

FY24 RAN Informational Session Transcript

Adia Brown: Good day everybody, and welcome to the final of our monitoring information series. This final session is about what we call RAN reviews or the Risk Assessment Notification reviews. These reviews are the reviews that grantees use or the Office of Head Start uses in order to help us to understand what happens when we have a child health and safety issue.

The goals for today's session are that we are going to introduce you to a lot of tools related to the RAN monitoring session. We're going to review the content and activities that are part of this review, and we're going to gather any questions that you may have. But with that, I'm going to turn it over to the Director of the Office of Head Start, Dr. Khari Garvin.

Khari Garvin: Thank you, Adia. Hello, everyone, and welcome to the Office of Head Start's FY2024 RAN, Special and Follow-up informational session. Thank you for taking the time out of your day to join us for this important informational session. We have some exciting updates for you and want all programs to be aware of some of the changes we have made to improve our processes when grant recipients have a reportable child health and safety incident.

We have a new tool to share with you and some updates that we think will make it easier for you to understand how the process works and what to expect. Enjoy the presentation, and most importantly, please jot down your questions so that when we share the link later; you can add them for the Office of Head Start to respond. Ask as many questions as you need to feel informed. As you know, the Office of Head Start holds a strong and uncompromising position when it comes to keeping our children safe.

We are not only committed to continuous quality improvement of our oversight of Head Start programs, but also committed to supporting our Head Start programs in preventing incidents that jeopardize the safety of children. We want you to be successful so that you can provide the high-quality services that our families deserve. As you see highlighted here in our national priorities, the Office of Head Start expects that each child served in Head Start and Early Head Start programs is kept safe and secure.

Head Start programs will be a safe space where children can thrive and reach their full potential. We must ensure that programs remain safe environments where children and families can trust in their care and critical services provided to support their success. I cannot overstate this. This is the ultimate thing that is most important for us as we think about delivering Head Start and Early Head Start services. We, the Office of Head Start, expect that our Head Start programs will implement and cultivate a culture and an environment of safety where children feel secure, where children will thrive, and that children and families trust to support their success.

Let's talk for a moment about Risk Assessment Notification reviews conducted in Fiscal Year 2023. The Office of Head Start conducts a monitoring review in response to a potential child safety issue such as inappropriate conduct, neglect or abuse, inadequate supervision, or an unauthorized release of a child. In Fiscal Year 23, as of September 1st, we reviewed 223 grants and shipped 245 reports.

These reports contained a total of 329 findings. The number of reviews last year was significantly higher than the previous year, especially in the area of inadequate supervision, and we are concerned about this trend. Let's look at the data. In 2022, we issued 95 findings in abuse, neglect, and inappropriate conduct. We issued 72 for inadequate supervision. We issued 15 findings for unauthorized release of a child. Additionally, we had 42 cases where recipients failed to report timely and received findings for reporting.

In 2023, as of September 1st, we have issued 126 findings in abuse, neglect, and inappropriate conduct, 107 for inadequate supervision, 24 for unauthorized release, and an additional 53 findings for reporting. We hope that by providing this update, bringing this to focus, and ensuring recipients are aware that we need to do better as a national program, we can work together with the Regional Offices, Regional Training and Technical Assistance, the National Centers to refine recipient systems that need improvement and implement practices that will prevent children from being at risk of harm. Tala, I give it to you. Take it away.

Tala Hooban: Thank you, Director Garvin. My name is Tala Hooban. I am the Deputy Director for the Office of Head Start. After hearing all that data, and the importance of Child Health and Safety Incidents, we're going to get into the heart of why the monitoring team is presenting to you all today. Let's talk about Child Health and Safety Incidents and what to do if an incident occurs at your program.

Head Start recipients are required to immediately report incidents affecting the health and safety of program participants. Reports should be submitted immediately through HSES correspondence, and no later than 7 calendar days following an incident. Incident reports must be sent to the Program Specialist or your Regional Program Manager at the Regional Office through HSES correspondence. This slide provides a list of the kind of information we need for each incident. Regional staff will also request supporting documentation.

The OHS considers a "significant incident" to be any incident that results in serious injury or harm to a child, violates Head Start standards of conduct at 45 CFR §1302.90(c), or results in a child being left alone, unsupervised, or released to an unauthorized adult. Please refer to ACF-IM-HS-22-07 Reporting Child Health and Safety Incidents for more information. If you have any questions about the reporting requirement, please contact your Program Specialist.

To support recipients in meeting this requirement, OHS is sharing a sample template that can be used to meet the reporting requirement. We think this form is helpful but is not required at this time. If you have another way of capturing this information, feel free to use that method. By providing these responses to the questions presented on the form, the regional staff will have many important details and can begin conversations with you to understand the incident and what may have prevented the incident from happening. Note that not all the questions will be applicable for every incident. Now, Adia is going to talk about what's new for Fiscal Year 24. Go ahead Adia.

Adia Brown: Thank you, Tala. What do you see on the screen right now is a graphic that shows you the two sides of what actually happens when you may have a child health and safety incident in your program. Look at the purple side. The purple side, we know that we want to gather lots of information about the incident itself. What happened? When did it happen? Who was involved? Those are things that your program specialist will help you to gather more information about and share with them.

The tool that Tala just showed on the screen, although not mandatory, is really helpful if you want to look at that tool, it'll be posted on ECLKC, and that tool helps you to understand the types of information we need to help us understand the incident. The green half of the slide is really about the systems that support health and safety. An incident happens, but then we really want to understand, well if you have systems in your program, what were some of the systems that you have and how did they actually help to either support the incident or how did they, maybe there may have been gaps that your program specialist and you will discuss to help you understand how an incident may have happened? When we talk about the incident, we want to know a few things.

We want to know the information about the child who was impacted. We want to know information about the adults that were involved. We want to know incident details like what happened, where it happened, and what happened. We want reporting details, whether you have reported to your local or State entities, whether parents have been informed, and if policy councils and boards are aware. The actions taken by the program immediately following the incident are super important.

We want to really understand those contributing factors, things that may have allowed the incident to occur. Sometimes, when we have an incident, you know the first thing that recipients and programs, you know, there's a shock, there's sort of a sticker effect of that incident. But after everything sort of settles down and the dust settles a lot of times, programs really say, "well, this was really based on human error." We found over our time of really looking at different incidents that it's often not just human error, but it is often something that happened in your system where a whole that you may not have identified previously may exist.

We want you to also look at the child health and safety incident resulting from systems failure and during this process your program specialist will have a conversation with you about the root cause. This is necessary to correct the issue that should have been prevented and the original incident. Do you have a system in place? Are the systems not being followed or the systems not strong enough or lacking specific elements? Specifically, some of the systems that may need improvement include HR, communications, monitoring and oversight, and maybe others.

When we talk about the root cause analysis, here's a guide that might be helpful to you. The program specialist will conduct the Root Cause Analysis Discussion with you, and you'll be asked to share your screen for examples of data that you collect during the discussion. Grant recipients will be provided with the RAN protocol to give them information about what will take place in the root Cause Analysis Discussion. There are several key areas that Program Specialists will focus on, your policies and procedures as well as staff training, ongoing monitoring, and staff supervision, promoting positive environments, and provisions of mental health supports.

Let's talk a little bit about the incident types. There's lots of types of incidents that have been in Head Start and Early Head Start programs. Some of them we consider at the Office of Head Start to be emergency incidents. These are incidents that when they happen, we want to know about them right away. We want to know about all incidents within, before, seven days has elapsed, but these incidents are ones that you should call your program specialist about immediately. They include things like physical abuse, sexual abuse, sexual harassment, inappropriate sexual conduct, or serious child injuries.

Physical abuse, so that folks really understand what that might look like in their program, in this case, we're thinking about things such as binding children, tying them, or taping them up, hitting children. Anything that's considered a smack, or swat, or tap, or slap, or spanking children, is considered physical abuse. Kicking, pinching, pulling, punching, pushing, shaking, or throwing, are all things that the Office of Head Start considers to be physical abuse and we want you to actually report those to your Program Specialist immediately.

Sexual abuse sort of explains itself. Inappropriate sexual conduct is the same thing. Serious child injuries that require either hospitalization or emergency room medical treatment, such as a broken bone, or a severe sprain, or chipped or cracked teeth, head trauma, deep cuts, contusion, lacerations, or animal bites. All these things should be considered emergencies and should be reported immediately. There are other incidents that are significant that we also want to hear about right away. These are things such as verbal or emotional abuse, neglect, inadequate supervision, unauthorized release, or inappropriate conduct.

Verbal and emotional abuse really occurs when an adult's action or inactions, causes harm to a child, psychological or intellectual functioning, which may be exhibited by severe anxiety, depression, withdrawal, or outward aggression, or a combination of those behaviors. Some things that we might see are using toilet learning or training methods that punish, demean or humiliate a child. The use of public or private humiliation, such as rejecting or terrorizing, extended ignoring, or corrupting a child, or the use of profane, sarcastic language, threats, or derogatory remarks.

We also think neglect is a significant incident, so these are things that are frequently defined as a failure of the staff member, with responsibility for the child, to provide needed food, clothing, shelter, or medical care. There's inappropriate conduct. These are things such as withholding food for punishment, the use of physical activity or outdoor time as punishment, the use of blame or negative labeling of a child, restraining that does not cause bodily injury, pulling that doesn't provide bodily injury, or pushing that doesn't cause bodily injury. There is a protocol available on ECLKC for you to use, utilize, that helps you understand more about what we're going to be looking for when you have a child health and safety incident.

As we continue to improve our processes, we have created this protocol to have the same look and feel as the protocols you're familiar with. This protocol walks you through the purpose of RAN reviews, the approach we use, the content areas, performance areas, and performance measures, and federal regulations that we will discuss when you have a child health and safety incident. The document shares examples of data, documents, and systems recipients should be prepared to discuss during the review.

Finally, lots of grantees have asked many questions about the difference between a substantial or systemic failure. We have a few slides here to try to help you understand what those two things are. During a RAN review, OHS may determine the area is under one or the other. Substantial failure is a significant one-time failure to meet the requirements. For example, when there is actual physical or emotional harm done to children or there is fraud, waste or abuse detected. Examples include kicking, punching, spanking, verbally assaulting, or sexually abusing children. Other examples include embezzlement of funds, lack of internal controls, and falsifying records.

Systems must be established to ensure all staff, consultants, contractors, and volunteers are in compliance with Head Start Program Performance Standards. These systems must include enough safeguards to ensure the health and safety of children, facilities, and federal funds are protected. A systemic failure could include but is not limited to monitoring staff, funds, or

facilities to ensure compliance, not training staff on the appropriate implementation and execution of policies and procedures, not ensuring staff abide by the programs code of conduct, and ensuring appropriate internal controls, or a high frequency of a problem across systems.

Systemic failure is not exclusively related to the number of times, percentages, or frequency an issue occurs. A systemic failure can be identified through a one-time occurrence that is representative of issues related to monitoring, training, or safeguarding children, parents, or staff, or federal funds in a program. I'm going to turn it over to Heather to talk about the Regional Office Supports.

Heather Wanderski: Thank you, Adia. Hello everyone. My name is Heather Wanderski. I am the Program Operations Division Director with the Office of Head Start. I wanted to spend a few minutes talking about the Program Specialists role and what support the Regional Office can provide to you as the recipient. Whenever a report comes into the Regional Office, whether it be through an incident report, complaint or other means, the program specialist is going to immediately follow up with your organization.

They're going to reach out. They'll want to know what happened in that situation. They will ask questions they are going to be looking for details about what happened related to that incident. But what I want to make to stress is that not every incident or complaint that is reported to the Office of Head Start is going to end up as a monitoring review. The Program Specialist role really is multi-faceted. Through the course of the conversation, they will have you, they will listen for multiple things, including how can the Office of Head Start support you? That could be through providing direct technical assistance in the conversation, or if additional supports are needed, it could result in deploying specialized technical assistance.

They could be following up and asking specifically around mental health supports, what things were happening in the program around the time the incident occurred and really essential following up on the details. Really, the purpose of the conversation is really about root cause exploration. We're really looking to get to the crux of what happened in that situation so that we can ensure that it doesn't happen again in the future, and that we are able to correct the incident that has manifested. During these conversations, the program specialist is going to listen from all different angles, and they are going take appropriate action, again, really depending on the full scope of the issue that's being presented.

As part of that, they may need to be part of multiple conversations. A lot of times when an initial incident is reported, we may not have all the details, or more information may still be needed. We are going to continue to ask questions and follow up depending on the situation.

We may need to start a review, or follow-up actions, depending on what is reported. At this point, I want to turn it over to Sharon who is going to talk with you a little bit more about what type of Training and Technical Assistance supports are available to you, as a recipient.

Sharon Yandian: Thanks, Heather. Hi, my name is Sharon Yandian. I am the Director of Comprehensive Services and TTA Division here at the Office of Head Start. When it comes to Child Health and Safety incidents and supporting recipients in program, I just wanted to take a few minutes to talk about the TTA supports are available to you through the OHS at no cost. Clearly, just briefly, we talk about the TTA system in three parts. TTA supports you, as recipients, directly in helping to identify systems and strategies to improve during correction action, or another times.

Also, to leverage the resources that we develop for you to be using. TTA can be requested at any time through your Program Specialist, not only when an incident occurs, but at other times, and the Regional Office will broker that TA with you. But here you can see I just wanted to give a little outline of how we talk about TTA supports. I just said, we talk about it in three parts. You can see the regional network in the 12 regions where the specialists are deployed. Some of you may have them assigned to your program and be aware of that. We also have the National Centers.

Those folks bring the evidence-based and developed materials, and you participate in their national webinars. Again, you can also use your funding, and you do use your funding to support, whether it's for prevention-related, correction, or other proactive activities. We just want to make sure you're leveraging the whole system and know what's available to you. When we think about regional TTA supports for responding to child incidents, we know that you know, the Head Start staff values every child and it's everybody's job to keep children safe.

You heard Adia talk about the root cause analysis, and here one of the areas that TTA has been supporting you, or can support you, is completing a Root Cause Analysis. They can also help you identify strategies and evidence to demonstrate compliance, develop a comprehensive plan, implement, and monitor the plan, and support the implementation of prevention strategies. I know many of you have taken advantage of your TTA folks. We know also that the converse, the role of the specialist is not to investigate whether child abuse and neglect has occurred. That is, of course, is CPS' role, but please take advantage of your regional folks.

The most common topics addressed during TTA around child incidents, since we have it here, as the root cause of each incident varies, the TTA specialists can provide that individualized

support that will best help you address the incident that happened and help ensure it doesn't happen again. Over the last year, you can see here that TTA covered a broad range of topics in their support of addressing child health and safety incidents. Of course, safety practices were the topic often reported, but TTA also addressed supporting planning and services in your programs, developing QIPs, and wellness, and supporting recipients with ensuring their ongoing monitoring systems were strong to help prevent future incidents.

TTA also supports recipients with their human resource systems, ensuring high-quality learning environments, and effective and positive teaching and caregiving practices. We have just a little bit of data here to help us understand what is the type of work that is happening. Here on this side, I wanted to highlight just a little bit, we've been able to look at our data, and while we know that 97% of recipients have worked with our regional TTA folks on many, many topics ranging from coaching to family engagement to ERSEA, to data and evaluation, only 51% of recipients worked with regional TTA around the corrective action.

We know that there is an opportunity here to take advantage, at no cost, funded by our office and we wanted to just make you aware that we have folks that are here to support you in your success and continued wonderful services you provide to children and families. That was a helpful little pull out to see who is utilizing the TA for what purpose. The last slide is just a little bit of a commercial. We always like to have a commercial. You may know the National Centers really are the ones that developed the resources and the Regional TTA are kind of the boots on the ground and go and work with you.

They also do national webinars, and they do work in your region in many ways around communities of practices and working at trainings that you may attend. In addition to the individualized supports offered by your Regional TTA provider, the National Centers here have these resources we've listed out that really helps with preventing child health and safety incidents. This slide here links to five that are supporting developing and implementing a culture of safety and active supervision strategies which we talk a lot about. Culture of safety is really where an organization is committed to safety at all levels, from frontline providers to managers and executives.

These resources, and when you have a chance to take a look at them, they'll really help you provide a holistic view of what is needed, including addressing staff wellness and integrating proactive HR policies and procedures. We have quite a following, I wanted to say, of Health Managers on our National webinars, and many of you bring different people to the table as you are addressing your incident. They have attended quite a few of the sessions that we've done

that have addressed these resources. I just wanted to make sure that you were aware of that. Adia, back to you.

Adia Brown: Well, thank you all and we appreciate you taking your time today to participate in this information session. We hope that you got lots of information about the new tools that are going to be available for you. You can check ECLKC where those tools will be posted. On ECLKC there will be a copy of the FY24 RAN protocol. Please feel free to take that protocol down, use it with your staff. It has lots of information on the types of questions that you may want to ask yourself or your staff when you have an incident.

We also wanted to share with you our sample form. Make sure that you take a look at the sample form and, if you can use it, if it's something that you find helpful to you, please use the sample form. It will help you to report your incidents and make sure that you have all the information that you need to do that. Finally, use your resources from your Regional Program Specialist. Your regional staff is always there to support you when child health and safety incidents happen. They are there to provide you with the guidance, and the support, and help that you need to help you make it through.

None of these. None of these health and safety incidents are easy for any of us and easy for any of you as grantees out there. But there are lots of people who want to support you through the process. Your Program Specialist and your Region will do that. Finally, as Sharon just said, TTA is always available to you. It's free to you as a grantee, they have so many different things that they can do and help you think about your root causes, and when you do, you know, you may think of things such as, you know, maybe you want to change your hours of your staff, or maybe you want to think about more staff education for early childhood development. Lots of different things that really helped to reduce and prevent and mitigate child health and safety issues.

The Office of Head Start is really all about the mitigation of these incidents about the prevention of the incidents. We want to see less and less of these in our Head Start community, but while we know that it has been a very tough few years with the pandemic and all the different things that we have experienced, we know that those things have been tough. We want to make sure that we give you the support and the answers that you need when you have these incidents. Because this was a recorded session, we do have a different question-and-answer format. You can use the link that is included in this recording to ask any of the questions that you may have about child health and safety incidents.

We will monitor that link and then we'll put out a frequently asked question document to follow up on that. We hope this session was both informative and insightful for you, and we realize this is a difficult topic, but we know that together we can help to prevent and lessen child health and safety incidents across Head Start programs. Thank you, Sharon, Heather, Tala, and Director Garvin for coming today and really helping to spread this information for grantees. I know that they're going to be really thankful for everything that you guys have done just as much as we are thankful for all the work that they do out in the field. Thank you and have a really great day and enjoy the rest of your Head Start season.