

RESEARCH-TO-PRACTICE SUMMARY

Child Care Health Consultation: Improving the Health and Safety of Children in Child Care

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This research study addressed the effect of the activities of Child Care Health Consultants (CCHCs) in North Carolina over two years of intervention. The hypothesis was that child care health consultation is associated with changes in child care program policies and caregiver practices and that these changes would result in an improvement in children's health by increasing the children's access to preventive health care.

The US experienced a dramatic and steady increase in the number of young children participating in out-of-home child care beginning in the 1970s (Federal Interagency Forum on Child and Family Statistics, 2010). This expanded use of child care increased young children's risk of illness due to the fact that children in group care are exposed to more pathogens than if they were cared for at home by their families (Churchill & Pickering, 1997; Hurwitz, Gunn, Pinsky & Schonberger, 1991; Aronson & Shope, 2009). Early childhood professionals across the nation, dissatisfied with this increased risk of illness, called for improvements in the quality of child care particularly in the area of health and safety. In response to this national call to action, the American Public Health Association (APHA) and the American Academy of Pediatrics (AAP), published *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Out-Of-Home Child Care Programs (CFOC)* (AAP, APHA, 1992). Among the CFOC standards is the recommendation that every out-of-home child care program identify, engage and partner with a CCHC (Standard 1.6.0.1). A 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" (AAP, APHA, NRC, 2011).

Pediatric health and early childhood professionals supported the concept of child care health consultation, but an existing work force of trained professionals did not exist. Initial efforts designed to convince state/territory administrators of the importance of this service were mainly

based on professional judgment (Dooling & Ulione, 2000; Dunderstadt & Cohen 2004; Evers, 2002; Ulione, 1997) and advocacy (Lucarelli, 2002). Many states were successful in establishing a CCHC role at the state level (mainly utilizing funds from the US Maternal and Child Health Bureau's "Healthy Child Care America Initiative"). However, attempts to establish child care health consultation at the local level were less successful. This lack of success may be attributed to financial constraints, but it could also have been due to the lack of scientific evidence about the impact of a CCHC on child health and safety.

In an attempt to explain the process of achieving positive child health and safety outcomes, Alkon, To, Wolff, Mackie, & Bernzweig (2006) developed a stepwise model (see Figure 1) based on a formative evaluation of the CCHC network in California. This model suggested that research must first reveal the impact of CCHC activities on the precursors of child health and safety before a link could be established to child health and safety outcomes. The precursors in the model, education of the child care staff and CCHCs, consultation between the CCHC and child care staff, development of health and safety policies that are in compliance with national standards, and improvement in child care staff practice, have since been examined (Alkon, To, Mackie, Wolff, & Bernzweig, 2010; Alkon, Fernzweig, To, Wolff, & Mackie, 2009; Alkon et al., 2008; Farrer, Alkon, & To, 2007; Crowley & Kulikowich, 2009). However, a void continued to exist concerning evidence that child care health consultation improved child health and safety.

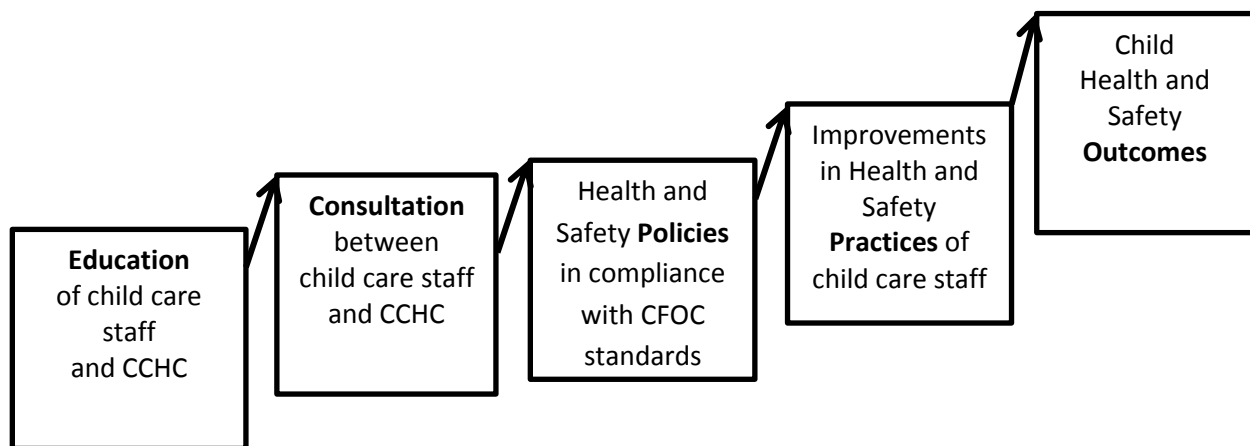


Figure 1. California Child Care Health Program's Stepwise Model of How Health Consultation Improves Children's Health (Alkon, 2006 Personal communication)

CCHC=Child Care Health Consultation

CFOC= *Caring for Our Children. National Health and Safety Performance Standards. Guidelines for Early Care and Education Programs.* (1992, 2002, 2011)

An understanding of child health and safety in child care involves an evaluation of both formative (e.g., prevention activities that a CCHC delivers to the child care program such as health and safety trainings and provision of written or electronic resources) and summative (e.g., access to health care, immunization status, absences due to illness, and medically-attended injury) data. Yet, it is difficult to document that a specific preventive health measure taken with respect to a specific health risk actually prevented a specific individual from getting ill or injured. Thus, to determine the impact of child care health consultation prevention activities, the data collected

over time must be aggregated at the child care program level (Hegland et al., 2011).

HOW WAS THE STUDY CONDUCTED?

This study aggregated and analyzed data at the child care program level for two years. Individual children were not followed. To do this, 15 Child Care Health Consultants (CCHC) recruited 264 child care programs from across the state of NC. Every six months, the CCHCs collected data using two instruments that were developed specifically for the study. These two instruments allowed the CCHC to collect information on program policies, staff practices, and child medical information that was recorded in the child care program's records. A third form documenting the CCHC's activity was completed each time the CCHC provided consultation/service to the program. This information was important to the study as a way of insuring that any demonstrated change in policies, practices or children's access to health care was due to the same amount of involvement (consultation) with the CCHC. At the end of the two years, 77 child care programs had complete data from the five data collection periods (baseline and 4 follow-ups).

Impact at the child care program level

- The CCHCs had a statistically significant, positive impact on nine written health and safety policies. In most cases, the child care programs developed policies that exceeded the state's licensing requirements and achieved policies that met or exceeded the national standards that are outlined in CFOC.
- Changes in children's access to health care were linked to the CCHC through written health and safety policies that required families interested in child care services to conform to the program's established policies. For example, policies guide admission criteria (e.g., immunizations must be up-to-date) as well as requirements for current emergency medical information on all children.

Impact at the child level

The most important result of this study was the impact of the CCHCs at the child level.

- An increase of 6% in up-to-date immunizations was documented. If this percentage were applied to the total number of children in child care in NC an additional 15,629 would have been protected from common childhood illnesses.
- Statistically significant increases in four specific screening tests: 1) developmental, 2) hearing, 3) oral, and 4) vision, were also documented. The results from screenings guide interventions that may have a profound effect on a child's readiness for and success in school and in life.
- A statistically significant improvement in the percentage of children with a medical home on record was documented. An "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, culturally effective" (Hagan, Shaw, & Duncan, 2008) primary care provider is an indicator of accessible, preventive health

care for children.

- A statistically significant improvement in the percentage of children with health insurance was also documented. Children with health insurance are more likely to receive the preventive, acute and chronic care that promotes their overall well-being.

Impact on the Staff

- Statistically significant improvement in staff practice in the areas of sanitation (e.g., hand washing, diaper-changing), playground safety (e.g., observation of all areas, developmentally appropriate equipment), emergency preparedness (e.g., evacuation plans, drills) and nutrition (e.g., nutrition standards) was documented. Such improvements can have a direct impact on the health and safety of the children as well as on the staff.

CONCLUSION

When early care and education providers are supported by a CCHC, improvements in policies, staff practices and children's access to health care are statistically and practically significant for the children, the staff and the program.

Tips/Suggestions for Head Start and other child care practitioners

1. CCHCs often work for publically funded agencies. Therefore, their consultation services may be available free of charge or for a small fee.
2. CCHCs can provide health and safety training and resources for program staff and families.
3. CCHCs can help child care programs write policies that are specific to their local need.
4. CCHCs can link the child care program to health care providers in their area.
5. CCHCs can serve on local interagency coordinating and/or Head Start Health Services Advisory Committees.
6. To find a CCHC in a specific area, the program can contact the state licensing agency, Child Care Resource & Referral agency, and/or the state public health department.
7. Resources and materials on CCHCs can be found at: <http://nrckids.org/>

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