for COVID-19 typically lasts a minimum of 10 days and until fever has resolved for 24 hours and other symptoms have improved.

Impact on the immediate grouping:

If the individual is in the program when the test result is returned, other children and staff in the same group do not need to be isolated or picked up immediately, however extra attention should be paid to keeping that group from mixing with any other group, and the exposed individuals in the group must quarantine at home and not return to child care for 14 days (which aligns with the Health Attestation question regarding exposure).

Determining the infectious period: When you speak to the DPH representative, they will want to know if the individual was in your facility while they were considered infectious. The infectious period begins 2 days before symptoms start (or if they tested positive without any symptoms, two days before the test date).

Answers to the following questions will help determine if other children and staff in your facility have been exposed:

- What date did the symptoms develop?
- What date did the individual get tested?
- When was the individual last in your facility?

A DPH Epidemiologist will discuss this information with you and help to determine if there was an exposure at your facility. If there was an exposure:

- anyone with close contact (within 6 ft for 15 minutes or more) is considered exposed and will need to be excluded from care.
- exposed individuals will need to quarantine at home for a full quarantine period (which is typically 14 days from their last exposure).
- a public health authority (such as a DPH Epidemiologist or your Local Board of Health) will help you determine exact dates of quarantine and can provide you with template letters to inform the children and staff.

Impact on the program:

In programs with more than one grouping, when stable groups have been maintained (including children and staff), there would likely be no additional exposures outside of the immediate grouping. This means that any temporary closures could be limited to only the stable group which the COVID-19 positive individual was a member of.

Links and Resources Cont.

Additional considerations may include:

- If other staff or children from outside the individual's group had close contact with the individual while they were infectious, those additional contacts may also need to be quarantined.
- Any additional household contacts and/or siblings (if the confirmed case is a child) will also need to be excluded for a quarantine period as determined by a public health authority.

If you have additional questions about this scenario or are not sure if the staff member had contact with students or staff because of their specific job, make sure to discuss them with the DPH Epidemiologist when they respond to your report. Continued follow-up beyond this initial guidance from a DPH Epidemiologist should be coordinated with your Local Board of Health.

Communicating with families:

The DPH Epidemiologist will work with you to understand which families need which level of detail and if there are any more specific communications that need to be shared.

SCENARIO 2: A MEMBER OF A CHILD'S HOUSEHOLD OR A HOUSEHOLD MEMBER OF AN FCC EDUCATOR TESTS POSITIVE FOR COVID-19...

Reporting:

For the member of a child's household, complete the online reporting form located in your LEAD account to alert the Massachusetts Department of Public Health (DPH) and receive guidance for follow-up. Examples of household members may include a parent, caregiver, sibling, or other member of the household that likely has routine home contact with the child. For a household member of an FCC educator, no DPH Positive Reporting form is necessary.

Impact on the individual:

The child or FCC educator is now considered a close contact of a COVID-19 positive individual and should be excluded from child care until they complete a full quarantine period at home which typically lasts 14 days. Please note: This is aligned with the Health Attestation that asks about exposure to a COVID-19 positive individual in the past 14 days. The individual's quarantine will be determined by a public health authority (such as the Local Board of Health or DPH) based upon additional information regarding the household and exposure setting. The Local Board of Health will release the individual from quarantine when he or she may safely return to care.

Impact on the child's immediate grouping at child care:

In most cases where a household member is the positive case, the child that attends care is only a contact and not yet a positive case. If the child is now quarantining at home, there is unlikely to have been an exposure at your facility. The remaining children and staff in the classroom do not need to be excluded and the classroom does not need to close at this time.

If the child moves from a contact to a confirmed positive then follow guidelines in Scenario 1.

Impact on the FCC program:

If an FCC educator's household member tests positive for COVID-19, the FCC educator must now quarantine and thus may not provide care for children during this time.

Communicating with families:

The DPH Epidemiologist will work with you to understand which families need which level of detail and if there are any more specific communications that need to be shared.

If you have additional questions about this scenario, make sure to discuss them with the DPH Epidemiologist when they respond to your report. However, there is likely no additional required action by you at this time. Continued follow-up beyond this initial guidance from a DPH Epidemiologist should be coordinated with your Local Board of Health.

Links and Resources Cont.

SCENARIO 3: A CHILD OR STAFF MEMBER IS IDENTIFIED AS A CONTACT OF SOMEONE WHO IS NOT THEIR HOUSEHOLD MEMBER...

Reporting:

Complete an incident report in LEAD as you would for any other infectious disease. The incident report will not initiate a follow-up call from Massachusetts Department of Public Health (DPH).

Impact on the individual:

Anyone who is identified as a close contact to a confirmed case needs to be excluded from child care and needs to stay at home for 14 days from the date of their last exposure to the confirmed case. Please note: This is aligned with the Health Attestation that asks about exposure to a COVID-19 positive individual in the past 14 days.

Impact on the grouping and program:

If the child or staff member who is a contact has not had any symptoms and has not yet tested positive themselves, they do not represent an exposure to others in the child care setting. If the original COVID positive individual has not been in the child care space, there is a good chance no additional children or staff would be considered a close contact, and therefore no further action needs to be taken.

If the child moves from a contact to a confirmed positive then follow guidelines in Scenario 1.

Communicating with Families:

You are not required to send a general notification to families when a child or staff is named as a contact; however, a DPH Epidemiologist or the Local Board of Health can provide a template letter if requested.

SCENARIO 4: I HAVE PREVIOUSLY REPORTED A POSITIVE CASE THROUGH THE POSITIVE REPORTING FORM AND NOW ADDITIONAL CONFIRMED CASES OF COVID-19 HAVE OCCURRED IN STAFF, CHILDREN, OR A CHILD'S HOUSEHOLD MEMBER...

Reporting:

A COVID-19 positive reporting form (link available in your LEAD account) should be completed for each confirmed case associated with your child care program. This includes educators, staff members, children, or a child's household member.

Impact on the program:

Following submittal of the form, make sure to notify your Local Board of Health that you have been informed of additional cases related to your facility. The Local Board of Health and the DPH Epidemiologist will work with you to determine if the new cases are related to the first reported case, or if the new cases are unrelated. If there is evidence of transmission within the child care setting, additional guidance and recommendations may be applicable and will be provided by the Public Health representative.

Communicating with families:

The Public Health representative will help you determine what needs to be shared with families broadly and what additional specifics needs to be shared with individual families.

SCENARIO 5: AN INDIVIDUAL BECOMES SYMPTOMATIC WHILE IN CARE...

Reporting:

An incident report should be filed in LEAD as it would for any other possible infectious disease. Individuals with symptoms only should NOT be reported via the COVID-19 Positive Reporting Form unless and until the individual is identified as having had confirmed contact with a COVID-19 positive individual or gets a positive test themselves. The incident report will not initiate a follow-up call from Massachusetts Department of Public Health (DPH).

Links and Resources Cont.

Impact on the individual:

If a child begins showing symptoms while already at child care, they should be isolated as quickly as possible into a previously-designated area, away from close contact other children and adults, until they can be picked up. If an adult begins showing symptoms while already in the child care space they must remove themselves from the child care space and immediately go home or arrange for pick up to go home.

Individuals who develop symptoms should be assessed by a medical provider. A test for COVID-19 may not always be recommended, however, if it is, families are encouraged to inquire about testing locations with faster turnaround times for results.

Impact on the program:

Other children and staff should be watched for symptoms, but no additional action needs to be taken at this time.

Communicating with families:

No reporting to families is required for individuals who are symptomatic only.

SCENARIO 6: A HOUSEHOLD MEMBER OF A CHILD OR STAFF MEMBER IS QUARANTINING DUE TO A PUBLIC HEALTH NOTIFICATION REGARDING AN EXPOSURE TO A CONFIRMED CASE OF COVID-19...

Reporting:

No reporting is required at this time.

Impact on the individual:

In this case, the individual in the child care program is only a contact of a contact and has not been exposed themselves, so there is no action needed at this time.

At this time, the individual can still attend child care as long as the quarantining household member does not develop symptoms or test positive.

Please note: a quarantining individual must remain at home and isolated from others and thus may not be the one to be dropping off or picking up a child from child care.

Impact on the program:

At this time there is no impact on the program.

Communicating with families:

No reporting to families is required for individuals who are contacts of contacts.

SCENARIO 7: AN INDIVIDUAL HAS A HOUSEHOLD MEMBER WHO IS WAITING FOR THE RESULTS OF A COVID-19 TEST.

Reporting:

There is no reporting required while a household member is waiting for a test result.

Impact on the individual:

If the household member is not symptomatic, the individual may continue to attend child care.

If the household member's test is returned as a positive, please refer to Scenario 2.

Impact on the program:

There is no impact on the program at this time.

Communicating with families:

No reporting to families is required for household members awaiting test results only.

For help with scenarios that are not covered in this document, please reach out to your Local Board of Health, or the Massachusetts Department of Public Health's Division of Epidemiology at 617-983-6800 *or via email at* Childcare.covid19@mass.gov

Links and Resources Cont.

Early Childhood Mental Health Consultation

Families who return to care and staff who return to work may have experienced or may be experiencing trauma of many kinds during this time. The contacts listed below can help support your care of children and families. ECMHC are available for immediate assistance for urgent issues.

REGION	THE EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (ECMH)	
1 - Western MA	**Behavior Health Network, Inc.** **Early Childhood Mental Health Consultation Program** **110 Maple St., Springfield, MA 01105**	**Carolina Clark Maria** | Carolina.Clark@bhninc.org Phone: 413-304-2859 Website: http://www.bhninc.org **Carolyn Mazel** | earlychildhood@collaborative.org Phone: 413-586-4998, x 102
2 - Central MA	**Community Healthlink- Together For Kids (TFK) Program 335 Chandler Street, Worcester, MA 01602**	**Beth Ciavattone** eciavattone@communityhealthlink.org Phone: 508-791-3261 Ask for "TFK Consultation Services" www.communityhealthlink.org
3 - Northeast MA	**Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) Mental Health Consultation Program 439 South Union St., Lawrence, MA 01843**	**Jayna Doherty** Email: jdoherty@eliotchs.org 508-688-5408 www.mspcc.org
4 - Metro Boston	**Preschool Outreach Program 780 American Legion Highway, Roslindale, MA 02131**	**Rachelle Joyner-Jones** rjoyner@thehome.org 617-469-8594 Website: http://www.thehome.org
5 - Southeast	**Enable, Inc. Consultation Services for Children 605 Neponset St., Canton, MA 02021** **Justice Resource Institute, Inc.** **Early Childhood Training and Consultation** **35 Summer St., Taunton, MA 02780**	**Gail Brown** | ghbrown@enableinc.org 781-821-4422, ext. 300 www.enableinc.org **Stacey Gay** | sgay@JRI.org (508) 828-1308 ext. 2630 http://www.jri.org/ecs

Links and Resources Cont.

Professional Development Centers

EEC invests in important services, like the Professional Development Centers (PDCs), to support programs to address family needs. EEC encourages programs to use PDCs to assist with planning for and operating during the COVID-19 emergency. Please see the below contact information listing for these services across each region and visit EECStrongStart.org for more.

REGION	STRONGSTART PROFESSIONAL DEVELOPMENT CENTERS (PDC)
1 - Western MA	**Kimm Quinlan** **StrongStart Western Mass PDC Coordinator** 413-552-2593 WesternMaPDC@EECStrongStart.org
2 - Central MA	**Mary Watson Avery** **StrongStart Central Mass PDC Coordinator** 508-657-1249 CentralMaPDC@EECStrongStart.org
3 - Northeast MA	**Barbara Gallagher** **StrongStart Northeast PDC Coordinator** 978-682-6628 NortheastMaPDC@EECStrongStart.org
4 - Metro Boston	**Debra Johnston-Malden** **Metro-Boston PDC Coordinator** 617-287-4620 MetroBostonPDC@EECStrongStart.org
5 - Southeast	**Nicole Miles** **StrongStart Southeast PDC Coordinator** 781-870-7009 SoutheastMaPDC@EECStrongStart.org

Links and Resources Cont.

Background Record Checks

EEC's BRC requirements include Criminal Offender Record Information (CORI), Department of Children and Families (DCF), Sex Offender Registry Information (SORI), and state and national fingerprint-based checks.

- **Please Note: Individuals submitted and approved through the Urgent BRC process during the pandemic are required to complete the full BRC process because the Urgent BRC does not meet ongoing federal compliance requirements.**

FAMILY CHILD CARE

EEC has modified BRC processes and qualification guidance in order to streamline and reduce barriers to reopening.

FAMILY CHILD CARE EDUCATORS, HOUSEHOLD MEMBERS, REGULARLY ON PREMISES, AND THIRD PARTY AFFILIATES

- All family child care educators as well as their household members aged 15 years old or above; persons regularly on the premises aged 15 years old or above; all FCC assistants; and anyone who provides services on behalf of, or who affiliates with, or are present in such programs are required to undergo an EEC BRC and be found suitable. An example of an Affiliated individual includes FCC system staff and transportation personnel. Volunteers in FCC homes must be run under the role of a person regularly on the premises, meaning that such individuals must have an EEC BRC.

RETURNING PROVIDERS

- All child care program educators, assistants, household members or persons regularly on the premises of a family child care home, and third parties with unsupervised access to children shall have a current BRC with a status of suitable, and shall have completed a fingerprint-based check within the past three years. Therefore, a new EEC BRC is not required for the reopening process.

PROVIDERS IN RENEWAL

- The FCC educator will submit an application and then receive consent forms for themselves, household members, and those identified as regularly on premises. The FCC should contact their EEC Licensor if the consent forms are not received. The consent forms will start the BRC process. Individuals will receive Fingerprint Notification Letters through the mail with instructions on how to schedule a fingerprint appointment with Identogo. EEC will run the other three checks (SORI, CORI, and DCF) simultaneously.

- All FCC educators must notify their licensor in the event that their household composition has changed, in order to obtain a consent form for that individual. Checks of all third party affiliates with unsupervised access to children must be run, even if the individuals are only present on a temporary basis.

CHANGES

- A BRC will affect a reopen transaction if an FCC provider lists a new Household Member or Regular on premises. This includes FCC providers who do not have all their Household Members and/or Regular on Premises listed in LEAD, and anyone who has not processed a transaction in LEAD since it went live in 2018.

- In the event an FCC provider lists all their Household Members in the reopen transaction, even though they might not technically be "new," LEAD sees them as new and will send out BRC forms. Such FCC providers must **notify their EEC Licensor that the Household Member and/or Regular on Premises are not new, so that the BRC requirement can be removed from the LEAD transaction.**

- If a new BRC is run as part of the reopen, the provisional legal letter will go out before the BRC is back, but the final legal letter will not go out until the BRC is complete and a suitable determination has been issued.

Links and Resources Cont.

IN HOME NON-RELATIVE CAREGIVER OR INFORMAL CARE

- If an individual is caring for an unrelated child in the child's own home and receiving funding through EEC to provide subsidized child care, that individual must also complete the EEC BRC and be found suitable prior to receiving EEC funding.
- A family member (grandparent, aunt, uncle, or sibling by blood, marriage, or adoption of a child) that receives subsidy funding through EEC must complete a SORI prior to receiving funding from EEC. In the event a family member's SORI returns a crime that is on the mandatory disqualification listing, they will be subject to the mandatory disqualification, preventing them from being paid by EEC for this care.

GROUP AND SCHOOL-AGE

- Group and School-Age programs, including all licensees, BRC program administrators, and all staff, are required to undergo an EEC BRC and to be found suitable. All staff includes Group and School Age staff, volunteers, interns, and transportation personnel. The individuals listed above will be referred to as "candidates."
- All current licensees, BRC program administrators, and employees shall have a current BRC with a status of Suitable or Provisional and shall have completed a fingerprint-based check within the past three years. **Provided all licensees and employees have a suitable status, a new EEC BRC is not required for the reopening process.**
- Group and School Age programs must update the staff checklist with the BRC status of all staff and the last date the BRC was run.

MODIFICATIONS TO BRC PROCESS

- For new employees, the BRC process must be completed in its entirety, including fingerprinting. During this reopening phase EEC will not be requesting Mental Health Assessments or Criminal Justice Letters from the candidates with presumptive records as allowed by current regulation.
- **Note for all candidates: the name entered on the Consent Form must be an **exact match to the official form of identification you will bring to Identogo to be fingerprinted.** Identogo will not be able to process fingerprints without matching identification.

DEPARTMENT OF CRIMINAL JUSTICE INFORMATION SERVICES SAFIS RESPONSE UNIT: ACCEPTABLE FORMS OF IDENTIFICATION-TEMPORARY OPERATIONAL CHANGE

In response to COVID-19, many states have implemented extensions on expired driver licenses and state identification cards as of June 8, 2020. EOPSS has approved IDEMIA to accept from an applicant an expired driver license or state identification card from Massachusetts in accordance with Massachusetts' published guidelines:

- September 2020 expiration for license/ID expired between March 1, 2020 – May 30, 2020.
- October 2020 expiration for license/ID expiring in June 2020.
- November 2020 expiration for license/ID expiring in July 2020.
- December 2020 expiration for license/ID expiring in August 2020.

A listing of acceptable forms of identification can be found here: https://www.identogo.com/uploads/general/MA_SAFIS_AcceptableFormsofID_04012017_003.pdf

Should you have any comments or concerns, please reach out to the SAFIS Response Unit at 617- 660-4790 or via email at safis@mass.gov.

Links and Resources Cont.

Subsidy Policies

EEC has modified policies to accommodate families and the providers who serve them during this time. These modified policies will remain in effect until June 30, 2021. A full Revised Financial Assistance Policy Guide can be found here.

ATTENDANCE AND REIMBURSEMENT POLICIES

- EEC has eliminated limits on the total number of explained absences a child may have. Policies regarding unexplained absences remain in effect.
- EEC has created flexibility for parents who do not wish to return to care immediately but who wish to remain with their current providers. Providers should communicate with families to let them know that they do not currently need to attend care to maintain their subsidy. The parent must indicate their desire to stay enrolled on the Parent Enrollment Confirmation Form and may change their mind at any time by submitting a new form.
- EEC will continue to pay providers based on confirmed enrollment through the end of Fiscal Year 2021. Parents must continue to abide by all subsidy requirements, including reauthorizing by their end date. Providers must remain in communication with the parents at least twice a month to confirm continued enrollment and to provide parents with educational supports.
- EEC will pay the full-day rate for school age children attending for more than 6 hours of care, including programs that are expanding options for care during remote learning. Funding will be limited to licensed or approved programs. Summer care will continue to be paid full time until the start of the school calendar year.
- Information on how children should be marked in CCFA to allow for payment during this period is available here. Providers should follow all instructions contained in the Financial Assistance Procedures Manual Chapter 10.

AUTHORIZATION/ELIGIBILITY POLICIES

- All authorizations that end between March 16 and July 31, 2020 have been automatically extended. The reauthorization process has resumed for all families who expire after July 31, 2020.
- Comprehensive policies streamlining the reauthorization process and giving families options to maintain their subsidy even with uncertain employment or service need can be found in the Financial Assistance Policy Guide Chapter 5.
- EEC extended the amount of time allowed, through provisional authorizations, for job search from 12 to 26 weeks and will allow access to provisional authorizations for all families who are reauthorizing with limited documentation.

Links and Resources Cont.

- Virtual appointment options are now available for reauthorization.
- Guidelines for authorizing and enrolling new subsidy families with limited documentation can be found here in the Financial Assistance Policy Guide.
- Parents must still report changes in service needs; however, all COVID-19 related changes will be categorized as Temporary Changes to give parents the maximum amount of time to find or return to a qualified service need to maintain subsidy.
- Federal Pandemic Unemployment Compensation is not counted as a part of a parent's income. Normal unemployment income will remain included.

PARENT FEE POLICIES

- Parents may continue to report changes in income to reduce the parent fee listed on their authorization, including those parents who have provisional authorizations. EEC created streamlined documentation requirements and will allow parent fees to be changed during provisional authorizations.
- EEC will continue to pay parent fees for all families through the fall. EEC will inform providers at least 30 days in advance before parent fees are reinstated.

CLOSURE DAY POLICIES

- Planned changes to closure policies in fiscal year 2021 continue, including the option for all providers to have a total of five professional development days, regardless of QRIS level.
- COVID-19 related emergency closures approved by a Regional Office will be paid.

PRICING LIMITATION LAW WAIVER

Beginning in March 2020 and extending through State Fiscal Year 2021 (ending June 30, 2021) EEC will not enforce the requirement that Child Care Educators/Providers charge private families a rate equal to or higher than the state subsidized rate. This will allow Child Care Educators/ Providers to have tuition flexibility for private pay Families and allows discounts and tuition waivers to be offered without requiring restricted revenue to cover the differential pricing.

- All Subsidy Administrators should continue to keep published private rates on file, which includes any discounts, tuition waivers, and/or discounts for staff.
  - **Direct Contract Providers should ensure the rates in CCFA are equal or above the EEC Daily Reimbursement Rate**
  - **For Voucher Only Providers, CCRRs have already made updates to voucher only provider rates.**

Links and Resources Cont.

FAMILY PRIORITIZATION AND COMMUNICATION:

Providers working with families receiving subsidized care are asked to speak with all returning families to determine the balance between provider capacity and the timeline for families choosing to return.

For those providers who have more families than space to care for them, EEC asks that subsidized families are prioritized. If there are more subsidized families requesting attendance than the program can accommodate, the following prioritization criteria should be followed:

1. Highest priority for enrollment: Families who are expected to return to work at a location outside of the home and have no alternative care for their child during work hours, or cannot safely care for their child at home.
2. Programs should prioritize DTA families, with those who need to return to work at a location outside of the home being highest priority. If a child holds a voucher from DTA but the family does not currently need in person attendance, the program is not expected to require attendance.
3. Families that are currently working or attending school at home, on temporary furlough, on job search, or on another type of leave are not required to be prioritized at this time.
4. If a family is referred from DCF, the provider should coordinate prioritization and attendance expectations with the DCF Area Office.

- If a provider is unable to serve all subsidized families requesting a return to in person attendance, the provider should work with the family and the CCR&R to find an alternative placement.

Please use the following tools, available in CCFA, when confirming attendance plans with families supported by subsidies:

- Parent Enrollment Confirmation Form: programs can use this form to confirm that families intend to re-enroll in their program when they return to child care, even if they are not ready to return right away.
- Subsidy Parent Letter: providers issue this letter that outlines subsidy options to. It can be downloaded here and customized as needed to help explain the process for confirming subsidies.

Links and Resources Cont.

Educator Qualifications

RECIPROCITY FOR GSA AND FCC EARLY EDUCATORS TO BECOME FAMILY CHILD CARE CERTIFIED ASSISTANTS

In order to streamline the process to become an FCC Certified Assistant for currently certified educators with certain qualification, EEC created a new working procedure outlining the necessary steps.

- **Group and School Age Reciprocity** - Individuals holding an EEC Teacher Certification (Infant/Toddler, Preschool, Lead Teacher, or Director) shall be considered to meet the qualifications as a Certified Assistant and must complete the following steps to become an FCC Certified Assistant.

1. Complete the FCC Certified Assistant application process through the LEAD portal.
2. Complete a new Background Record Check (BRC).
3. Upload evidence of completion (certificates or date of completion) for the Family Child Care Potential Provider Meeting: Part One training and Part 2 Q&A Session, EEC Essentials trainings , and the new "Guidance for Reopening Child Care" course.
4. Upload the current EEC Teacher Certification an Additional Attachment to the transaction.

- **Family Child Care Educator Reciprocity** - Family Child Care Educators seeking to work as a Certified Assistant shall be considered to meet the qualifications as a Certified Assistant and must complete the following steps to become an FCC Certified Assistant.

FCC Educators seeking to work as an FCC Certified Assistant ***permanently*** must:

1. Complete the FCC Certified Assistant application process through the LEAD portal.
2. Complete a new Background Record Check (BRC).
3. Upload certificates of completion for EEC Essentials and the new "Guidance for Reopening Child Care" course.
4. Close FCC program through LEAD via the Close Prior to Expiration transaction.
5. Return the FCC license to EEC.

FCC Educators seeking to work as an FCC Certified Assistant ***temporarily*** must:

1. Complete the FCC Inactivate transaction through the LEAD portal.
2. Return the original FCC license to EEC.
3. EEC will re-issue an amended FCC license with the condition that the educator is functioning as an assistant and care is not to occur on the premises.

Links and Resources Cont.

FAMILY CHILD CARE REQUIRED QUALIFICATIONS

EEC has modified required qualifications and administration time for FCC programs. Please refer to the charts below for staff guidance.

ADMINISTRATOR LEVELS			
Capacity	Hours of Operation	Required Admin time	Administrator Qualifications
Please see guidance	Any	0	FCC Provider

STAFF NEEDS AND CERTIFICATION TABLES	
Age	Staff Needs and Certification Levels
Multi-Age All Age Groups	FCC Provider and FCC Assistant or Teacher I/T and/or PS

New Education Profile Function in LEAD

FCC providers and assistants can now update their Education Profile in LEAD as it relates to the completion of the following qualifications, if applicable:

- EEC Teacher Certification
- Child Development Associate (CDA)
- Department of Elementary and Secondary Education (DESE) Licensure
- Department of Public Health (DPH) Early Intervention certificate
- Associate, Bachelor, or Advanced Degree Diploma (only if diploma shows major i.e. Associates of Arts in Early Childhood Education)
- Official or Unofficial Transcripts showing completed degree, major, and graduation year
- College Early Childhood Certificate

Although this update is not required, FCC educators and assistants are encouraged to submit their education for the purposes of documenting the educational background of all educators for future EEC credentialing processes.

For more information and instructions on how to upload these documents, please log into your LEAD account and click on the 'Education Profile' tab.

Links and Resources Cont.

GROUP AND SCHOOL-AGE EDUCATOR QUALIFICATIONS

EEC is modifying the Educator Qualification requirements specifically for the reopening of Group and School Age child care programs. To qualify for one or more of these positions, educators must meet the specified work experience and education requirements detailed in the Modifications to Work Experience Requirement Towards EEC Certification and Modifications to Educational requirements towards EEC Certification section.

- **Modifications to Work Experience Requirements Towards EEC Certification**
  Experience in providing direct care and teaching during all types of program activities to a group of children, under seven years of age and not yet enrolled in first grade, or special needs children up to age 16, at least 12 hours per week, on a regular basis, in periods of at least four weeks in one program.
  EEC is accelerating work hours gained during the COVID-19 program closures beginning March 23, 2020 through the end of the Executive Order

- **Modifications to Educational Requirements Towards EEC Certification**
  EEC is expanding the teacher qualifications requirements to accommodate educators with higher education degrees and work experience (see chart).

Degree-based Qualifications Towards Certification

Revised Educational Requirements	Work Experience Requirements
TEACHER INFANT TODDLER AND/OR PRESCHOOL CERTIFICATION	
Associates, Bachelor's, or Advanced Degree in Early Childhood Education (ECE) or Related Field	Three (3) months in related age groups
LEAD TEACHER INFANT TODDLER AND/OR PRESCHOOL CERTIFICATION	
Associates, Bachelor's, or Advanced Degree in Early Childhood Education	Nine (9) months in related age groups For Lead Teacher Infant/Toddler, a course in Infant Toddler Care is required
Associates, Bachelor's, or Advanced Degree in Related Field, plus → 12 ECE Credits	Nine (9) months in related age groups For Lead Teacher Infant/Toddler, a course in Infant Toddler Care is required
DIRECTOR I CERTIFICATION	
Meets Lead Teacher requirements, plus → 4 CEUs or → 3 credits in Child Care Administration	Fifteen (15) months in related age groups An Educator does not need to work as an EEC Certified Lead Teacher prior to obtaining a Director I certification.
DIRECTOR II CERTIFICATION	
Meets Director I requirements, plus → 4 CEUS or 3 Credits in a Child Care Leadership Course → (Category of Study 8, 9,10, 11, 12)	No additional work experience required

Links and Resources Cont.

**Unrelated and non-degree Educators must meet all of the General Educator Qualification requirements.*

- **Modification to course requirement: Child Growth and Development Course**

  For Educators with an unrelated degree or no degree, a Child Growth and Development course is still a requirement. EEC has modified what will be accepted towards Child Growth and Development:

  - Three Continuing Education Units (CEU) will be accepted towards Child Growth and Development. CEUs can be obtained from any International Association for Continued Education and Training (IACET) accreditation and the course focus must be Child Growth and Development.
  - EEC is also accepting Life Span courses such as Human Development and Developmental Psychology through Life Span to fulfill the Child Growth and Development Requirement.

GROUP SIZES, RATIOS, AND REQUIRED QUALIFICATION

EEC has modified the required qualifications and administration time for Group and School Age programs. Please refer to the charts below for staff guidance.

GROUP AND SCHOOL-AGE ADMINISTRATOR LEVELS			
Capacity	**Hours of Operation**	**Required Administrator Time**	**Administrator Qualifications**
No more than 10	Any	0	Teacher or Site Coordinator
11 through 13 infant - preschool	Any	0	LT
14 through 26 infant - preschool	Less than 4	0	LT
14 through 26 Infant - preschool	Four or More	0	DI
27 through 39 infant - preschool	Any	50% FTE	DI
40 through 79 infant - preschool	Any	50% FTE	DI
80+ infant - preschool	Any	50% FTE	DI
11 through 52 school-age children	Any	20% FTE	School-Age Administrator
53+ school-age children	Any	20% FTE	School-Age Administrator

Links and Resources Cont.

GROUP AND SCHOOL AGE STAFF NEEDS AND CERTIFICATION LEVELS

GROUP AND SCHOOL-AGE STAFF NEEDS AND CERTIFICATION LEVELS	
Age	**Staff Needs and Certification Levels**
Infant	At least two Teacher Infant/Toddler Or One Teacher Infant/Toddler and One Assistant
Toddler	At least two Teacher Infant/Toddler Or One Teacher Infant/Toddler and One Assistant
Preschool	At least one Teacher Preschool Or One Teacher Preschool and One Assistant
School-Age	At least one Group Leader
Multi-Age All Age Groups	At least one Infant/Toddler and Preschool Teacher Or at least two Preschool Teachers *Programs must assign at least one qualified staff person to meet the youngest age group.

LARGE GROUP CHILD CARE LICENSING/TEMPORARY APPROVAL AS ADMINISTRATOR:

To address the immediate need for an Administrator within a Large Group Child Care program, EEC is revising the Temporary Approval as Administrator. Lead Teachers and Director I certified staff that are lacking a single college course or the total work experience of 15 months may be approved to serve as Director I or Director II, respectively, for a maximum of 3 consecutive semesters while completing the education or experience required for permanent certification. Lead Teachers and Directors seeking to serve as Director I or Director II must submit to the Department a written request for temporary approval and a plan for completion of education and work experience requirements. To request approval form, please email the TQ Unit at eecprofdev@mass.gov.

EDUCATOR QUALIFICATION CERTIFICATION PROCESS MODIFICATIONS

- EEC will accept electronically scanned applications for certification priority processing and upgrades.
  - For first time applicants, utilize the General Application packet on EEC's website.
  - For Upgrades, utilize the Professional Qualifications Upgrade Application
- Submit all the required documentation in PDF form (**No .jpegs or pictures taken by phone;** PDF scanner apps are available for mobile phones).
- Please also note that EEC will not be accepting e-transcripts sent directly from a college/university. Transcripts must be included in the application packet in PDF form.
- Email complete application packet to eecprofdev@mass.gov with the subject line **"Submission of EEC Application for Certification Priority or Upgrade (Reopening)"**

Definitions

Center-Based Care – Child care provided in a non-residential setting.

Clean – Cleaning removes germs, dirt, and impurities from surfaces or objects. Cleaning works by using soap (or detergent) and water to physically remove germs from surfaces. This process does not necessarily kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.

Communicable Disease – A disease that is spread from one person to another in a variety of ways, including travel through the air, contact with bodily fluids, contact with a contaminated surface, object, food or water, and certain animal or insect bites.

Coronavirus – Any of a family (Coronaviridae) of large single-stranded RNA viruses that have a lipid envelope studded with club-shaped spike proteins, infect birds and many mammals including humans, and include the causative agents of MERS, SARS, and COVID-19.

COVID-19 – A mild to severe respiratory illness that is caused by a coronavirus (severe acute respiratory syndrome coronavirus 2 of the genus betacoronavirus), is transmitted chiefly by contact with infectious material (such as respiratory droplets) or with objects or surfaces contaminated by the causative virus, and is characterized especially by fever, cough, and shortness of breath and may progress to pneumonia and respiratory failure.

DESE – The Massachusetts Department of Elementary and Secondary Education.

Disinfect – Disinfecting kills germs on surfaces or objects. Disinfecting works by using chemicals to kill germs on surfaces or objects. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after cleaning, it can further lower the risk of spreading infection. Disinfecting may be appropriate for diaper tables, door and cabinet handles, toilets, and other bathroom surfaces. Changing tables should be cleaned and then disinfected after each use.

DPH – The Massachusetts Department of Public Health.

EEC – The Massachusetts Department of Early Education and Care.

Exposed – Having had close contact with someone symptomatic of COVID-19 from the period of 48 hours before symptom onset until 10 days from when they first had symptoms. Close contact is generally defined as less than 6 feet, for greater than 10 minutes. Consider how close the person was, how long the exposure occurred for, and whether the person with COVID-19 was symptomatic (e.g. coughing).

Fever – A measured or reported temperature of > 100.0° F.

Group – Two or more children who participate in the same activities at the same time and are assigned to the same educator for supervision, at the same time.

Health Care Consultant – A Massachusetts licensed physician, nurse practitioner, or physician's assistant with pediatric or family health training and/or experience.

Health Care Practitioner – A physician, physician's assistant or nurse practitioner.

Isolation - Isolation separates sick people with a contagious disease from people who are not sick.

Family Child Care – Child care provided in a professional caregiver's home.

Parent – Father or mother, guardian, or person or agency legally authorized to act on behalf of the children in place of, or in conjunction with, the father, mother, or guardian.

Personal Protective Equipment (PPE) – PPE is used to minimize exposure to hazards that cause serious illness or injury. Gloves, masks, face shields, goggles, and gowns are all examples of PPE. Different types of PPE are worn for different types of situations.

Premises – The facility or private residence that is used for the child or youth serving summer program and the outdoor space on which the facility or private residence is located.

Program – An organization or individual that provides early education and care services to children or youth. Programs may include family child care, center-based child care, or school-age child care.

Program Staff – All individuals working with children and/or youth in early education and care. Staff may include directors, administrators, family child care educators, approved assistants, group leaders, camp counselors, nurses, educators, and other individuals employed by the child or youth serving program who may have contact with children.

Quarantine - Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick.

Sanitize – Sanitizing lowers the number of germs on surfaces or objects to a safe level, as judged by public health standards or requirements. This process works by cleaning and then sanitizing surfaces or objects to lower the risk of spreading infection. Surfaces used for eating and objects intended for the mouth (food service tables and highchair trays, pacifiers, mouthed toys, etc.) must be cleaned and then sanitized both before and after each use.

What to do in the event of a

COVID-19 Positive Case

If a child, staff member, educator, or household member of a child in the program tests positive for COVID-19, follow these 4 steps:

1. REPORT. Immediately report to the Department of Public Health using the short COVID-19 Positive Reporting Form. **LINK TO REPORTING FORM IS AVAILABLE IN LEAD.**

2. CONNECT. A Public Health representative will call to ask follow-up questions to help you determine a plan that may include enhanced monitoring, enhanced cleaning, or closure of a grouping or program.

3. IMPLEMENT. Share only pertinent information and instructions with families while maintaining the confidentiality of individuals.

4. SUBMIT.
Within 48 hours, submit an incident report in the LEAD system, just as you would with any other infectious disease.

Please visit your LEAD account for the link to the DPH COVID-19 Positive Reporting Form.

**If, for any reason, you have not been able to get in touch with Public Health, please notify your licensor for assistance.*

For other medical or scientific questions programs may also reach out to State Department of Public Health epidemiologists at **childcare.covid19@mass.gov or **617.983.6800**.*

It's up to each of us

to keep our community safe & healthy

We are doing everything we can to minimize health risks
This includes wearing masks; cleaning, disinfecting and sanitizing; encouraging physical distancing

Help us minimize risk by keeping your child home if they show any signs of illness
Keeping sick children home helps us stay open for other children and so your child can return as soon as he or she is healthy

Please keep your child home if they are showing any of the following symptoms:

- Fever of 100.0° F or higher
- Cough
- Sore Throat
- Rapid breathing or difficulty breathing (without recent physical activity)
- Flushed cheeks
- Gastrointestinal symptoms (diarrhea, nausea, vomiting)
- Fatigue (Fatigue alone should not exclude a child from participation)
- Headache
- New loss of smell/taste
- New muscle aches
- Sore Throat
- Any other sign of illness

or if your child has been in close, prolonged contact with someone who is COVID-19 positive.

NAME OF CHILD: _____ DATE: _____

BEST CONTACT NUMBER TODAY: _____

Daily Health Attestation

Please complete the following for each child. If you answer yes to any of the following, please do not bring the child to care.

SYMPTOMS OBSERVED IN CHILD OR HOUSEHOLD MEMBER IN THE PAST 24 HOURS?	YES	NO
Fever of 100.0° F or higher		
Cough		
Sore throat		
Rapid breathing or difficulty breathing (without recent physical activity)		
Gastrointestinal symptoms (diarrhea, nausea, vomiting)		
Fatigue (fatigue alone should not exclude a child from participation)		
Headache		
New loss of smell/taste		
New muscle aches		
Any other sign of illness		
WITHIN THE LAST 14 DAYS	**YES**	**NO**
Have you or your child had close contact with a COVID-19 positive individual?		

Please list where your child has been (excluding their primary residence) since they were last in child care:

_____

PARENT/GUARDIAN SIGNATURE: _____ STAFF SIGNATURE: _____

NAME OF CHILD: _____ DATE: _____

BEST CONTACT NUMBER TODAY: _____

Daily Health Attestation

Please complete the following for each child. If you answer yes to any of the following, please do not bring the child to care.

SYMPTOMS OBSERVED IN CHILD OR HOUSEHOLD MEMBER IN THE PAST 24 HOURS?	YES	NO
Fever of 100.0° F or higher		
Cough		
Sore throat		
Rapid breathing or difficulty breathing (without recent physical activity)		
Gastrointestinal symptoms (diarrhea, nausea, vomiting)		
Fatigue (fatigue alone should not exclude a child from participation)		
Headache		
New loss of smell/taste		
New muscle aches		
Any other sign of illness		
WITHIN THE LAST 14 DAYS	**YES**	**NO**
Have you or your child had close contact with a COVID-19 positive individual?		

Please list where your child has been (excluding their primary residence) since they were last in child care:

_____

PARENT/GUARDIAN SIGNATURE: _____ STAFF SIGNATURE: _____