CHILD CARE HEALTH CONSULTATION NEEDS ASSESSMENT REPORT

Submitted to the
Wisconsin Department of Children and Families

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EXECUTIVE SUMMARY

In Wisconsin, increased support of early care and education (ECE) providers is needed to help achieve the goal of flourishing, thriving children, particularly in the areas of health and well-being. Child care health consultants (CCHCs) can act as a positive influence and support to bolster the ongoing efforts of ECE providers in these areas. With their expertise in pediatrics and consultation skills, CCHCs can guide ECE providers through health-related concerns, with developing health policies that align with best practices, and via providing technical assistance with troubleshooting, community connections, and communication with parents. This report outlines the steps taken to ascertain, evaluate, and establish the need for potential CCHC initiatives in Wisconsin including alignment with the Wisconsin Department of Children and Families' (DCF) priority areas as well as various tier models. This report reviews findings from a needs assessment survey and a policy scan to better understand the areas of focus for Wisconsin ECE providers as well as the DCF licensing, regulation, and quality staff.

A Wisconsin CCHC program supports three of the DCF's priority areas. First, CCHCs can help ECE providers across the state achieve already-established quality and safety standards. Second, CCHCs can help develop and act as an additional resource to address needs of underserved populations that utilize ECE programs. Finally, CCHCs can help build the ECE providers' and staffs' understanding of, comfort with, and implementation of best health practices for children. The CCHC role can be implemented to various degrees of intensity, ranging from basic to intense depending on the desired level of support and resources available. The specific CCHC model can be tailored based on the needs of the ECE landscape in Wisconsin, and can be implemented in stages if so desired.

Through surveying Wisconsin ECE providers and scanning online health policies from Wisconsin ECE providers' websites, overlapping trends regarding current needs were identified. Many ECE providers reported using a combination of sources (both formal and informal) to help develop their health policies, which was evident through the variations noted between ECE providers during the policy scan. The national, "gold standard" *Caring for Our Children (CFOC)* standards on common inclusion/exclusion criteria due to illness health topics were utilized as a framework for evaluation and as a comparison with online ECE providers' health policies and available resources offered by state organizations. Divergent comparison scores from the ECE providers' health policies to the *CFOC* standards during the policy scan aligned with the survey findings that few ECE providers reported familiarity with the *CFOC* standards. In addition, various resources from state level organizations were noted to have recommendations that in some cases differed from the *CFOC* standards. ECE providers indicated value and interest in further support regarding the *CFOC* standards. Additionally, ECE providers expressed the need for health consultation including — yet not limited to — child health resources, answers to general questions, and review of health policies.

It also is evident that while this needs assessment and project was planned over a year ago, the intercurrent pandemic has only highlighted even more starkly the needs for consistent health consultation for early childhood settings. While not intended explicitly and solely as a pandemic response, the implementation of a CCHC model will assist with these widespread needs and support the early childhood workforce with coping with the fallout from this society-wide upheaval.

Based on these key findings, this report outlines three major recommendations:

First, a CCHC pilot program could help address a significant number of the noted and observed needs of ECE providers. Initially, this CCHC support could be done remotely in a virtual format via a trained registered nurse (RN) under the oversight of a physician with knowledge about child health consultation. This would offer direct support for ECE providers to seek guidance on general and mental health topics, including their health policies.

Second, centralized, consistent, and easily accessible resources aligned with the *CFOC* guidelines would assist and improve the development and implementation of ECE providers' health policies in a resource-efficient manner. By placing aligned resources on a singular landing page or website, ECE providers could easily access and utilize high-quality recommendations and guidelines. Consistent resources could also supportively address variations between ECE providers' health policies and reduce obstacles to best health practices, such as over- or under-inclusion/exclusion through illness policies not in keeping with best practices. Additionally, this would offer support for ECE providers when communicating with families around the reasoning for particular practices.

Finally, in order to support awareness and further success of a CCHC pilot, training on the resources and capabilities of the program could be provided to state licensing/regulation staff and ECE providers. Training can promote buy-in with the program and engagement with future initiatives. Through these recommendations, opportunities for improvement can become available for ECE providers across Wisconsin.

In addition, further evaluation of current initiatives in a pilot as well as assessment of higher-tier needs — such as individualized consultation around the needs of specific children — would be incorporated to help further refinement of the program as well as expand services where such need is identified. By reviewing the current needs and identifying focus areas, targeted interventions including a CCHC pilot can offer layers of support. Successful growth of ECE providers' understanding and implementation of best health practices would have a positive impact on the health promotion for children in Wisconsin.

TERMS:

Child Care Health Consultants (CCHCs): Health professionals with a background in pediatrics or training in child health and development in the context of early childhood education settings. These individuals work with early care and education programs to address health and safety needs.

Early Care and Education (ECE): A broad term used to describe any type of education program that serves children in preschool years, before entering kindergarten. This may range from infants through preschool years. ECE programs include child care centers, family child care, and Head Start Programs.

Early Childhood Providers: Individuals who care for, supervise, and teach children from birth through preschool, before children enter kindergarten.

Clinicians: All health care providers who provide direct patient care (e.g., pediatricians, family medicine physicians, physician assistants, nurse practitioners), in the context of this report largely in ambulatory settings (e.g., primary care, urgent care).

Caring for Our Children **(CFOC):** set of national standards for health and safety promotion of children in early child care and education settings developed by the American Academy of Pediatrics (AAP) and the American Public Health Association (APHA).

INTRODUCTION

Background

ECE programs have a significant impact on children's development, educational achievement, life-long health and economic productivity.[1,2] Children rely on quality child care, and supporting Wisconsin ECE programs in turn aids communities and families.[3] A majority of children under five spend a significant amount of time in ECE programs. In 2018, 74% of Wisconsin children lived in households where both parents work outside of the home and throughout the state, over 270,000 children attended child care programs.[4,5] Research has shown that the quality of child care programs can have a major impact on children's development, educational achievement, and life-long health.[3] In addition to helping children reach their fullest potential, the evidence shows that funding ECE yields a good return on investment-- improving both health, social, and economic outcomes and reducing the need for more costly spending in the future.[6]

In Wisconsin, significant programs exist to support and encourage the existence of quality ECE programs. Of children enrolled in YoungStar rated programs, 72.1% attended programs that were considered high-quality care (i.e., rated between 3–5 Stars).[5] However, health and safety specific policies vary in different locations and there are not specific regulations requiring review of child care programs' specific health policies by a health professional. Wisconsin has endorsed *Caring for Our Children* (*CFOC*), which is the joint AAP/APHA guidelines for child care, discussed further below.[7] However, there is still a disconnect between these recommendations and the health policies practices adopted by child care programs.[7]

A published 2010 study of child care providers in Wisconsin found that 62% of child care directors were unfamiliar with the 2002 version of *CFOC* for health and safety and 57% of children would be unnecessarily excluded from ECE programs for mild illnesses that do not require exclusion based on *CFOC*.[7] The gap between the state-accepted national guidelines and ECE program practices suggests a need for more training and education to help reduce unnecessary exclusions from child care programs in Wisconsin.[7] A 2012 study on return to care policies for children with mild illnesses came to a similar conclusion—a need for more education involving child care staff and parents on health guidelines.[8] The study's finding suggests that the adoption of *CFOC* for children returning to child care would decrease the need for urgent medical care, relieve the burden on parents who need to take work leave, and reduce unnecessary treatment (e.g., antibiotics).[8]

To support ECE programs' efforts to provide high quality learning, several states have implemented CCHC programs as a strategy to support ECE staff and incorporate child health into ECE systems.[9] CCHCs could be used in Wisconsin to support health and safety within ECE centers and promote the quality of early education for children. There are many stakeholders involved in the process of developing support and programs to promote the health of children in ECEs. See Figure 1 (page 26) for examples of the complex inter-relationship between stakeholders, as well as obstacles and recommendations for supporting healthy children in Wisconsin.

Who are Child Care Health Consultants?

CCHCs are professionals with knowledge and training on health-related issues in an early childhood education context. The National Association for the Education of Young Children (NAEYC) recommends that early learning programs develop an ongoing relationship and contract with a

healthcare professional to improve the health and safety of the children in their care.[10] Further, collaboration between ECE providers and a CCHC is considered a best practice to support health and safety and promote high-quality early childhood education by the AAP, APHA, and NAEYC.[10,11,12] To support these frameworks, the National Resource Center for Health and Safety in Child Care and Early Education develops and maintains *CFOC,* a collection of evidence-based, expert-panel-created standards representing best practices for health and safety in ECE settings, now in its fourth edition.[13] A database with searchable standards for health and safety is freely and openly available to the general public, providing access to up-to-date information.[14] There are also *CFOC* resources available in Spanish, further expanding accessibility.[15] In response to the pandemic, a COVID-19 *CFOC* crosswalk document was created to help provide guidance to ECE providers on common questions and concerns related to the pandemic.[16]

CFOC Standard 1.6.0.1 defines CCHCs as "a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation" (See Appendix I).[12] In general, CCHCs do not primarily provide direct health care services to individuals, but instead share general health expertise, answer questions, conduct health and safety assessments, interpret policies, make referrals to community resources, and assist with connecting families to a primary care medical home when necessary.[12]

CCHCs are often nurses, nutritionists, mental health professionals, or other safety and health experts.[17] According to the AAP, the number of pediatricians who work as CCHCs or medical directors for ECE programs is increasing.[17] The AAP provides resources to clinicians who are interested in working with communities in the area of ECE as a consultant (See Appendices II-IV).[17-19] Pediatricians can also promote ECE program development through collaborating with ECE providers and families as a medical home.[20] Further recommendations to support on multiple levels can include supporting local CCHC nurses, encouraging quality health and safety standards aligned with *CFOC*, and advocating for improved funding for CCHCs.[20] Having a collaborative network between CCHC, community health, and ECE providers are key components for a CCHC program.[21] Through these collaborations, CCHC programs can be established with nurses acting as leaders in the improvement of ECE providers' health and safety policies and practices.[21]

A CCHC should demonstrate strong consultation skills while working as a part of an interdisciplinary consultative team (e.g., mental health, nutrition, early childhood education).[12] With access to individuals with specialized expertise, CCHCs can collaborate to meet specific areas of need while utilizing their consultation skills to provide coordination and broad overviews. It is important to recognize that the CCHCs may, in some circumstances, need backup from those with deeper expertise in both pediatric medicine and health consultation, as some complex or unusual needs may not be within the typical experience of CCHCs. Oversight, training, and continuing education needs are best managed by such an individual(s).

A study of a pilot training program involving CCHCs found that training health consultants for their role has a positive effect on the health and safety of child care programs as well as the CCHC's perception of their role.[22] In particular, networking opportunities, training module presentations, written materials, and planning of programs were found to be valuable to CCHCs in their evaluation of the training.[22] The National Center for Education in Maternal Child Health and Georgetown University National Center on Early Childhood Health and Wellness have developed materials for CCHC curricula, toolkits, and skill building modules (See Appendix V).[23] Skill building modules

specifically designed for CCHCs are also available from the Head Start Early Childhood Learning and Knowledge Center (See Appendix VI).[24]

On the national level, Head Start recognizes CCHCs as invaluable resources for improving health and safety of early education and child care programs.[25] The National Center for Early Childhood Health and Wellness framework for CCHCs consists of 16 competencies and areas of expertise specific to health, safety, and wellness (See Appendix VII).[26] Each competency defines what a CCHC should be able to do and can be used to assess readiness for the role and professional development. [26]

Head Start and Early Head Start programs encourage collaboration with communities at the local level with a requirement for Health Services Advisory Committees to support healthy children and communities.[27] In Wisconsin, 15,411 children were enrolled by Head Start and Early Head Start in 2019.[28] In addition, 8,692 families enrolled in Head Start participated in some form of health education in 2018.[28]

The Evidence Base for Child Care Health Consultation

Evidence exists that CCHCs support ECE providers in improving the health and safety of children and promote high quality ECE programs (See Appendix VIII).[9,22,29-34]Research shows that ECE programs that utilize CCHCs improved their written health and safety policies and health practices in a variety of areas, including medication administration, exclusion of sick children, and guidance on sanitizing and cleaning.[29] Another study found a relationship between ECE programs that received more hours of health consultation and improved pest management knowledge and practices.[30] CCHCs have also been shown to impact health at the child level.[34] Researchers studied the effect of implementing CCHCs at 77 child care centers over a two-year period in North Carolina, and found that after the intervention there were increased rates of recommended vaccines, well-child physicals, and use of primary care medical homes ("regular, consistent primary care clinics") within the sample.[34]

Length of collaboration and trust are likely key factors in CCHC program effectiveness. One study looked at the effect of mental health consultation and found that there was an increase in teachers' competence and self-efficacy, as well as overall quality, after at least one year of consultation at their center.[31] The Child Health and Development Institute found that CCHC collaboration with primary care medical homes can help provide support and prevention services to children.[9] While there are programs that focus specifically on infant and toddler mental health, behavior and development can frequently exist in a "watershed area" which can have both medical and mental health causes, and may require both types of consultation in order to effectively disentangle and address the situation productively. CCHCs can, if needed, connect children and their families to a medical home and resources that are available to support children's healthy development.[12]

Wisconsin Department of Children and Families (DCF) Vision and Goals

The development of a CCHC program addresses three of DCF's current priority areas:[35]

> "Systematically increasing access to quality early care and education programs that support the needs of children and families statewide."[35]

- CCHCs support and promote the health of children and help increase quality and safety within the settings that they work.

"Dedicating additional resources to support vulnerable and historically underserved youth, specifically teenage girls, kids with complex care needs, and youth transitioning out of the foster care system."[35]

- CCHCs may support children with complex medical needs and provide resources to ECE programs across WI to care for children, including respite care centers that provide services to underserved youth. Additionally, families who have historically been marginalized by both early childhood and health care systems will have access to an additional source of expert support that can help advocate for their needs to be addressed.

"Fostering a workplace where agency staff feel engaged, valued, and connected to our vision."[35]

- CCHC collaboration may increase ECE staff comfort and confidence working with and responding to children's health-related needs. Licensure staff may have greater confidence in discussing health-related needs by having higher-level CCHCs available to answer questions and provide input, and DCF programs will have ready access to expert advice.

PROGRAM MODELS

Several states have implemented CCHC programs and have regulations requiring health consultation as a feature of early childhood education. In the most recent report of CCHC requirements in 2015, 17 states had regulations requiring health consultation in early child care settings.[9] A majority of programs received federal or state funding for CCHC positions, however, in some states (e.g., Minnesota, Virginia) private funding is also utilized and consultants are hired by child care programs to provide consultation services and to review program health and safety policies.[9,36] The program structure for CCHCs and regulations for state licensed child care programs vary (See Appendix IX for details).[9,36]

In these various models, the CCHC role can be fulfilled by a licensed RN with training in children's health. Depending on the needs of ECE programs, the role of a CCHC may be filled by an advanced practice provider (e.g., nurse practitioner (NP), physician assistant (PA)), mental health professional, nutrition specialist, or a physician.[9,17,36] The CCHC role varies by program, setting, and state regulations the ECE operates under. CCHCs are employed through a wide variety of settings including state or local agencies (e.g., health, education, family service or child care agencies, private sources, local community action program, health professional organizations, self-employed).[12]

In addition, some states in which CCHCs are not under a centralized model utilize registries to help connect ECE providers with CCHCs, strengthening the network of support. Development of a state CCHC registry would allow for centralized data and knowledge regarding the workforce of CCHCs in the state.[37] State registries can also help states gather information regarding the type of training CCHCs currently have in the state and what resources or trainings may be helpful to them in the future.[37] Resources for ECE providers can also be informed by state registries.[37] For example, information regarding common questions from ECE providers can be collected within the registry.[37]

Notably, there are existing resources for CCHCs which can be utilized in various state models. One example of a developed CCHC resource is a Health and Safety Checklist based on *CFOF* standards which was designed to help CCHCs assess and improve health standards within ECE programs.[38] Having resources which are already developed specifically for CCHCs can help make the implementation of CCHC programs or trainings more efficient and effective.

A review of the evidence supporting health consultation and a scan of CCHC programs, both within Head Start and broadly in ECE in other states, reveals CCHC services implemented across these programs vary with state regulations for CCHCs, specific responsibilities for CCHCs, the employment type, and the size of the program.[9,37]

TIERS OF HEALTH CONSULTATION

The implementation of CCHCs can be customized based on intended outcomes and degree of support. The following tiers are an outline of three levels of CCHC implementations that range from basic, to moderate, to intensive. The degree of implementation can be dynamic and developed based off the specific needs of the community at that point in time. An in-depth description of examples of CCHC program models from various states is included (See Appendix IX). [39-53]

Tier 1
Level of Support: Basic
The CCHC role is generally filled by RNs. CCHCs may collaborate with a physician or medical director as an extension of state or local health departments. CCHCs are available by email or phone to provide general health guidance and answer questions related to health and safety topics and best practices. CCHCs may manage an informational website with links to resources (e.g., training topics, health and safety policies and resources, ECE standards, health fact sheets).

Tier 2
Level of Support: Moderate
The CCHC role may be filled by an RN, NP, PA, or physician. Tier 2 CCHC programs include all of the functions of Tier 1 with added support for reviewing ECE's health and safety policies and providing technical assistance and training to individual ECE programs on a variety of health-related topics. Tier 2 CCHC programs place a greater emphasis on disseminating information about community resources (e.g., WIC, Medicaid) than Tier 1. In addition, CCHCs may provide consultation related to the needs of an individual child, at the request of the center and with the consent of the parents.

Tier 3
Level of Support: Intensive
The CCHC role may be filled by an RN, NP, PA, or physician. Tier 3 CCHC programs include all of the functions of Tier 1 and Tier 2 with the addition of in-person training, on-site assessment of health and safety environments, and technical assistance as needed. In addition to annual review of ECE program health and safety policies, the CCHC role in Tier 3 places a greater emphasis on reviewing records to ensure children are receiving preventative care, helping to connect a family to a primary care medical home, and providing guidance in regard to an individual child. In general, the additional services provided in Tier 3 are in response to state ECE program licensing requirements for Quality Rating and Improvement Systems.

CURRENT AREAS OF NEED

In order to better understand the current area of needs for ECE providers in the state of Wisconsin, a needs assessment survey and policy scan to inform stakeholder needs and attitudes as well as inform the state of current policies implemented around health were completed as key, core elements of this project

Needs Assessment Survey

35 Wisconsin ECE providers responded to a survey in the period July 21, 2020 to August 12, 2020 and were asked several questions about ECE program health policies, perceived health needs within the child care setting, and attitudes towards a CCHC program. Requests for survey completion were sent to 358 programs, but the intercurrent pandemic may have led to a far lower response rate.

Participation
All 5 regions of Wisconsin were represented. A majority of programs surveyed are categorized as group centers (59.58%) followed by licensed family (30.30%), certified family (6.06%), Head Start (3.03%), and public-school programs (3.03%) On average, an estimated 34.71% of children receive Wisconsin Shares and 72.14% participate in the Adult and Child Food Program in the ECE programs surveyed. The average program size is approximately 20 for the 3-5 age group. For 0-2 years and 2-3 years, the average capacity is 10 children. A majority of ECE providers have a high school/GED level of education, followed by bachelor's degree and associate degree.

Summary of Key Findings—Survey

Our analysis of the survey results identifies eight key takeaways about Wisconsin ECE health policies, health needs, health, and attitudes towards a CCHC program.

1. **The guidelines used to create health policies varies widely among ECE programs.** The CDC and the Wisconsin DCF/DHS (Department of Health Services) are most commonly cited for creating health policies, however, many centers reported using a combination of recommendations from other program**s**, online resources, and state licensing requirements for writing program policies. Only three respondents reported using input from a health care provider to create their health policies.

2. **Few ECE providers are familiar with *CFOC*.** When asked about their familiarity with child health standards and guidelines, almost all reported following guidelines from the Wisconsin DCF. Roughly 40% responded that they are familiar with the NAEYC guidelines and 27% reported familiarity with *CFOC*. Of those familiar with *CFOC*, roughly half felt that they could apply the information, yet many felt that a training session for educators and more translation of the material would be needed to practically use it.

3. **General health and mental health needs can be challenging to staff.** A large majority responded that it was either extremely or somewhat likely that they would work with a child with Type I Diabetes, asthma, allergies, or other special health care needs that require medication assistance in the future. Roughly 50% reported that they

may recommend a family transfer to other settings for behavioral/mental health needs, 17% for medical needs, and 7% for developmental/special needs. In the past two years, 17.65% reported that they have asked a family to leave their setting due to the extent of a child's needs. Of those who expelled a child in the past two years, 5 out of 6 believe that having behavioral support from a CCHC would have helped the child be successful in the setting.

> *"We really try to help everyone, but when it starts getting stressful for the other children, and the teacher can't meet other kids' needs, we will consider a move to another room and/or expulsion. It's only happened once that we couldn't manage, and the child ended up being diagnosed with autism a year later. I felt really bad, but we didn't know what to do."*

> *"We need resources for our children and our teachers. The teacher's pay is the first issue. Because of the pay we have lower quality- including high rates of turnover. It is difficult to pay for training and education of teachers when they usually leave the field. Our children need access to mental health consultants and behavioral therapists. Many children are not officially diagnosed with special needs until older (age 5) this does not mean the special needs did not exist, it means that children are struggling those early years, and their teachers are struggling to meet those needs. Hence, the high rate of ECE expulsion. Those children need support and resources, not to be kicked out. But we cannot access it. Children should not have to wait for a diagnosis before they can gain support. Our lack of support for your youngest and most vulnerable is negligent at best. Any help and support you can provide is appreciated and necessary."*

4. **There is an expressed need for health consultation in ECE settings.** Specifically, respondents expressed needs for child health resources (70%), answers to general questions (53%), recommendations for health promotion and injury prevention (50%), help with health needs for a specific child (30%), review of health policies (20%), and direct observation of practices (20%). A majority would utilize no-cost consultative services and agreed that having access to a CCHC would help improve staff knowledge and enable them to meet the individual needs of children in early learning settings. In the instances where health consultation was not thought to be needed, high staff comfort managing health concerns and having an already-established health consultant are cited as reasons.

> *"All of ECE needs to have access to consultants for their children. Early prevention and intervention is what is best for children, families, and the community."*

5. **ECE providers would consult with CCHCs on a variety of health topics.** The top five health priority areas include: mental and behavioral health (72.73%), children with special needs (57.58%), cultural diversity and inclusion (51.52%), managing and preventing infectious diseases (51.52%), and referrals to community resources (45.45%). A full list of health topics is provided in Appendix X.

6. **A majority of ECE providers trust nurses and clinicians to fill the role of CCHC for consultation.** Reported trust increases with level of education and years of

experience on the part of the consultant. 80% reported that knowing that a physician oversees the program would increase their trust in a CCHC. Roughly 60% responded that meeting licensing requirements, certification, and pediatrics experience would increase their trust in CCHCs. 50% felt that ECE provider involvement in program creation would increase trust. In general, comfort accepting guidance was not dependent on level of training. However, mental health, special needs, managing infectious diseases, and writing health policies were more likely to be identified as requiring training as a clinician. Referrals, child abuse/neglect, nutrition and feeding, and medication administration were considered appropriate to be managed by not only clinicians, but also potentially individuals with expertise in other areas.

7. **Virtual consultation would be appropriate for a majority of ECE program needs**. Email is the preferred method for communication. A majority reported that it is extremely likely they would use a website with links to resources. There was also interest in other methods - including phone calls, video conferencing, and other messaging services for consultation. Few (6%) felt that an in-person visit would be required to address their needs. Specifically, working with children with special needs, assessing behavior, training on G-tube feeds or insulin administration, observing practices, talking to parents, and building trust were identified. Most felt that 24 hours to a week is a reasonable amount of time to wait for a response from a CCHC over phone or email. Longer wait times of a few weeks to months were thought to be reasonable for scheduling an in-person visit, webinars, or website update.

> *"I think building trust in the provider is easier in person and possibly to have them observe behaviors of a child if that was the concern. Most of the time I would think that a phone call/zoom call would be sufficient.*"

> *"I have children with special needs, who are not diagnosed and whose parents at this time are not comfortable with this. As an ECE teacher we generally have low status and this effects the information and guidance that we try to provide, in a way that parents do not always find our information as relevant to them. Parents are more apt to listen to a medical profession when it comes to talking about their child having special needs."*

> *"Have someone bilingual (Spanish) available to answer questions"*

8. **Resources are needed to help parents accept guidance.** A majority believe that navigating conversations about health policies with parents can be challenging. In addition to concerns about parental support, a majority reported that conflicting advice, confidentiality concerns, and lack of financial resources are additional barriers.

> *"Just getting parents to follow my health guidelines is always a struggle. I feel that parents get frustrated when children are sent home when sick, I feel parents blame things on teething, I think a lot of times parent give children Motrin in morning before arrival to get the children thru the day to mask fevers.*"

Policy Scan

A policy scan of ECE providers' online health policies was completed from September 14th, 2020 to October 21st, 2020 to compare alignment with the *CFOC* guidelines. The policy scan reviewed five common health topics related to inclusion/exclusion due to illness: pink eye, fever, lice, ringworm, and vomiting. These five topics were identified taking into account prior evidence that these likely represent common inaccurate health exclusions and also as topics which are easily comparable with ideal policies.[7] Specific rating criteria for each health topic were defined based off the *CFOC* Standard 3.6.1.1 (See Appendix XI).[54]

Each health topic received a rating score from 0-2 based off the established criteria. The score of 0 represents no presence of the health topic in the center's online health policy, the score of 1 represents presence yet without a complete alignment with the *CFOC* standard, and the score of 2 represents near-complete or complete alignment with the *CFOC* standard. The maximum possible rating for a health policy with complete alignment to the *CFOC* standards would therefore be a rating of 10. ECE providers were identified from the DCF's Childcare Finder Tool website during the research period.[55] Research for the providers' websites and health policies was conducted in weekly segments. Any unclear indication of provider website, policy, or location was not included in the policy scan.

Separate, independent scoring by two raters of each health policy was conducted with weekly discussion of inconsistencies to promote strong interrater reliability. The sum of all health topic ratings provided a singular score for each ECE center's health policy. Scores were summarized for further analysis in an Active Provider table provided by DCF on September 17th, 2020.

Description of Sample

Of the 4,537 licensed providers in Wisconsin at the time of the policy scan, 550 online health policies were found. The percentage of licensed providers in Wisconsin with health policies found online was roughly 12%. Notably, licensed group providers made up the majority of this sample. Licensed family providers were present but clearly underrepresented in the sample. The option of reaching out to licensed family providers in an effort to include more of their policies was discussed but ultimately decided against after discussion with the DCF to avoid placing additional burdens on these centers at the time of this work. In addition to licensed group and licensed family providers, the other category types present in the sample were public school program and regular certified providers.

Summary of Key Findings — Policy Scan

1. **The average health policy score in the sample indicates notable divergence between the analyzed health policies and the *CFOC* standards.** Across all providers with online health policies found, the average total score was 3.5 out of 10. Because a score of 10 would indicate that all five health topics matched the *CFOC* standards, the average score illustrates the existence of a significant gap between online health policies and the *CFOC* standards. When analyzed by category type (i.e., licensed group, licensed family, public school program, and regular certified), the highest

average score was found within the licensed family category. However, the average scores within category types all remained between a range of 3 – 3.67 indicating a similar average level of divergence across categories. In addition, because some category type subgroups had fewer centers with found online health policies, these average scores may be less representative (i.e., licensed group n=497, licensed family n=24, public school program n=27, and regular certified n=2).

2. **No online health policy was found at all that completely matched the *CFOC* standards for all five health topics.** The highest total score in the sample was a 7, highlighting the fact that no online health policy was found which matched all five health topics when compared with the *CFOC* standards. Within specific health topics, a score of 2 was uncommon. Though many health policies mentioned three or more of the five health topics, most did not match the specific *CFOC* standards. It should be noted that raters were conservative in their grading, and a score of 2 was only given when policies matched each component of the specific *CFOC* standards used (See Appendix XI).[54]

   The following examples are excerpts of ECE providers' online health policies with comparisons excerpts of related *CFOC* standards (See Appendix XI). Any identifying details were removed to keep centers anonymous:

   "To reduce the spread of many illnesses, please keep your child home with the following:

   - *<u>Pink Eye</u>: Children with red, itchy, draining, or crusty eyes may be showing signs of Pink Eye. If your child is displaying these above symptoms we may require you to take them to see a doctor for diagnosis. If the child does in fact have pink eye he/she may return...after being on medication for 24 hours.*

   If your child becomes sick during the day, you will be notified, described the situation and be asked to pick up your child within one hour."

   This example excerpt from an ECE providers' online health policy is divergent from the *CFOC* standards. According to *CFOC* Standard 3.6.1.1, pink eye does not require exclusion.[54]

   "Children who are ill are not to be brought to the provider. The following are examples of children who are ill:

   - *Fever*
     - *Under arm 99°F+*
     - *Oral 100°F+*
     - *Rectal/Temporal/Ear 100.4°F+"*

   Fever is identified as a temperature greater than 101 degrees Fahrenheit by any method that also includes a behavior change in children greater than two months of age based

on *CFOC* Standard 3.6.1.1.[54] Fever in this ECE providers' online health policy example would be divergent in definition of temperature grade and method location.

> "*A child who has head lice must be NIT-FREE before returning to the center. Upon returning to the center, the child must be thoroughly checked for any remaining nits or lice by a director or staff member trained in recognition of lice before the child may return to his or her classroom. The classroom of the child concerned will be thoroughly cleaned and vacuumed immediately and all non-washable items will be bagged and sealed for a period of no less than three weeks."*

The nit-free notation and the degree of response in this ECE providers' online health policy example diverges from the *CFOC* standards. According to *CFOC* Standard 3.6.1.1, no exclusion is needed for lice as long as treatment is started before coming back the next day.[54]

> *"Your child will be sent home and should not be brought to the Center if any of the following are present:*
>
> - *Suspected lice or ring worm"*

This ECE providers' online health policy example diverges from the *CFOC* standards, since it expresses that children with the presence of suspected ringworm should be excluded. *CFOC* Standard 3.6.1.1 expresses no exclusion is needed for ringworm as long as treatment is started before coming back the next day.[54]

> *"Children will be isolated and sent home with parents for the following reasons:*
>
> - *Vomiting once (not being a gag reflex). Child may return after symptom free for after 24 hours."*

The exclusion of children after one episode of vomiting diverges from the *CFOC* standards. The *CFOC* Standard 3.6.1.1 explains that exclusion for vomiting is recommended for more than two times in 24 hours.[54]

3. **When providers with online heath policies were grouped by YoungStar rating, a weak positive correlation was found between average total score and YoungStar rating.** Within our sample of providers with online health policies, providers with YoungStar ratings of 5-stars, 4-stars, 3-stars, 2-stars, and 1-star were represented. In addition, providers who were not participating in YoungStar and providers who were participating but not yet rated were also present in the sample. The average total score for providers with a 5-star rating was 3.87, with this average decreasing to an average total score of 3.24 among the 2-star rated providers (See Appendix XII). All average scores were within a 1 point range, indicating that there

were not large differences between average scores. It is important to note that group aggregate data does not apply to all individual providers. For example, a 1-star rated provider in our sample received a score of 4 while a 5-star provider received a score of 2 illustrating the fact that there were possible examples of variation counter to YoungStar rating categories.

4. **Aligned resources could support consistent and improved health policies among ECE providers.** There were noted inconsistencies among ECE providers' online health policies. Policies varied in the depth of definition for each of the five researched health topics and the number of those health topics covered. As noted in the key findings of the needs assessment survey, many centers reported using various sources including online resources to develop their health policies. A Family Child Care Policy Sample is available online from the Wisconsin DCF Child Care Information Center.[56] The policy sample had differences on inclusion/exclusion guidelines due to illness when compared to the *CFOC* standards (See Appendix XIII).[54,56] The Wisconsin Childhood Communicable Diseases chart, created by the Bureau of Communicable Diseases and Emergency Response within the Wisconsin Department of Health Services, was sometimes linked as a health resource on provider websites. The chart had similarities and a few differences on inclusion/exclusion guidelines due to illness when compared to the *CFOC* standards (see Appendix XIV).[54,57]Additionally, some ECE providers' online health policies specifically referenced state licensing policies and laws as driving their inclusion/exclusion guidelines. This was noted in both aligned and divergent examples compared to the *CFOC* standards.

TRAINING REFLECTION

A two-part PDG Healthcare Policy Consultation Training was conducted for DCF in order to share project findings and recommendations as well as facilitation of discussion and reflection regarding the child care health consultation needs assessment. The first training consisted of over 60 attendees including licensors, regulators, YoungStar quality staff, and DCF administrators. The second training had a similar structure with about 55 attendees of both new and returning participants from the first session. Both trainings were conducted virtually due to the intercurrent pandemic. We present observations from these sessions in order to help incorporate the perspective and response of DCF staff to this work.

As part of the first training, participants were presented with three scenarios from the Hashikawa study and were asked if they would exclude the child described in the scenario.[7] Strikingly similar to the child care directors in the original study, the participants excluded children an average of 38% of the time, even though, in each scenario, when following AAP/APHA guidelines, none of the children in the scenarios required immediate exclusion. Participants were then presented with policy excerpts from real child care center policies in Wisconsin which were found during the policy scan. The participants were asked to respond to a poll which asked whether or not the example policy reflected what they would consider ideal practice, and if the policy aligned with the guidelines they use to advise ECE providers. Across the five example policies presented, responses were varied regarding each of the examples and there was often no clear consensus when deciding whether or not the policy aligned with ideal practice or current guidelines.

Participants offered several suggestions for consideration regarding future program implementation. Virtual online training for ECE providers was recommended to support the understanding of available health policy guidelines. Considerations for supporting children with special health care needs was noted. Including laminated, easily-posted reference guides was another suggestion to help offer preferred resource formats for ECE providers. Additionally, it was recommended to explore dissemination options to ensure resources are reaching the intended audience effectively and efficiently.

During the questions and reflections portion of the training, some participants pointed out concerns they had regarding encouraging change in ECE center policies. It was expressed that providers may be reluctant to change their policies, especially if their current policy has been in place for a longer period of time. Parental concerns were brought up as a potential obstacle to changing health policies. It was also suggested that providing reassurance to centers that there would not be regulatory consequences if they were to change their policies would be an important part of this transition. Emphasizing that consultation is intended to be a benefit and not punitive appears key to building openness and trust.

The second training session included opportunities for deeper discussion among participants in small groups with a larger group report-out. Various topics for better understanding and resources to promote effectiveness in their roles were identified. Questions were asked both from the attendees' perspectives on their role and their perspective on the ECE providers' areas for growth. Consistent guidelines, trainings, policy templates, available resources by region, and online health assessments were noted as recommendations. For example, it was mentioned that out-of-date resources including

older versions of the DHS Wisconsin Childhood Communicable Diseases chart were continuing to be used. Participants expressed that working with a health consultant could indeed be another valuable resource. Consultation to support mental health topics were noted as a need. The discussion identified additional layers of support such as onsite nursing services, family engagement, and resources for parents. Supporting a collaborative network among ECE providers was also suggested.

During the training discussion, participants outlined potential obstacles for future health promotion with ECE programs. It was expressed that ECE providers may have significant incentive to accommodate parents' wishes or concerns since they are considered their direct and primary customers. Low pay, high turnover, and limited available time of ECE providers could also be barriers as shared by training attendees.

In order to promote the health of children at ECE programs, there are opportunities to leverage the strengths recognized during this second training session. Attendees described what it means for a child to be healthy as loved, safe, nourished, energetic, and happy. While some of these words are more difficult to measure, participants recognized that the key themes are being promoted and prioritized by ECE providers. Further support of ECE providers for health promotion of children can build from this common understanding.

RECOMMENDATIONS

The needs assessment survey and policy scan results indicate that there is a need for CCHCs in Wisconsin. This appears to be true even when assessments were made prior to the intercurrent pandemic, and are starkly even more evident now. Based on the assessment of needs from ECE providers and policy scan evidence, the following recommendations are made.

- **Establish CCHC pilot program focusing on the expressed general and mental health needs and priority health topics based on evidence-based research and state models.** Virtual consultation would be appropriate for a majority of ECE program needs (e.g., email, phone, website with links to resources) with room to expand to more intensive consultation (e.g., webinars, in-person consultation) if demand and funding increase. A majority of ECE providers trust nurses and clinicians to fill the role of CCHC for consultation, so a staff profile could include hiring a licensed RN with program oversight from a physician. Consultants should be trained in pediatrics or have experience working with children. Additionally, consultants should have consultative experience or knowledge to support the improvement of ECE providers' health policies. Through collaboration with the DCF, implementation considerations regarding scope and scale would be developed. Notably, initial implementation can include basic levels of intensity, but can also include additional work to judge the feasibility and need for more intensive levels of support.

- **Create a centralized website/landing page with resources and online trainings to help ECE providers adopt and understand the *CFOC* guidelines for health and safety policies.** *CFOC* guidelines for health and policies should be easily accessible. Websites that are currently being used by ECE providers to help guide their policy development could act as a bridge by hyperlinking to a common resource landing page. On this landing page, resources can include sample policies and templates that utilize and link to the *CFOC* guidelines. Having more streamlined resources could help reduce the variation in sources for developing health policies.

- **Coordinate trainings for Wisconsin Child Care Licensing and ECE providers to get buy-in on CCHC program and reduce barriers to participation.** Opportunities should be provided for ECE providers and parents to provide input on program design process. Resources should be provided to help ECE providers productively and collaboratively communicate with parents about health consultation to help accept guidance from CCHCs. Further training on aligned resources should be made available to promote consistency among statewide ECE providers' health policies, including inclusion/exclusion due to illness.

CONCLUSION

The results of the needs assessment survey, policy scan, and PDG Healthcare Policy Consultation Training are concordant in their indication that there is an existing need for a CCHC program in Wisconsin.

A CCHC pilot program is recommended to help meet the needs of ECE providers. A CCHC pilot program could easily begin with an RN who receives oversight from a physician. A pilot program would allow for expansion depending on the level of need and the budget. Not only would a CCHC pilot program aid in the creation of center health policies, but it would help address specific concerns and provide guidance for providers on topics like mental health. In addition to mental health being an area of concern in the needs assessment survey, mental health was brought up as an area of need by the licensors, regulators, and DCF staff at the training. Upon completion of the needs assessment survey, policy scan, and training, the underlying need and desire for consultation among ECE providers is clear.

The creation of consistent resources is also supported by the results of each project component. Licensors, regulators, and DCF staff at the training highlighted the fact that providers may be using out-of-date resources. In addition, both the needs assessment survey and policy scan provided evidence that a variety of resources were referenced when creating health policies. By creating accessible, consistent, and easy to understand resources, providers will be better supported in formulating health policies and seeking guidance.

ECE providers, licensors, and regulators all voiced the desire for training opportunities to better support communication with parents and effective policy development. Training can help support providers' understanding of aligned resources and aid in their communication of policies to parents.

Continued evidence and support for the implementation of a CCHC program in Wisconsin has been established after analyzing a needs assessment survey, conducting a policy scan across the state of Wisconsin, and hosting a training among licensors, regulators, and DCF staff. The three stated recommendations, a pilot program, consistent resources, and training opportunities, will all aid in the creation of a supportive CCHC program which will benefit ECE providers in Wisconsin.

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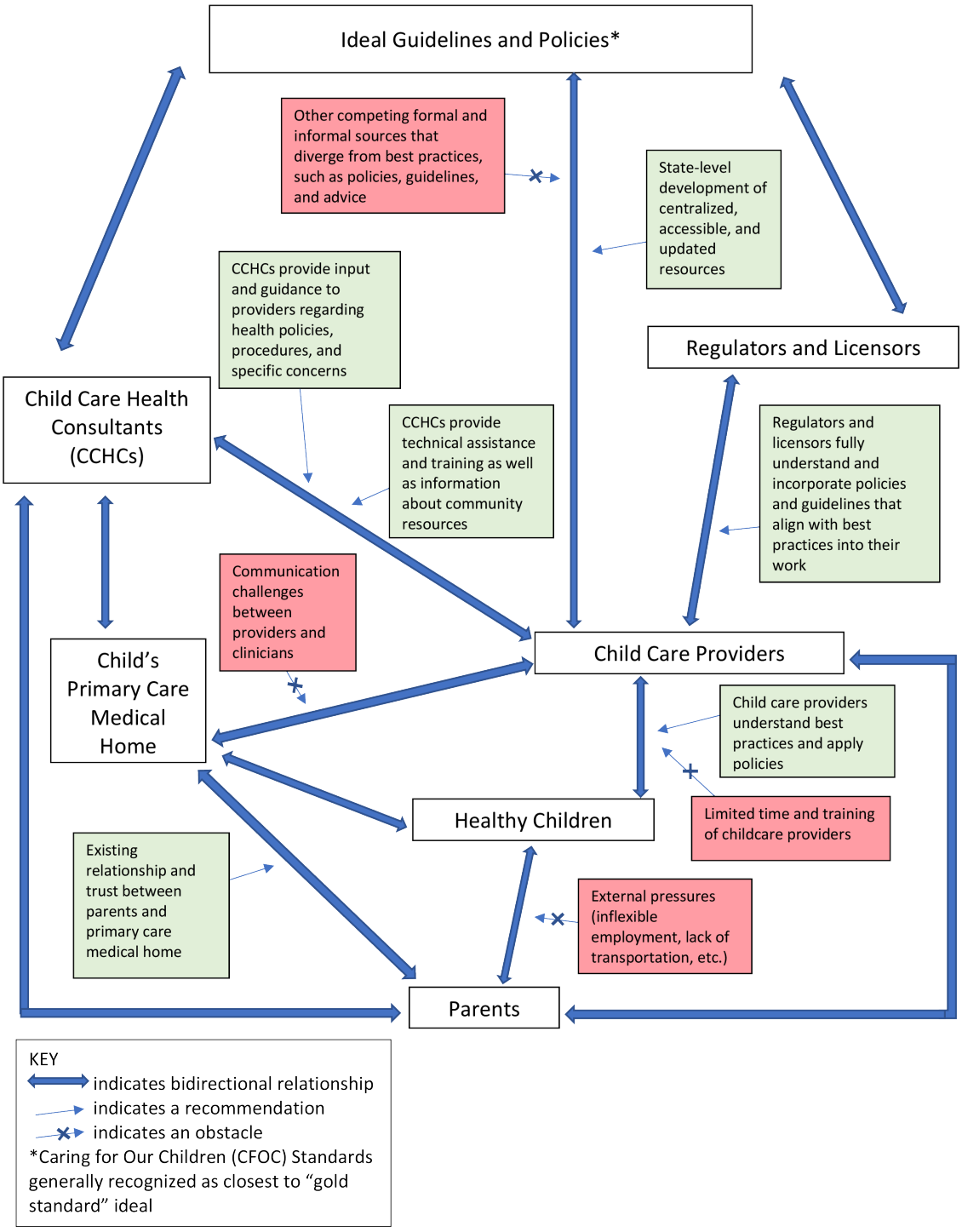
Figure 1: Recommendations and Obstacles on the Path Toward Healthy Children



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Appendix I:
Caring For Our Children: Child Care Health Consultants

Source: National Resource Center for the Health and Safety in Child Care and Early Education (NRC)
URL: https://nrckids.org/cfoc/database/1.6.0.1

The section below is a verbatim excerpt from the source:

1.6.0.1: Child Care Health Consultants

A facility should identify and engage/partner with a child care health consultant (CCHC) who is a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation.
CCHCs have knowledge of resources and regulations and are comfortable linking health resources with child care facilities.
The child care health consultant should be knowledgeable in the following areas:

a. Consultation skills both as a child care health consultant as well as a member of an interdisciplinary team of consultants;
b. National health and safety standards for out-of-home child care;
c. Indicators of quality early care and education;
d. Day-to-day operations of child care facilities;
e. State child care licensing and public health requirements;
f. State health laws, Federal and State education laws (e.g., ADA, IDEA), and state professional practice acts for licensed professionals (e.g., State Nurse Practice Acts);
g. Infancy and early childhood development, social and emotional health, and developmentally appropriate practice;
h. Recognition and reporting requirements for infectious diseases;
i. American Academy of Pediatrics (AAP) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening recommendations and immunizations schedules for children;
j. Importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children's Health Insurance Program (SCHIP);
k. Injury prevention for children;
l. Oral health for children;
m. Nutrition and age-appropriate physical activity recommendations for children including feeding of infants and children, the importance of breastfeeding and the prevention of obesity;
n. Inclusion of children with special health care needs, and developmental disabilities in child care;
o. Safe medication administration practices;
p. Health education of children;
q. Recognition and reporting requirements for child abuse and neglect/child maltreatment;
r. Safe sleep practices and policies (including reducing the risk of SIDS);
s. Development and implementation of health and safety policies and practices including poison awareness and poison prevention;
t. Staff health, including adult health screening, occupational health risks, and immunizations;
u. Disaster planning resources and collaborations within child care community;
v. Community health and mental health resources for child, parent/guardian and staff health;
w. Importance of serving as a healthy role model for children and staff.

The child care health consultant should be able to perform or arrange for performance of the following activities:

a. Assessing caregivers'/teachers' knowledge of health, development, and safety and offering training as indicated;
b. Assessing parents'/guardians' health, development, and safety knowledge, and offering training as indicated;
c. Assessing children's knowledge about health and safety and offering training as indicated;
d. Conducting a comprehensive indoor and outdoor health and safety assessment and on-going observations of the child care facility;
e. Consulting collaboratively on-site and/or by telephone or electronic media;
f. Providing community resources and referral for health, mental health and social needs, including accessing medical homes, children's health insurance programs (e.g., CHIP), and services for special health care needs;
g. Developing or updating policies and procedures for child care facilities (see comment section below);
h. Reviewing health records of children;
i. Reviewing health records of caregivers/teachers;
j. Assisting caregivers/teachers and parents/guardians in the management of children with behavioral, social and emotional problems and those with special health care needs;
k. Consulting a child's primary care provider about the child's individualized health care plan and coordinating services in collaboration with parents/guardians, the primary care provider, and other health care professionals (the CCHC shows commitment to communicating with and helping coordinate the child's care with the child's medical home, and may assist with the coordination of skilled nursing care services at the child care facility);
l. Consulting with a child's primary care provider about medications as needed, in collaboration with parents/guardians;
m. Teaching staff safe medication administration practices;
n. Monitoring safe medication administration practices;
o. Observing children's behavior, development and health status and making recommendations if needed to staff and parents/guardians for further assessment by a child's primary care provider;
p. Interpreting standards, regulations and accreditation requirements related to health and safety, as well as providing technical advice, separate and apart from an enforcement role of a regulation inspector or determining the status of the facility for recognition;
q. Understanding and observing confidentiality requirements;
r. Assisting in the development of disaster/emergency medical plans (especially for those children with special health care needs) in collaboration with community resources;
s. Developing an obesity prevention program in consultation with a nutritionist/registered dietitian (RD) and physical education specialist;
t. Working with other consultants such as nutritionists/RDs, kinesiologists (physical activity specialists), oral health consultants, social service workers, early childhood mental health consultants, and education consultants.

The role of the CCHC is to promote the health and development of children, families, and staff and to ensure a healthy and safe child care environment (11).

The CCHC is not acting as a primary care provider at the facility but offers critical services to the program and families by sharing health and developmental expertise, assessments of child, staff, and family health needs and community resources. The CCHC assists families in care coordination with the medical home and other health and developmental specialists. In addition, the CCHC should collaborate with an interdisciplinary team of early childhood consultants, such as, early childhood education, mental health, and nutrition consultants.

In order to provide effective consultation and support to programs, the CCHC should avoid conflict of interest related to other roles such as serving as a caregiver/teacher or regulator or a parent/guardian at the site to which child care health consultation is being provided.

The CCHC should have regular contact with the facility's administrative authority, the staff, and the parents/guardians in the facility. The administrative authority should review, and collaborate with the CCHC in implementing recommended changes in policies and practices. In the case of consulting about children with special health care needs, the CCHC should have contact with the child's medical home with permission from the child's parent/guardian.

Programs with a significant number of non-English-speaking families should seek a CCHC who is culturally sensitive and knowledgeable about community health resources for the parents'/guardians' native culture and languages.

RATIONALE

CCHCs provide consultation, training, information and referral, and technical assistance to caregivers/teachers (10). Growing evidence suggests that CCHCs support healthy and safe early care and education settings and protect and promote the healthy growth and development of children and their families (1-10). Setting health and safety policies in cooperation with the staff, parents/guardians, health professionals, and public health authorities will help ensure successful implementation of a quality program (3). The specific health and safety consultation needs for an individual facility depend on the characteristics of that facility (1-2). All facilities should have an overall child care health consultation plan (1,2,10).
The special circumstances of group care may not be part of the health care professional's usual education. Therefore, caregivers/teachers should seek child care health consultants who have the necessary specialized training or experience (10). Such training is available from instructors who are graduates of the National Training Institute for Child Care Health Consultants (NTI) and in some states from state-level mentoring of seasoned child care health consultants known to chapter child care contacts networked through the Healthy Child Care America (HCCA) initiatives of the AAP.

Some professionals may not have the full range of knowledge and expertise to serve as a child care health consultant but can provide valuable, specialized expertise. For example, a sanitarian may provide consultation on hygiene and infectious disease control and a Certified Playground Safety Inspector would be able to provide consultation about gross motor play hazards.

Appendix II:
Providing Guidance on Quality Child Care to Families, Child Care Programs and Policymakers

Source: the American Academy of Pediatrics
URL: https://www.aap.org/en-us/Documents/GuidanceforQualityEECC.pdf

Note: While written for pediatricians, the following recommendations from the AAP can be applied by all clinicians serving the role of a CCHC.

The sections below are verbatim excerpts from the source:

> The following information is based on the AAP manual "The Pediatrician's Role in Promoting Health and Safety in Child Care." Depending on your interest and time available, below are suggestions on how pediatricians can be involved in children care on different levels.
>
> **Level One: Providing Guidance to Families on Child Care Issues**
> There are opportunities for incorporating child care issues into individual clinical services that you provide the families you serve. Advice on finding high quality child care, providing timely health information forms, especially for children with special needs, and giving clear advice about return to care after illness can be very helpful to families. These tips require very little extra time to implement. Further details are provided in the document Providing Guidance on Quality Child Care to Families, Child Care Programs and Policymakers.
>
> **Level Two: Providing Health Consultation to Child Care Programs**
> For pediatricians who are interested in providing communication based services, you can establish an ongoing relationship with a child care program to promote health and safety. Learn more about being a health consultant in this document...
>
> **Level Three: Advocating for Quality Child Care**
> Promoting quality child care in your community and beyond is also needed through community outreach, education and advocacy. Learn more about advocacy opportunities to promote health and safety in early education and child care in this document.

Become A Health Consultant to a Child Care Program

> Health and safety issues in out-of-home child care settings can range from simple to complex. Early education and child care programs can handle certain health matters on their own, such as responding to a minor injury or developing materials and procedures based on their state's child care regulations. However, when programs face more complex health concerns, such as determining a "safe sleep" policy, developing a care plan for children with chronic medical conditions, or responding to an infectious disease outbreak, they can benefit greatly from expert health consultation.
>
> Caring for Our Children: National Health and Safety Performance Standards, Third Edition, 2011 is an evidence informed resource that is invaluable in any work done in the field of quality early childhood education.

The National Association for the Education of Young Children (NAEYC), the foremost professional association for the early childhood field promoting high-quality early learning for all children, birth through age 8, has revised its criteria for accrediting licensed early learning programs, and now recommends that early learning programs contract and form an ongoing relationship with a health care professional to improve the health and safety of the children enrolled in that program.

According to Caring For Our Children (CFOC), a Child Care Health Consultant (CCHC) is "a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation" (CFOC, 3rd Ed., Standard 1.6.0.1). According to CFOC, CCHCs have knowledge of child care practices, rules, and regulations, infant and early childhood development, a range of health topics relevant to young children, and community health resources to support staff wellness, program preparedness for emergencies, and family health and mental health.

Currently, a majority of child care health consultants (CCHCs) are nurses, mental health professionals, nutritionists, or other health and safety experts. Yet, there is an increasing number of pediatricians who serve as CCHCs or medical directors for local child care programs.

Recommendations for Pediatric Involvement:

- Build relationships with child care providers
- Conduct a needs assessment
- Visit the program and observe practices and facilities
- Promote effective communication
- Develop and review child care health policies
- Ensure medical homes and preventive care
- Develop plans to care for children with chronic conditions
- Provide health education for staff, families, and children
- Review illness and injury logs
- Provide ongoing health consultation

Other Issues to Remember:

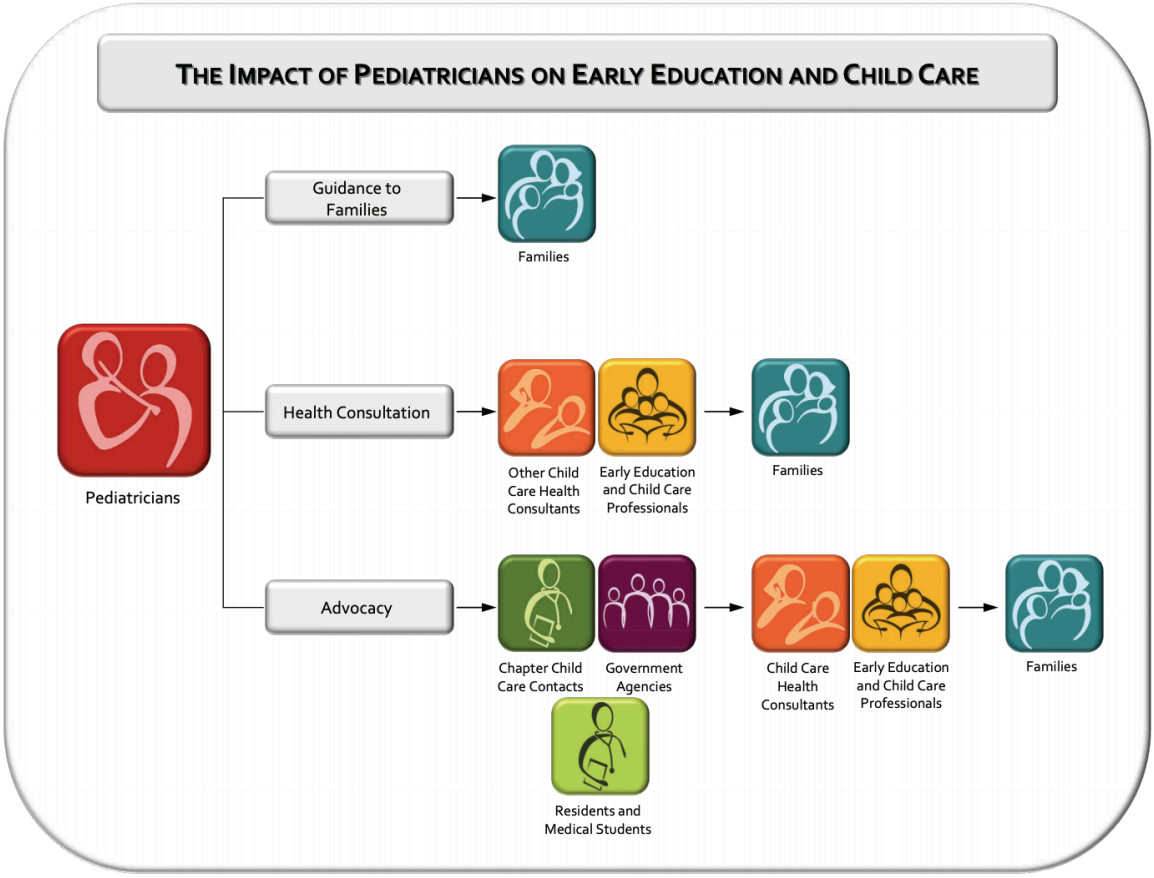
- Laws and regulations
- Consent and confidentiality
- Liability

Appendix III:
Pediatricians' Role in Early Education and Child Care
Source: The American Academy of Pediatrics
URL: https://www.aap.org/en-us/Documents/ImpactPeds_QualityEECC.pdf

Note: While written for pediatricians, the following recommendations from the AAP can be applied by all clinicians serving the role of a CCHC.

The section below is verbatim excerpt from the source:

> With your trusting relationship with families and frequent contact during children's early years, you can make a difference by counseling families on how to find child care that is best for their child. With your respected role in the community, you also can help improve health and safety standards in child care by providing health consultation to community child care programs.
>
> The Impact of Pediatricians on Early Education and Child Care
> This diagram illustrates how pediatricians can be involved and how their work impacts families, child care providers, child care health consultants, government agencies, and other health care professionals.



Appendix IV:
Tips for Engaging in a Health Consultation Relationship
For Early Education and Child Care Professionals and Pediatricians Who Want to Partner
Source: the American Academy of Pediatrics
URL: https://www.aap.org/en-us/Documents/Tips_HealthConsultationRelationship.pdf

The section below is a verbatim excerpt from the source:

> To learn how best to support all programs to achieve the health-related criteria, the American Academy of Pediatrics (AAP) coordinated the 6-month pilot program *Increasing Health Professional Involvement in Child Care Programs to Improve Quality Care and Outcomes for Children* to offer pediatric health professional consultation services to child care centers.
>
> The following tips and resources may help other early education and child care professionals and health care professionals who engage in similar partnerships.
>
> Tips for Early Education and Child Care Professionals who want to partner with a child care health consultant:
>
> - Determine who from the program will be responsible for interacting with the child care health consultant. Will this be the director, a designated health coordinator or advocate, or another person?
> - Create a written agreement with your child care health consultant. The agreement should include the details of the relationship, specify the qualifications of the consultant, and serve as an outline for ongoing consultation activities including a program follow-up plan based on consultant recommendations. Place the agreement in your program portfolio as evidence for meeting the NAEYC accreditation criteria, and use it as a reference when describing the consultation process and purpose with staff and families.
> - Be prepared. Determine what health and safety issues your program faces. Have a list of questions available and any program practices or policies for which you would like help. Organize a staff meeting to discuss health and safety issues, and identify opportunities for the child care health consultant to provide professional development for staff or provide educational sessions for parents.
> - Know how the child care health consultant prefers to be contacted. Many child care health consultants are comfortable with responding to E-mails or phone calls once a relationship has been established.
> - Be patient as health care professionals become familiar with the world of early education and child care. Interdisciplinary work requires educating one another about the concepts, terms, and operations in each other's usual area of function.
> - Be open to change. Do what you can now, and then schedule other needed improvements. Sometimes it can seem overwhelming and difficult if the result of the child care health consultation is a long list of suggestions. Through collaboration with the child care health consultant and program staff, discussion regarding the rationale, and compromise, you can set priorities. Establish an action plan that will make steady progress to improve the safety and health of the children and staff in your program.

- Understand the child care health consultant's purpose. A child care health consultant reviews and advises on the needs of the child care program as a whole. It is not appropriate for the child care health consultant to give specific advice on an individual child. For such advice, you need to contact that child's health care professional in that child's medical home.

Tips for Pediatricians who want to partner with an early education and child care program by working as a child care health consultant:

- Establish some practical guidelines for the early education and child care program.
    - Who is the responsible person with whom you will work at the program? Does this person have the authority or a direct line to a person with the authority to address the health and safety issues involved in your consultation?
    - How do you want the program to contact you for specific situations –by telephone, E-mail, fax, or letter?
    - When do you prefer the program to contact you –on a spontaneous basis, only during specific office hours, or on a regularly scheduled basis (ie, 1st Monday of each month)?
    - What is the most effective way for early education and child care professionals to present you with observations, questions, and concerns?
- Become familiar with licensing rules and regulations for the child care program. In time, you will develop ideas that you can use to advocate for better licensing rules and regulations.
- Visit the program to personally meet the staff, and familiarize yourself with the setting. Take time to observe what occurs in an early education and child care setting, gaining a perspective of a "day in the life of an early education and child care professional" as well as what children experience in a group setting.
- Demonstrate an appreciation for the particular circumstances of the early education and child care program, its challenges and its strengths.
- Understand that you are an "outside expert" and have no authority within the program to make decisions and ensure that the program follows the recommendations.
- Create a trusting and consistent relationship with the educators at the program.
- Listen carefully, ask questions, and clarify the issues involved.
- Recognize and respect each other's unique knowledge, experience, and feelings (ie, early education and child care professionals, families, and child care health consultants).
- Show empathy and understanding of the constraints of operation of the early education and child care program. Provide the rationale for following certain recommendations. Knowing what harm is being avoided makes it more likely that the recommendations will be followed.
- Understand that illnesses in an early education and child care setting may be treated differently than in the child's home. For example, even if a particular child's diarrhea is not considered particularly infectious, changing diapers containing diarrhea or soiled clothing

poses an increased sanitation risk and strains the ability of the early education and child care professional to supervise and care for a group of children.

- Make recommendations that reinforce and build on the positive things already being done, that are cost-effective, and are easily implemented.

- Prioritize the concerns you identify from your observations and what you hear from staff and parents. Avoid overwhelming the program with too many recommendations at one time.

- Promote, but do not interfere with existing relationships between families and their children's medical homes.

- Give clear and simple advice, verbally. Then, after discussing your recommendations and incorporating the results of a collaborative discussion, follow-up by providing an outline of the resulting suggested actions in writing with your signature and title. Written advice gives early education and child care professionals something to refer back to and share with staff. Documenting the results of the collaborative discussion and intended actions prevents errors. It also gives the early educators something they can show to parents if their credibility is questioned when implementing changes.

- Pursue a long-term consulting relationship to allow the opportunity to follow-up and evaluate progress, to develop and revise action plans, and to establish a continuous process in pursuit of quality.

Appendix V:
Child Care Health Consultant Curricula and Toolkits

Source: National Center for Education in Maternal Child Health
URL: https://www.ncemch.org/child-care-health-consultants/

The section below is verbatim excerpt from the source:

> These materials are from the National Training Institute (NTI) for Child Care Health Consultants, a National Healthy Child Care America Cooperative Agreement Program funded from 1997-2013 by the U.S. Maternal and Child Health Bureau. They include train-the-trainer modules and toolkits to address the needs of child care health consultants.
>
> **Building Consulting Skills**
> Module: Building Consultation Skills Training Module (version 3)
> Module: Building Curriculum Development and Training Skills Appendixes (version 1)
> Toolkit: Building Curriculum Development and Training Skills (slides)
> Toolkit: Training Selection Flowchart
> Toolkit: Building Curriculum Development and Training Skills: Trainer's Guide for the NTI Facilitator (version 1)
> Toolkit: Welcome to the National Training Institute for Child Care Health Consultants (slides)
> Toolkit: Training Selection Flowchart
> Toolkit: Managing Stress in the Child Care Environment: Audience Analysis
> Toolkit: Managing Stress in the Child Care Environment: Overview of Training Session
> Toolkit: Managing Stress in the Child Care Environment: Overview of Training Session
> Toolkit: ACTIVITY: Practice Writing Training Objectives
> Toolkit: ACTIVITY: Practice Writing Training Objectives
> Toolkit: Building Curriculum Development and Training Skills: Trainer's Guide (version 1)
> Toolkit: Building Curriculum Development and Training Skills (slides)
>
> **Building Curricula Developing Skills**
> Module: Building Curriculum Development and Training Skills: Training Module (version 1)
> Toolkit: Action Plan
> Toolkit: Consultant On-site Consultation Checklist
> Toolkit: Contact Summary
> Toolkit: Participant Evaluation of Consultation
> Toolkit: Building Consultation Skills: Advocacy (slides)
> Toolkit: Building Consultation Skills: Advocacy Trainer's Guide (version 1)
> Toolkit: Child Care Health Consultant: Knowledge and Skills Crossword Puzzle
> Toolkit: Building Consultation Skills: Child Care Health Consultant (slides)
> Toolkit: Building Consultation Skills: Child Care Health Consultation Trainer's Guide (version 1)
> Toolkit: Building Consultation Skills: Cultural Competence and Communications Skills (slides)
> Toolkit: Building Consultation Skills: Cultural Competence and Communications Skills Trainer's Guide (version 1)
> Toolkit: Building Consultation Skills: Health Education Trainer's Guide (version 1)
> Toolkit: Building Consultation Skills: Health Education (slides)
> Toolkit: Building Consultation Skills: Policy Development (slides)
> Toolkit: Building Consultation Skills: Policy Development Trainer's Guide (version 1)
> Toolkit: Building Consultation Skills: Resource & Referral and the Medical Home (slides)
> Toolkit: Building Consultation Skills: Resource & Referral and the Medical Home Trainer's Guide (version 1)
> Toolkit: ACTIVITY: Crossword – Knowledge and Skills of the CCHC
> Toolkit: Consultation Forms: Action Plan

Toolkit: Building Consultation Skills: Child Care Health Consultation NTI Facilitator Trainer's Guide (version 1)
Toolkit: Building Consultation Skills: Child Care Health Consultation (slides)
Toolkit: Building Consultation Skills: Policy Development (slides)
Toolkit: SAMPLE Child Care Observation Letter

Caring for Children Who are Ill
Module: Caring for Children Who are Ill: Training Module (version 3)
Toolkit: Caring for Children Who are Ill: Trainer's Guide (version 1)
Toolkit: Caring for Children Who are Ill (slides)

Child Maltreatment
Module: Caring for Children Who are Maltreated: Training Module (Version 3)
Toolkit: Caring for Children Who are Maltreated (slides)
Toolkit: Caring for Children Who are Maltreated Trainer's Guide (version 1)

Children with Special Health Care Needs
Module: Caring for Children with Special Needs: Training Module (version 4)
Toolkit: Children with Special Needs Trainer's Guide (version 1)
Toolkit: Caring for Children with Special Needs (slides)

Environmental Health (Including lLad)
Module: Environmental Health in Child Care: Lead (version 2)
Module: Environmental Health in Child Care: Training Module (version 4)
Toolkit: Environmental Health in Child Care: Trainer's Guide (version 1)
Toolkit: Environmental Health in Child Care (slides)
Toolkit: Environmental Health in Child Care: Lead - Trainer's Guide (version 1)
Toolkit: Environmental Health in Child Care: Lead (slides)

Field of Child Care
Module: Overview of the Field of Child Care: Training Module (version 4)
Toolkit: Overview of the Field of Child Care: Trainer's Guide (version 1)
Toolkit: Overview of the Field of Child Care (slides)

Infectious Diseases
Module: Infectious Disease in Child Care Settings: Training Module (version 3)
Module: Infectious Disease in Out of Home Child Care, Part I
Module: Infectious Disease in Out of Home Child Care, Part II
Module: Infectious Disease in Out of Home Child Care, Part III
Toolkit: Infectious Disease in Child Care Settings (slides)
Toolkit: Infectious Disease in Child Care Settings Trainer's Guide (version 1)

Injury Prevention A and B
Module: Injury Prevention in Child Care Part A: Playground… (version 4)
Module: Injury Prevention in Child Care Part B: Common… (version 4)
Module: Matching Children and Play Equipment
Module: Playground Surfacing Materials: ADA-Approved and Non-Approved
Toolkit: Injury Prevention in Child Care: Playground… (slides)
Toolkit: Injury Prevention in Child Care Part A: Playground… Trainer's Guide (version 1)
Toolkit: Injury Prevention in Child Care Part B: Common… (slides)
Toolkit: Injury Prevention in Child Care Part B: Common… Trainer's Guide (version 1)

Mental Health
Module: Mental Health in the Child Care Setting – Supporting… (version 3)
Module: Early Brain Development: Implications for Early Childhood Programs

Toolkit: Mental Health in the Child Care Setting – Supporting… Trainer's Guide (version 1)
Toolkit: Mental Health in the Child Care Setting (slides)

Nutrition and Physical Activity
Module: Nutrition and Physical Activity in Child Care (version 5)
Module: Making Food Healthy and Safe for Children (2nd edition)
Toolkit: Nutrition and Physical Activity in Child Care (slides)
Toolkit: Nutrition and Physical Activity in Child Care Trainer's Guide

Oral Health
Module: Caring for Children's Oral Health (version 5)
Toolkit: Healthy Smiles: Caring for Children's Oral Health (slides)
Toolkit: Healthy Smiles: Caring for Children's Oral Health Trainer's Guide (version 1)
Toolkit: Primary Teeth Eruption Chart
Toolkit: My Survey: Which Toothpaste do You Use?

Quality in Child Care
Module: Quality in Child Care and How to Measure It (version 4)
Module: Assessing Environments with the Environmental Rating Scales: Group Leader Guidelines
Module: ITERS-R Interrater Reliability
Module: SCORE SHEET: Infant/Toddler Environment Rating Scale-Revised Edition
Module: Environmental Rating Scales Observation Guidelines
Toolkit: Quality in Child Care and How to Measure It… Trainer's Guide (version 1)
Toolkit: Quality in Child Care and How to Measure It… (slides)

Staff Health
Module: Promoting the Health and Safety of Child Care Staff (version 3)
Toolkit: Promoting the Health and Safety of Child Care Staff (slides)
Toolkit: Promoting the Health and Safety of Child Care Staff Trainer's Guide (version 1)
Toolkit: Promoting the Health and Safety of Child Care Staff Trainer's Guide (NCAEYC version)
Toolkit: Caring for the Caregivers: Promoting Health and Safety of Child Care Staff (slides)
Toolkit: Caring for the Caregivers: Promoting Health and Safety of Child Care Staff Trainer's Guide for CCHCs

General Documents for Each Toolkit
Toolkit Evaluation
Presentation Template
Evaluation of Trainer Form
Notes for Making an NTI Toolkit (1.29.2007 revised)
Trainers Guide Template
Training Checklists (version 1)

Appendix VI:
Child Care Health Consultation: Skill-Building Modules
Source: Head Start Early Childhood Learning & Knowledge Center
URL: https://eclkc.ohs.acf.hhs.gov/health-services-management/article/child-care-health-consultation-skill-building-modules

The section below is verbatim excerpt from the source:

> Child care health consultants (CCHCs) can use these modules to explore six interactive, realistic scenarios to build and enhance consultation skills in the following areas:
>
> - Creating collaborative relationships with programs
> - Using cultural competence to solve problems
> - Applying consultation skills to oral health promotion
> - Identifying and resolving concerns
> - Improving communication skills
> - Building trust with programs
>
> For more about how to use these modules, read the Q&A. Select this link for more information about how the modules were developed.
>
> Explore Resources
>
> 1. Creating Collaborative Relationships with Programs
> 2. Using Cultural Competence to Solve Problems
> 3. Applying Consultation Skills to Oral Health Promotion
> 4. Identifying and Resolving Concerns
> 5. Improving Communication Skills
> 6. Building Trust with Your Programs
>
> These modules were inspired by the article: Crowley, A. A., Sabatelli, R.M. Collaborative Childcare Health Consultation: A Conceptual Model. *Journal for Specialists in Pediatric Nursing, 13* (2008):74–90. When downloading or using these modules, the above citation must be included for this copyrighted paper.
>
> In addition, the CCHC training modules and toolkits developed by the National Training Institute (NTI) for Child Care Health Consultants served as inspiration for these interactive learning activities. NTI was funded from 1997–2013 by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau as a National Healthy Child Care America Cooperative Agreement Program. When downloading or using these modules, the above citation must be included.

Appendix VII:
Child Care Health Consultant Competencies

Source: National Center on Early Childhood Health and Wellness
URL: https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/child-care-health-consultants.pdf

The sections below are verbatim excerpts from the source:

> The competencies reflect best practices. They provide a detailed view of how CCHCs working in any ECE setting can apply their specialized knowledge and skills in the workplace to improve health, safety, and wellness outcomes.
>
> **General Areas of Expertise**
>
> 1. Consultation Skills
> 2. Quality Health, Safety, and Wellness Practices
> 3. Policy Development and Implementation
> 4. Health Education
> 5. Resource and Referral
>
> **Subject Matter Areas of Expertise**
>
> 6. Illness and Infectious Diseases
> 7. Children with Special Health Care Needs
> 8. Medication Administration
> 9. Safety and Injury Prevention
> 10. Emergency Preparedness, Response, and Recovery
> 11. Infant and Child Social and Emotional Wellbeing
> 12. Child Abuse and Neglect
> 13. Nutrition and Physical Activity
> 14. Oral Health
> 15. Environmental Health
> 16. Staff Health and Wellness

Appendix VIII:
Selected Studies on Child Care Health Consultant Effectiveness

The following outlines a literature review exploring the effectiveness of CCHCs for ECE programs.

Source	Date	Journal	Summary
Honigfeld L, Pascoe T, Macary S, Crowley A. *Promoting Children's Health in Early Care and Education Settings by Supporting Health Consultation.* Child Health and Development Institute of Connecticut, Inc. February 2017. Accessed November 18, 2020. https://www.chdi.org/index.php/publications/reports/impact-reports/promoting-childrens-health-early-care-and-education-settings-supporting-health-consultation	2017	Child Health and Development Institute	CCHCs can collaborate with primary medical care homes and families in order to connect resources and prevention services and support the health needs of children in ECE programs.
Crowley AA, Kulikowich JM. Impact of training on child care health consultant knowledge and practice. *Pediatr Nurs.* 2009;35(2):93-100.	2009	Pediatric Nursing	This pilot training of nurse health consultations, child care directors, and community team members surveyed participants to evaluate the impact of training. After completing training, participants demonstrated improved perspectives of the health consultant role, increased knowledge, and improved health and safety policy and practices after the training.
Alkon A, Bernzweig J, To K, Wolff M, Mackie JF. Child care health consultation improves health and safety policies and practices. *Acad Pediatr.* 2009;9(5):366-370. doi:10.1016/j.acap.2009.05.005	2009	Academic Pediatrics	As part of this study, ECE programs that had CCHC as the designated intervention experienced greater number and improved quality on 9 out of 10 health and safety policies than the comparison programs. Policies that were rated included exclusion of ill children, inclusion of children with special needs, and emergency preparedness.
Alkon A, Nouredini S, Swartz A, et al. Integrated Pest Management Intervention in Child Care Centers Improves Knowledge, Pest Control, and Practices. *J Pediatr Health Care.* 2016;30(6):e27-e41. doi:10.1016/j.pedhc.2016.07.004	2016	Pediatric Health Care	Nurse consultation was seen to improve integrated pest management (IPM) through increased number of IPM practices at the center, increased knowledge of IPM interventions among ECE staff, and decreased prevalence of pests at the centers. Centers with a greater number of consultation hours demonstrated a greater number of IPM practices. Through nurse-led interventions, centers can better provide healthier environments for children without exposure to pesticides or pests.

Alkon A, Ramler M, MacLennan K. Evaluation of Mental Health Consultation in Child Care Centers. *Early Childhood Education Journal*, 2003;31 91-99. doi:10.1023/B:ECEJ.0000005307.00142.3c	2003	Early Childhood Education Journal	Teacher competence, self-efficacy, and overall quality increased with ECE programs that had consultation for over a year. Satisfactory mental health consultation was also expressed by staff.
Alkon A, Sokal-Gutierrez K, Wolff M. Child care health consultation improves health knowledge and compliance. *Pediatr Nurs*. 2002;28(1):61-65.	2002	Pediatric Nursing	Child care health consultation provided to the intervention group in the study resulted in a greater understanding of child health issues among childcare providers. Results showed that childcare providers in the intervention group demonstrated improved compliance with health standards following 7-month intervention. Centers that had previously established relationships with public health nurses were more receptive to using health consultation services in the study, showing that relationship building may contribute to compliance and program success.
Hanna H, Mathews R, Southward LH, et al. Use of paid child care health care consultants in early care and education settings: results of a national study comparing provision of health screening services among Head Start and non-Head Start centers. *J Pediatr Health Care*. 2012;26(6):427-435. doi:10.1016/j.pedhc.2011.05.008	2012	Pediatric Health Care	Both Head Start and non-Head Start programs with employed CCHCs had higher reported rates of health-promotion screening and assessments for children enrolled in their ECE program.
Isbell P, Kotch J, Savage E, Gunn E, Lu L, Weber D. Improvement of child care programs' policies, practices, and children's access to health care linked to child care health consultation. *NHSA Dialog: A Research to Practice Journal*. 2013;16(2):34-52. Accessed November 18, 2020. https://journals.uncc.edu/dialog/article/view/93	2013	NHSA Dialog: A Research to Practice Journal	The impact of CCHCs was studied in North Carolina over a two-year period. After implementing CCHCs within ECE programs, improvement was found in center's practices and policies when compared to before the intervention. In addition, there were improvements found on the child level, including increased vaccination rates, and documented health screenings.

Appendix IX:
State Models for Child Care Health Consultant Programs

The following outline of CCHC programs are compiled from various state models. These tiers represent varying levels of support (i.e. Tier 1 Level of support – Basic, Tier 2 Level of support – Moderate, Tier 3 Level of support – Intensive).

Tier 1: Level of support - Basic

Indiana

Source:
https://www.in.gov/fssa/carefinder/provider-resources/child-care-health-consultant-program/

Program Structure

- "A free, voluntary child care health consultation program is available to all out-of-home child care providers in Indiana. Health professionals are available to providers as a support resource for multiple health and nutrition issues. Consultants are available by email or phone to provide educational information." [39]

Responsibilities

- Provide general health information and available to answer questions [39]
- List of policies, health fact sheets, and links to resources are provided online [39]
- AAP Training topics and links to policy are provided [39]

Regulation

- Voluntary participation, no charge [39]

Tier 2: Level of support - Moderate

Minnesota

Sources:
https://mncchc.com/
https://healthconsultantsforchildcare.com/aboutus.html
https://www.revisor.mn.gov/rules/9503.0140/.

Program Structure

- Private CCHC organizations help ECE centers meet licensing needs through health policy review and consultation services (e.g. Minnesota Health consultants, Health Consultants for Child Care, Inc.) [40,41]

Responsibilities

- Private CCHC groups (Minnesota Health consultants, Health Consultants for Child Care, Inc) utilize CCHCs with nursing backgrounds including registered nurses and public health nurses [40,41]
- Review of policies is required before initial licensure of program and again following changes to center policy and after outbreaks of contagious illness [42]

Regulation

- Regulation requires that a health consultant reviews each center's policies annually in the areas of first aid, safety, and sanitation for food preparation to ensure children's health is protected [42]

Colorado

Sources:
https://healthychildcareco.org/health/child-care-health-consultation/
https://healthychildcareco.org/programs/find-a-trainer/
https://coloradocprpros.com/nurse-consulting-2/

Program Structure

- "A CCHC must hold a Colorado license as a registered nurse, pediatric nurse practitioner, family nurse practitioner, or pediatrician with knowledge and experience in maternal and child health" [43]
- Healthy Child Care Colorado is a nonprofit 501(c)3 that trains CCHCs and provides mentorship and professional development opportunities, and creates competencies for CCHCs in Colorado [43]
- Healthy Child Care Colorado offers a search tool online for ECE providers to explore CCHCs by location and by specific state approved trainings [44]

Responsibilities

- CCHCs "help with creating program policies related to health and safety, illness and injury prevention and documentation, infectious disease management, health and safety trainings, consultation in the classroom, emergency preparedness, infant safe sleep, and sharing helpful community resources" [43]
- At minimum, CCHCs visit child care facilities once per month [43]
- Several individual nurses and private nurse consultant groups exist throughout Colorado (e.g. Colorado CPR Pros) [45]

Regulation

- "All licensed child care centers and preschools in Colorado are required to have a minimum of one monthly visit with a child care health consultant (CCHC). . . Healthy Child Care Colorado serves as the statewide hub for health consultation in Colorado" [43]
- "CCHCs are required to: Attend Child Care Health Consultation 101 training, Complete annual immunization training, Give the early childhood program documentation of their current medical or nursing license, biography, and training certificates" [43]

North Carolina

Sources:
https://healthychildcare.unc.edu/child-care-health-consultants/about-cchc/.
https://healthychildcare.unc.edu/files/2018/11/CCHC-info-1-pager-August-2020-2.pdf
https://healthychildcare.unc.edu/find-a-cchc/find-a-cchc/
https://healthychildcare.unc.edu/child-care-health-consultants/nccchc-course/

Program Structure

- "CCHCs work with programs to assess, plan, implement, and evaluate strategies to achieve high quality, safe and healthy child care environments. Qualified CCHCs in North Carolina have completed the NC Child Care Health Consultant Training Course" [46]
- 42 CCHCs provide coverage for 32 counties [47]
- North Carolina Child Care Health and Safety Resource Center offers a CCHC directory for ECE providers to connect with CCHCs including their county and contact information [48]

Responsibilities

- The following responsibilities are verbatim from the source: [46]
    - Assess health and safety environments in child care centers and homes
    - Develop strategies for inclusion of children with special health care needs
    - Support early educators with preventing and managing injuries and infectious disease
    - Connect early educators and families to community health resources

- Provide up-to-date information on regulations and best practices
- Provide health and safety technical assistance and training

Regulation

- NC Child Care Health Consultant Training Course [49]

Tier 3: Level of support – Intensive

Iowa

Sources:
https://idph.iowa.gov/Portals/1/userfiles/128/ITPCCNC%20Brochure%20FY20%20final.pdf
https://idph.iowa.gov/Portals/1/userfiles/128/SFY18%20CCNC%20role%20guidance%20final%2010 2017.pdf

Program Structure

- "Child Care Nurse Consultants (CCNCs) are RNs who provide on-site consultation, training, and technical assistance to early childhood care and education providers" [50]
- The following qualifications are verbatim from the source: [51]
  - Registered Nurse with current Iowa licensure
  - Bachelor of Science in Nursing or related degree, or Minimum of two-years experience as a Registered Nurse in community health or pediatric practice
  - Completion of the Iowa Training Project for Child Care Nurse Consultants (ITPCCNC)
  - Employed or contracted (MOU) by an Iowa Maternal Health and Child & Adolescent Health (MCAH) agency
  - Able to work at minimum .5 FTE as a CCNC
- Required to complete the Iowa Training Project for Child Care Nurse Consultants (ITPCCNC) training [51]

Responsibilities

- "The CCNC maintains communication capability for receiving and disseminating child care health and safety information" [51]
- "Promote and refer families to the resources hawk-i, Medicaid, WIC, and the Title V MCAH program" [51]
- "Refer children and families to needed primary health care or specialty health care services. (medical, dental home)" [51]
- "The CCNC develops and maintains a linkage with child care regulatory personnel and child care partners" [51]
- Child Record Reviews: "identify if children are receiving preventive health services and screenings; to identify special health or development needs; and to assist families in securing needed health care services through referral and care coordination" [51]
- "Conduct health and safety assessments and support the development of health/safety plans with child care businesses" [51]
- Iowa Quality Rating: ECE centers may use assessment documents from CCNC for QRS

Connecticut

Source:
https://www.chdi.org/index.php/publications/reports/impact-reports/promoting-childrens-health-early-care-and-education-settings-supporting-health-consultation

Program Structure

- Health consultant can be a physician, physician assistant, advanced practice registered nurse or registered nurse [9]
- "ECE centers other than Head Start in Connecticut pay for health consultation through tuition payments and their general operating budgets" [9]

Responsibilities

- "Weekly, monthly, or quarterly health and safety rounds" [9]

Regulation

- "Annual review of written policies, plans, and procedures" [9]
- "Reviewing the policies, procedures, and required documentation for the administration of medications" [9]
- "Availability by telecommunication for advice regarding problems" [9]

Washington

Source:
https://www.dcyf.wa.gov/services/early-learning-providers/cchc
https://www.dcyf.wa.gov/sites/default/files/pdf/reports/ChildCareHealthConsultantReport.pdf

Program Structure

- "Child care health consultants currently provide services to centers in Washington State through monthly onsite nurse visits in infant rooms, as well as by phone or email consultation" [52]
- "Conducts assessments of child, staff and family health needs; and makes referrals to community resources as necessary or requested by the staff and families" [52]
- CCHCs are employed by local jurisdictions [53]
- As of 2019: "each child care provider contracts with and pays for their own child care health consultant. There is consequently a large amount of variety and inconsistency for consultants, child care providers and child care licensing staff. The price of a monthly contract varies by the consultant, depending on the area and need for travel, among other considerations. The average cost is $100 per month." [53]

Responsibilities

- "Provide services to centers in Washington State through monthly onsite nurse visits in infant rooms, as well as by phone or email consultation, as needed" [52]
- "Shares health and developmental expertise; conducts assessments of child, staff and family health needs; and makes referrals to community resources as necessary or requested by the staff and families" [52]
- "Assist families in care coordination with their medical home and other health and developmental specialists or assist the child care provider in addressing developmental concerns with families" [52]
- "Collaborate with an interdisciplinary team of early childhood consultants, such as early childhood education, mental health, nutrition consultants and Early Achievers coaches" [52]

Regulation

- Centers that care for infants are required to have a nurse consultant [52]
- CCHCs must report monthly reports to the Department of Children, Youth, and Families [52]

Appendix X:
Health Consultation Priority Areas
(Q: Which of the following topics would you likely consult with a CCHC about?)

	%	Count
Mental health and behavioral issues	72.73%	24
Children with special health needs	57.58%	19
Cultural diversity and inclusion	51.52%	17
Managing and preventing infectious diseases	51.52%	17
Referrals to other community resources (nutrition assistance, housing assistance, Birth to 3, School for 3+, Medicaid)	45.45%	15
Child growth and development	42.42%	14
Writing health policies	39.39%	13
Communicating confidently about health-related topics with families	36.36%	12
Child abuse and neglect	33.33%	11
Toileting	24.24%	8
Digital media/ screen use	24.24%	8
Nutrition and feeding	21.21%	7
Sleep	21.21%	7
Medication administration	15.15%	5
Injury prevention	15.15%	5
Playground safety	12.12%	4
Physical activity	12.12%	4
Oral health	9.09%	3
Help effectively connecting with a child's primary care medical clinic	9.09%	3
Other	3.03%	1
		33

Appendix XI:
Caring for Our Children: Inclusion/Exclusion due to Illness

Source: National Resource Center for the Health and Safety in Child Care and Early Education (NRC)
URL: https://nrckids.org/CFOC/Database/3.6.1.1

The following table highlights the key definition for each health topic related to the inclusion/exclusion due to illness CFOC standards. The policy scan rating criteria definitions were established based on the *CFOC* standards noted in the table below.

CFOC Standard 3.6.1.1 Source Link: https://nrckids.org/CFOC/Database/3.6.1.1		**Health Topic**
3.6.1.1 Conditions/Symptoms That Do Not Require Exclusion, c)	"Pinkeye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep…Exclusion is no longer required for this condition."	pink eye
3.6.1.1 Key Criteria for Exclusion of Children Who Are Ill Part 2, d)	"Fever (temperature >101°F [38.3°C] by any method) with a behavior change in infants older than 2 months. For infants younger than 2 months, a fever (temperature >100.4°F [38°C] by any method) with or without a behavior change or other signs and symptoms (eg, sore throat, rash, vomiting, diarrhea) requires exclusion and immediate medical attention."	fever
3.6.1.1 Conditions/Symptoms That Do Not Require Exclusion Part 2, c)	"Lice or nits treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed."	lice
3.6.1.1 Conditions/Symptoms That Do Not Require Exclusion Part 2, d)	"Ringworm treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed."	ringworm
3.6.1.1 Special Circumstance that require specific exclusion criteria, b)	"Vomiting more than 2 times in the previous 24 hours, unless the vomiting is determined to be caused by a noninfectious condition and the child remains adequately hydrated."	vomiting

3.6.1.1: Inclusion/Exclusion/Dismissal of Children

The section below is a verbatim excerpt from the source:

Conditions/Symptoms That Do Not Require Exclusion

a. Common colds, runny noses (regardless of color or consistency of nasal discharge).
b. A cough not associated with fever, rapid or difficult breathing, wheezing, or cyanosis (blueness of skin or mucous membranes).
c. Pinkeye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. This may be thought of as a cold in the eye. Exclusion is no longer required for this condition. Health care professionals may vary on whether or not to treat pinkeye with antibiotic drops. The role of antibiotics in treatment and preventing spread of conjunctivitis is unclear. Most children with pinkeye get better after

5 or 6 days without antibiotics. Parents/guardians should discuss care of this condition with their child's primary health care provider and follow the primary health care provider's advice. Some primary health care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If no treatment is provided, the child should be allowed to remain in care. If the child's eye is painful, a health care professional should examine the child. If 2 or more children in a group develop pinkeye in the same period, the program should seek advice from the program's health consultant or a public health agency.

d. Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness.
e. Yellow or white eye drainage that is not associated with pink or red conjunctiva (ie, the whites of the eyes).
f. Fever without any signs or symptoms of illness in infants and children who are older than 4 months regardless of whether acetaminophen or ibuprofen was given. For this purpose, *fever* is defined as temperature above 101°F (38.3°C) by any method. These temperature readings do not require adjustment for the location where they are made. They are simply reported with the temperature and the location, as in "101°F in the armpit/axilla."

Fever is an indication of the body's response to something but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever, the child should be monitored but does not need to be excluded for fever alone. For example, an infant with a fever after an immunization who is behaving normally does not require exclusion.

a. Rash without fever and behavioral changes. **Exception:** Call EMS (911) for rapidly spreading bruising or small blood spots under the skin.
b. Impetigo lesions should be covered, but treatment may be delayed until the end of the day. As long as treatment is started before return the next day, no exclusion is needed.
c. Lice or nits treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed.
d. Ringworm treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed.
e. Scabies treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed.
f. Molluscum contagiosum (does not require covering of lesions).
g. Thrush (ie, white spots or patches in the mouth or on the cheeks or gums).
h. Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared.
i. Methicillin-resistant *Staphylococcus aureus* (MRSA) without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded.
j. Cytomegalovirus infection.
k. Chronic hepatitis B infection.
l. HIV infection.
m. Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. **Note:** These agents are not common, and caregivers/teachers will usually not know the cause of most cases of diarrhea.
n. Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans With Disabilities Act. The

act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

Written notes should not be required for return to ECE for common respiratory illnesses that are not specifically listed in the excludable condition list.

Key Criteria for Exclusion of Children Who Are Ill

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home (ie, should be temporarily excluded from child care). Most illnesses do not require exclusion. The caregiver/teacher should determine if the illness

a. Prevents the child from participating comfortably in activities
b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children
c. Poses a risk of spread of harmful diseases to others

If any of these criteria are met, the child should be excluded, regardless of the type of illness. Decisions about providing care that is comfortable for the child while awaiting parent/guardian pickup should be made on a case-by-case basis, considering factors such as the child's age, surroundings, potential risk to others, and type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in his or her usual care setting while awaiting pickup, the child should be separated from other children by at least 3 feet until the child leaves to help minimize exposure of staff and children who were not previously in close contact with the child. All who have been in contact with the ill child should wash their hands. Toys, equipment, and surfaces used by the ill child should be cleaned and disinfected after the child leaves.

Temporary exclusion is recommended when the child has any of the following conditions:

a. The illness prevents the child from participating comfortably in activities.
b. The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children.
c. A severely ill appearance—this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash.
d. Fever (temperature >101°F [38.3°C] by any method) with a behavior change in infants older than 2 months. For infants younger than 2 months, a fever (temperature >100.4°F [38°C] by any method) with or without a behavior change or other signs and symptoms (eg, sore throat, rash, vomiting, diarrhea) requires exclusion and immediate medical attention. When taking temperatures remember that:
    - The amount of temperature elevation varies at different body sites.
    - The height of the temperature does not indicate a more- or less-severe illness. The child's activity level and sense of well-being are far more important that the temperature reading.
    - If a child has been in a very hot environment and heatstroke is suspected, a higher temperature is more serious.
    - The method chosen to take a child's temperature depends on the need for accuracy, available equipment, the skill of the person taking the temperature, and the ability of the child to assist in the procedure.
    - Oral temperatures are difficult to take for children younger than 4 years.

e. Diarrhea is defined by stools that are more frequent or less formed than usual for that child and not associated with changes in diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing "accidents." In addition, diapered children with diarrhea should be excluded if stool frequency exceeds 2 stools more than typical for that child during the time in the program day, because this may cause too much work for the caregivers/teachers, or if stools contain blood or mucus. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are not having "accidents," and when stool frequency is no more than 2 stools more than typical for that child during the time in the program day.

Special circumstances that require specific exclusion criteria include the following[1]:

a. A health care professional should clear the child or staff member for readmission for all cases of diarrhea with blood or mucus. Readmission can occur following the requirements of the local health department authorities, which may include testing for a diarrhea outbreak in which the stool culture result is positive for *Shigella, Salmonella* serotype Typhi and Paratyphi, or Shiga toxin–producing *Escherichia coli* (STEC). Children and staff members with *Shigella* should be excluded until diarrhea resolves and test results from at least 1 stool culture are negative (rules vary by state). Children and staff members with STEC should be excluded until test results from 2 stool cultures are negative at least 48 hours after antibiotic treatment is complete (if prescribed). Children and staff members with *Salmonella* serotype Typhi and Paratyphi are excluded until test results from 3 stool cultures are negative. Stool should be collected at least 48 hours after antibiotics have stopped. State laws may govern exclusion for these conditions and should be followed by the health care professional who is clearing the child or staff member for readmission.
b. Vomiting more than 2 times in the previous 24 hours, unless the vomiting is determined to be caused by a noninfectious condition and the child remains adequately hydrated.
c. Abdominal pain that continues for longer than 2 hours or intermittent pain associated with fever or other signs or symptoms of illness.
d. Mouth sores with drooling that the child cannot control unless the child's primary health care provider or local health department authority states that the child is noninfectious.
e. Rash with fever or behavioral changes, until the primary health care provider has determined that the illness is not an infectious disease.
f. Active tuberculosis, until the child's primary health care provider or local health department states child is on appropriate treatment and can return.
g. Impetigo, only if the child has not been treated after notifying family at the end of the prior program day. Exclusion is not necessary before the end of the day as long as the lesions can be covered.
h. Streptococcal pharyngitis (ie, strep throat) until at least 12 hours after treatment has been started.[1,2]
i. Head lice, only if the child has not been treated after notifying the family at the end of the prior program day. **Note:** Exclusion is not necessary before the end of the program day.
j. Scabies, only if the child has not been treated after notifying the family at the end of the prior program day. **Note:** Exclusion is not necessary before the end of the program day.
k. Chickenpox (varicella), until all lesions have dried or crusted (usually 6 days after onset of rash and no new lesions have appeared for at least 24 hours).
l. Rubella, until 7 days after the rash appears.
m. Pertussis, until 5 days of appropriate antibiotic treatment.
n. Mumps, until 5 days after onset of parotid gland swelling.
o. Measles, until 4 days after onset of rash.

p. Hepatitis A virus infection, until 1 week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. **Note:** Protection of the others in the group should be checked to be sure everyone who was exposed has received the vaccine or receives the vaccine immediately.
q. Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

Appendix XII:
Policy Scan Findings Summary Tables

The tables below outline the summary findings from the policy scan conducted from 9/14/20-10/21/20. The first table reviews data of online health policies for ECE providers by their category type. The second table reviews data of online health policies for ECE providers by their YoungStar rating.

Category Type Review	**Providers by Category Type**							
	in home provision certified	in home regular certified	licensed family	licensed group	provisional certified	regular certified	public school program	Total
Total population (all providers listed on the Active Provider list provided from DCF on 9/17/20)								
Total number of providers in total population	1	5	1,539	2,327	10	468	187	4,537
Percentage of category type in total population	0.02%	0.11%	33.92%	51.29%	0.22%	10.32%	4.12%	
Sample (all providers with located online health policies during research period of 9/14/20-10/21/20)								
Total number of providers in sample	0	0	24	497	0	2	27	550
Percentage of category type in sample	0.00%	0.00%	4.36%	90.36%	0.00%	0.36%	4.91%	
Average rating score in sample	-	-	3.67	3.51	-	3	3.3	3.5
Percentage of providers with located online health policies by category type in total population								
	0.00%	0.00%	1.56%	21.36%	0.00%	0.43%	14.44%	

YoungStar Review	Providers by YoungStar Rating						
	5 Star	4 Star	3 Star	2 Star	1 Star	Participating, not yet rated	Not participating
Total population (all providers listed on the Active Provider list provided from the DCF on 9/17/20)							
Total number of providers in total population	503	214	1099	1559	22	320	820
Percentage of category type in total population	11.09%	4.72%	24.22%	34.36%	0.48%	7.05%	18.07%
Sample (all providers with located online health policies during research period of 9/14/20-10/21/20)							
Total number of providers in sample	125	40	133	165	1	13	73
Percentage of category type in sample	22.73%	7.27%	24.18%	30.00%	0.18%	2.36%	13.27%
Average rating score in sample	3.87	3.75	3.4	3.24	4	3.54	3.48
Percentage of providers with located online health policies by YoungStar Rating in total population							
	24.85%	18.69%	12.10%	10.58%	4.55%	4.06%	8.90%

Appendix XIII:
Wisconsin Department of Children and Families Policy Sample the Comparison with the Caring for Our Children Standards

The following table compares health topics related to inclusion/exclusion due to illness from the Wisconsin DCF Family Child Care Policy Sample with the *CFOC* standards. The comparison reviews seven health topics in sequence of occurrence on the policy sample. Key noted differences were bolded in the text to clearly indicate comparisons on each health topic.

Health Topic	**Family Child Care Policy Sample Section V. Health**	**CFOC Standards 3.6.1.1: Inclusion/Exclusion/Dismissal of Children**
	Source Link: https://dcf.wisconsin.gov/files/ccic/pdf/policy-sample-fcc.pdf	Source Link: https://nrckids.org/CFOC/Database/3.6.1.1
Pink eye	Section V. Health, A. Child Illness/Injury "Children who are ill are not to be brought to the center. The following are examples of children who are ill: • A contagious disease, such as chicken pox, strep throat, or **pink eye**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion c)** **"Pinkeye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. This may be thought of as a cold in the eye. Exclusion is no longer required for this condition.** Health care professionals may vary on whether or not to treat pinkeye with antibiotic drops. The role of antibiotics in treatment and preventing spread of conjunctivitis is unclear. Most children with pinkeye get better after 5 or 6 days without antibiotics. Parents/guardians should discuss care of this condition with their child's primary health care provider and follow the primary health care provider's advice. Some primary health care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If no treatment is provided, the child should be allowed to remain in care. If the child's eye is painful, a health care professional should examine the child. If 2 or more children in a group develop pinkeye in the same period, the program should seek advice from the program's health consultant or a public health agency."
Fever	Section V. Health, A. Child Illness/Injury "Children who are ill are not to be brought to the center. The following are examples of children who are ill: **• A temperature of ___degrees F. or higher**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Key Criteria for Exclusion of Children Who Are Ill d)** **"Fever (temperature >101°F [38.3°C] by any method) with a behavior change in infants older than 2 months. For infants younger than 2**

		months, a fever (temperature >100.4°F [38°C] by any method) with or without a behavior change or other signs and symptoms (eg, sore throat, rash, vomiting, diarrhea) requires exclusion and immediate medical attention." 3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion f)** "Fever without any signs or symptoms of illness in infants and children who are older than 4 months regardless of whether acetaminophen or ibuprofen was given. For this purpose, ***fever*** **is defined as temperature above 101°F (38.3°C)** by any method. These temperature readings do not require adjustment for the location where they are made. They are simply reported with the temperature and the location, as in "101°F in the armpit/axilla." *Fever is an indication of the body's response to something but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever, the child should be monitored but does not need to be excluded for fever alone. For example, an infant with a fever after an immunization who is behaving normally does not require exclusion."*
Diarrhea	Section V. Health, A. Child Illness/Injury "Children who are ill are not to be brought to the center. The following are examples of children who are ill: • Vomiting or **diarrhea has occurred more than once in the past 24 hours**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Key Criteria for Exclusion of Children Who Are Ill e)** "Diarrhea is defined by stools that are more frequent or less formed than usual for that child and not associated with changes in diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing "accidents." In addition, diapered children with diarrhea should be excluded if **stool frequency exceeds 2 stools more than typical for that child during the time in the program day,** because this may cause too much work for the caregivers/teachers, or if stools contain blood or mucus. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are not having "accidents," and when stool frequency is no more than 2 stools more than typical for that child during the time in the program day."

Vomiting	Section V. Health, A. Child Illness/Injury "Children who are ill are not to be brought to the center. The following are examples of children who are ill: • **Vomiting** or diarrhea **has occurred more than once in the past 24 hours**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Special circumstances that require specific exclusion criteria include the following[1]: b)** "**Vomiting more than 2 times in the previous 24 hours**, unless the vomiting is determined to be caused by a noninfectious condition and the child remains adequately hydrated."
Strep throat	Section V. Health, A. Child Illness/Injury "Children who are ill are not to be brought to the center. The following are examples of children who are ill: • A contagious disease, such as chicken pox, **strep throat**, or pink eye"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Special circumstances that require specific exclusion criteria include the following[1]: h)** "Streptococcal pharyngitis (ie, strep throat) until **at least 12 hours** after treatment has been started.[1,2]"
Nasal discharge	Section V. Health, A. Child Illness/Injury "Children who are ill are not to be brought to the center. The following are examples of children who are ill: • Has a constant, **thick, colored nasal discharge**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion a)** "Common colds, runny noses (**regardless of color or consistency of nasal discharge**)."
Pick-up Timeframe	Section V. Health, A. Child Illness/Injury "**Children should be picked up within ___(timeframe)**."	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Preparing for Managing Illness, "Staff should notify parents/guardians of children who have symptoms that require exclusion, and **parents/guardians should remove the child from the child care setting as soon as possible.** For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable." 3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion c)** **"Lice or nits treatment may be delayed until the end of the day.** As long as treatment is started before returning the next day, no exclusion is needed." 3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion d)** **"Ringworm treatment may be delayed until the end of the day.** As long as treatment is started before returning the next day, no exclusion is needed."

		3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion f)** "**Scabies treatment may be delayed until the end of the day**. As long as treatment is started before returning the next day, no exclusion is needed."

Appendix XIV:
Wisconsin Childhood Communicable Diseases Comparison with the Caring for Our Children Standards

The following table compares health topics related to inclusion/exclusion due to illness from the Wisconsin Childhood Communicable Diseases with the *CFOC* standards. The Wisconsin Childhood Communicable Diseases chart was created by the Bureau of Communicable Disease and Emergency Response within the Wisconsin Department of Health Services. The comparison reviews fifteen health topics in sequence of occurrence on the Communicable Diseases chart. The bolded feature on the text was updated to indicate the key differences noted in the comparison.

Health Topic	**Wisconsin Childhood Communicable Diseases**	**CFOC Standards 3.6.1.1: Inclusion/Exclusion/Dismissal of Children**
	Source Link: https://www.dhs.wisconsin.gov/publications/p4/p44397.pdf	Source Link: https://nrckids.org/CFOC/Database/3.6.1.1
Mumps	Criteria for Exclusion from School or Group: "Exclude for 5 days after swelling onset (day of swelling onset is day zero); exclude susceptible contacts from day 12 through day 25 after exposure"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Special circumstances that require specific exclusion criteria include the following[1]: n) "Mumps, until 5 days after onset of parotid gland swelling."
Pink eye	Criteria for Exclusion from School or Group: "None, unless fever, behavior change or unable to avoid touching eyes; antibiotics not required for return"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Conditions/Symptoms That Do Not Require Exclusion c) "Pinkeye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. This may be thought of as a cold in the eye. Exclusion is no longer required for this condition. Health care professionals may vary on whether or not to treat pinkeye with antibiotic drops. The role of antibiotics in treatment and preventing spread of conjunctivitis is unclear. Most children with pinkeye get better after 5 or 6 days without antibiotics. Parents/guardians should discuss care of this condition with their child's primary health care provider and follow the primary health care provider's advice. Some primary health care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the

		condition is likely to be self-limited. If no treatment is provided, the child should be allowed to remain in care. If the child's eye is painful, a health care professional should examine the child. If 2 or more children in a group develop pinkeye in the same period, the program should seek advice from the program's health consultant or a public health agency."
Strep Throat	Criteria for Exclusion from School or Group: "**Exclude for 24 hours after initiation of appropriate antibiotic and fever resolved**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Special circumstances that require specific exclusion criteria include the following[1]: h)** "Streptococcal pharyngitis (ie, strep throat) until **at least 12 hours after treatment has been started.**[1,2]"
Pertussis	Criteria for Exclusion from School or Group: "Exclude until after 5 days of appropriate antibiotic treatment; if no antibiotic treatment, exclude 21 days after cough onset"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Special circumstances that require specific exclusion criteria include the following[1]: m) "Pertussis, until 5 days of appropriate antibiotic treatment."
Diarrhea	Signs and Symptoms: "3 or more loose stools in 24 hour period" Criteria for Exclusion from School or Group: "**Exclude until asymptomatic for 24 hours**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Key Criteria for Exclusion of Children Who Are Ill e)** "Diarrhea is defined by stools that are more frequent or less formed than usual for that child and not associated with changes in diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing "accidents." In addition, diapered children with diarrhea should be excluded if stool frequency exceeds 2 stools more than typical for that child during the time in the program day, because this may cause too much work for the caregivers/teachers, or if stools contain blood or mucus. **Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are not having "accidents," and when stool frequency is no more than 2 stools more than**

		typical for that child during the time in the program day."
Hepatitis A	Criteria for Exclusion from School or Group: "**Exclude for 14 days after onset of symptoms or 10 days after onset of jaundice**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Special circumstances that require specific exclusion criteria include the following[1]: p)** "Hepatitis A virus infection, **until 1 week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. Note:** Protection of the others in the group should be checked to be sure everyone who was exposed has received the vaccine or receives the vaccine immediately."
Fifth disease	Time Period When Person is Contagious: "Onset of symptoms until rash appears" Criteria for Exclusion from School or Group: "None"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Conditions/Symptoms That Do Not Require Exclusion h) "Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared."
Impetigo	Criteria for Exclusion from School or Group: "**Exclude until after initiation of appropriate antibiotic treatment and lesions are covered or crusted**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion b)** "Impetigo lesions should be covered, but treatment may be delayed until the end of the day. **As long as treatment is started before return the next day, no exclusion is needed**."
Lice	Criteria for Exclusion from School or Group: "Exclude at end of program or school day until after treatment or removal of live lice; "no-nit" policies are discouraged"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Conditions/Symptoms That Do Not Require Exclusion c) "Lice or nits treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed."
Measles	Criteria for Exclusion from School or Group: "Exclude for 4 days after rash onset; exposed susceptible individual from day 7 through day 21 following their earliest exposure"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Special circumstances that require specific exclusion criteria include the following[1]: o) "Measles, until 4 days after onset of rash."
MRSA	Criteria for Exclusion from School or Group: "**Exclude if drainage from lesions cannot be contained, until lesions resolve**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion i)**

		"Methicillin-resistant *Staphylococcus aureus* (MRSA) **without an infection or illness that would otherwise require exclusion.** Known MRSA carriers or colonized individuals should not be excluded."
Ringworm	Criteria for Exclusion from School or Group: "**Exclude until treatment is initiated or lesions are covered**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion d)** "**Ringworm treatment may be delayed until the end of the day.** As long as treatment is started before returning the next day, no exclusion is needed."
Rubella	Criteria for Exclusion from School or Group: "Exclude until 7 days after rash onset; exposed susceptible individual from day 7 through day 21 following earliest exposure"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Special circumstances that require specific exclusion criteria include the following[1]: l) "Rubella, until 7 days after the rash appears."
Scabies	Criteria for Exclusion from School or Group: "**Exclude until treatment is complete**"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, **Conditions/Symptoms That Do Not Require Exclusion f)** "**Scabies treatment may be delayed until the end of the day.** As long as treatment is started before returning the next day, no exclusion is needed."
Varicella	Criteria for Exclusion from School or Group: "Exclude until lesions have dried and crusted; exclusion of exposed susceptible usually not mandated, families should be notified of risk"	3.6.1.1: Inclusion/Exclusion/Dismissal of Children, Special circumstances that require specific exclusion criteria include the following[1]: k) "Chickenpox (varicella), until all lesions have dried or crusted (usually 6 days after onset of rash and no new lesions have appeared for at least 24 hours)."