Child Care Health Consultation Skills

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California Childcare Health Program
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FIRST 5 CALIFORNIA

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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To identify the partners and resources needed to promote healthy and safe early care and education (ECE) programs.

To describe the skills a Child Care Health Consultant (CCHC) needs to be an effective consultant, communicator and problem-solver.

To describe the roles of individuals involved in the consultation process.

To describe why ECE programs need to have clearly defined health and safety policies.

To identify the reasons why consultation plans and documentation are required in child care health consulting.

To identify community and family resources to assist and support ECE providers and families.

Building An Infrastructure: Advocacy and Professional Development

WHY IS BUILDING AN INFRASTRUCTURE IMPORTANT?

An integral part of child care health consulting is linking with other key agencies and players in the local community, state and country. Health professionals working in geriatrics naturally strive to improve the lives of seniors in all aspects of their lives. Oncology clinicians and educators frequently broaden their interests beyond immediate patient care to policy and legislation in the areas of tobacco and environmental health. This is how CCHCs will build successful CCHC practices as well—by educating themselves about wider early childhood initiatives and joining forces with agencies and organizations to improve the lives of children.

Through their experiences as nurses and other health professionals, CCHCs are used to advocating for patient safety, access to care, and other health care issues. They join coalitions to increase their strength and voices, and continually strive to stay at the forefront of their field and improve their clinical skills and knowledge. The same advocacy, coalition building and professional development strategies used by CCHCs in their previous work will apply to child care health consulting.

WHAT THE CCHC NEEDS TO KNOW

Advocacy

CCHCs can learn about national, statewide and local efforts to improve the quality and availability of ECE programs. Key areas of advocacy to study include:

- compensation and training for ECE providers
- health care reform and insurance coverage for children and families
- inclusion of children with disabilities and other special needs
- cultural diversity and competence in early childhood and health programs
- parent involvement in ECE policies and services
- federal and state budgets as they affect families and ECE programs
- environmental legislation and safeguards
- mental health services for children and families
- welfare reform and child care impact
- child abuse prevention

Coalition-Building

While there are likely to be existing coalitions working on the advocacy areas listed above, CCHCs may also find they can spearhead or facilitate the creation of new coalitions that focus on health and safety for ECE programs in areas such as:

- perinatal services
- nutrition issues, including anemia, food security, WIC and Child Care Food Program
- oral health
- car seat safety and other injury prevention efforts
- immunizations and other preventive health care services
- parental stress, domestic violence and other child abuse prevention services
- seamless access to services for children and families and other interagency efforts to streamline services

Professional Development

CCHCs are already familiar with the resources available in their communities for continuing education for nurses and other health professionals, but there are additional opportunities for professional development specific to child care health consulting. In addition to attending conferences and meetings on health issues such as asthma and other chronic health concerns, community violence prevention and indoor air quality, CCHCs can attend professional meetings of the following organizations:

Early Childhood Education Conferences and Meetings

- National Association for the Education of Young Children (NAEYC) conferences
- California Association for the Education of Young Children (CAEYC) conferences and those of their local chapters
- Program for Infant/Toddler Caregivers - West Ed
- Resource and Referral Network conferences and events—National and California Child Care Resource and Referral Network
- Local Child Care Planning Councils' meetings, conferences and workshops
- Head Start and Early Head Start
- Zero to Three

Conferences and Meetings of Health Professional Groups and Organizations

- National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)
- American Academy of Pediatrics (AAP)

- California School Nurses Organization (CSNO)
- American Dietetics Association (ADA)
- Physicians for Social Responsibility
- American Public Health Association and local affiliates

Conferences and Meetings Sponsored by State Agencies and Departments

- California Department of Health Services
- California Children and Families Commission—First 5 California
- California Department of Education/Child Development Division
- Community College Child Development Training Consortium
- California Department of Social Services Community Care Licensing Division
- California Maternal, Child and Adolescent Health Directors
- California Coalition for Childhood Immunizations
- California Childhood Lead Poisoning Prevention Program Branch of Department of Health Services

WHAT THE CCHC NEEDS TO DO

Establish an Infrastructure

CCHCs can begin by identifying the stakeholders in their communities and beyond to join with in collaboration. Consider who must be involved for the effort to succeed. Next, consider who wants to be involved. And finally, consider those whose involvement would greatly benefit the job.

The next step is to market the project to stakeholders. Attempt to identify the "angle" for each key player. How would both sides benefit from collaboration? Contact and introduce yourself and your project to a wide variety of early childhood and public health professionals. Consider ECE programs (staff, directors, center-based, family ECE providers), community college early childhood education departments, Community Care Licensing staff, clinicians, public health organizations, health and safety trainers, and ECE staff advocates.

Develop and follow a plan when working collaboratively. Set parameters for a mutually beneficial partnership.

Use the following ideas to establish an infrastructure:

Create and Share a Vision

- Establish a shared or linked philosophy and mission to provide a solid foundation for the partnership.
- Return to the shared mission if partners clash.
- Identify and assert the benefits of the partnership for children and families, and for each partner.
- Link the partnership to an overall commitment to and vision of quality. Return to this concept repeatedly.
- Start small. Set realistic expectations for change. Remember that systemic change is a long-term process. Create opportunities for success rather than disappointment.

Communicate

- Create and sustain a spirit of openness, flexibility and confidence about the partnership.
- Decide how and when partners will communicate to exchange information, and to address partnership issues. Communicate often, and consider the use of email bulletins to keep everyone up-to-date and involved.

Work at It

- Commit thoroughly to all aspects of partnership:

expectations, financial and legal requirements and standards, systems, resources, etc.

- Educate all entities/parties about relevant federal, state and local laws and regulations.
- Build an atmosphere in which you can apply the partnerships' "lessons learned" to future work together.
- Remember: successful partnerships create mutual benefits, but they also require mutual compromise and sacrifice.

Clarify Expectations

- Develop a detailed, written legal agreement with clear, measurable expectations tailored to the partnership's specific needs. Borrow from others' agreements but resist short-cuts and seek legal counsel in developing yours.
- Put all expectations in writing—who does what, how does it happen, what are expected outcomes for all parties.

Reach Out

- Reach out to the community to create more support for the partnership and to access additional resources.
- As much as possible, seek advice from specialists associated with the program (legal and financial especially), and training and technical assistance resources.
- Articulate the partnership's goals to federal, state and local officials.
- Network with colleagues who have experience with similar partnerships.

Advocate for Children

If the ECE program has a caregiver designated as the Child Care Health Advocate (CCHA), the CCHC should support and consult with him/her. If the facility does not have a CCHA, the CCHC should help the provider identify and train a staff member to fill this role.

The CCHC's role as an advocate, however, extends beyond issues specific to a given ECE facility. The CCHC is in a unique position to act as a class advocate for improved quality in ECE throughout the community, state and nation and to persuasively articulate and effectively advance the best interests of all children and their families.

To ensure that children's needs are met, the CCHC should serve as an advocate in areas such as communication, education, legislation and the environment. Advocating can be accomplished through a variety of channels, not just through legal or legislative means.

Network

- The CCHC should identify educational opportunities with groups such as local/state advocacy organizations, religious groups, and other community associations frequently identified as advocates for children. If funding restrictions do not allow the CCHC to engage in direct lobbying efforts, these groups may be willing to advocate and help with local resources and services for children and families.
- The CCHC should work to inform organizations and people that part of his/her role is to be an advocate for children. Speaking at community meetings and events can demonstrate that all are working towards the same goal of meeting the needs of children in out of home care.
- The CCHC should know people in the community who are associated with newspapers, television stations, and radio stations. Some ways to communicate with the media may be to write letters to the newspaper editor, talk with the television or radio stations about children's issues in the community, and invite the media to attend meetings and gatherings in the community pertaining to children.

Education

- CCHCs should learn as much as possible about the community and its resources. Find out about local health issues, gaps in services, influential community members, funding issues, and the major concerns of the community. CCHCs need to learn about the requirements for families and

children in programs such as Medicaid, State/Federal Children's Health Insurance Programs, Infant-Toddler Program, and Supplemental Security Income. Often training sessions on these issues are offered by community groups or the state and local governments. A number of organizations maintain listservs or email newsletters offering up-to-date information on legislation and health issues. CCHCs can also read newspapers, magazines, journals, studies, and other materials on the health of children or on ECE to become further informed about issued affecting children and families in the county.

- A key role of the CCHC is to educate parents, family members and ECE providers. This process can be as simple as passing out a flyer with basic immunization information or as complex as conducting a training session on managing the care of children with disabilities and other special needs.
- CCHCs play an important part in encouraging businesses, employers and others to make ECE programs affordable, safe and healthy for children. CCHCs can encourage these individuals and institutions to become active community participants by suggesting they volunteer time or make financial contributions.

Legislation

- CCHCs should keep up-to-date on current legislative agendas. Determine whether the funding source for the CCHC position restricts government lobbying. A CCHC should be aware of the agendas of governmental officials. What new legislation affecting children will local/county/city officials, the governor, state legislators, and the federal government be supporting? If possible, the CCHC should lobby legislators on issues involving ECE programs, health insurance for children, child abuse and neglect, public services, housing, etc.
- CCHCs should consider contacting elected representatives about ECE issues. CCHCs should be willing to show disapproval of weak public policies and demonstrate support for issues being debated in local, state, and federal government. This advocacy role includes scheduling meetings with legislators, writing letters of support, and working to mobilize community efforts.

Strategies for Successful Coalition-Building

There are many strategies which CCHCs can employ for successful professional development.

- Learn how to plan, host and administer effective meetings. Everyone is busy. Make sure you have agendas when you call people together, and that you stick to them. Follow up with minutes or some form of documentation. Only meet when you need to.
- Find your "specialty" niche. You can't be an expert in everything, so excel in the areas that particularly interest you. Seek out training that focuses on these areas, keeping in mind that you need to stay current on the issues that ECE providers need the most—whether they are your interest or not.
- Don't overcommit yourself. Collaborators need to know that you are reliable and dependable and available. Simply attending meetings might help you become educated, but it doesn't always help the coalition get the work done. Remember, this is about reciprocal relationships.
- Respect the expertise of your stakeholders, partners and collaborators. Each person in the collaboration brings a different expertise.

(Partnerships Basics, QUILT - Quality in Linking Together, Early Education Partnerships, www.quilt.org)

WAYS TO WORK WITH CCHAs

CCHCs can be of great assistance in helping to create partnerships with the early childhood community. CCHCs can tap into CCHAs' knowledge of agencies, boards, collaboratives, councils, etc. that focus on issues of quality in ECE programs. CCHCs can also encourage CCHAs to participate in meetings with these partnerships.

All the guidelines that apply to creating community infrastructure apply to relationships with CCHAs as well. Establish mutually beneficial partnerships based on awareness, collaboration and respect.

ACTIVITY 1:
MANY PARTNERS, MANY APPROACHES

In small groups, role play the process of developing a coalition. In this activity, each of you will represent one of the groups or agencies listed below. What would each organization bring to the table? What is mutually beneficial to your partnership? What would you contribute to the partnership? How might you tailor your services for more effective collaboration?

- Family Child Care Associations

- Health and Safety Trainers

- Community Care Licensing

- Local Child Care Planning Council

- Local First 5 California (Children & Families Commission)

ACTIVITY 2: WHO'S ON YOUR TEAM?

To assess the extent of your connection in the communities you serve, check off those entities from the list below which you have already contacted and circle those you would like more information about or need assistance contacting.

After breaking into small groups, discuss your experiences and needs and how to collaborate with the agencies listed:

- ❑ Family Child Care Associations
- ❑ Immunization Coordinator
- ❑ Lead Poisoning Prevention Coordinator
- ❑ Licensing Analyst
- ❑ Licensing Advocate
- ❑ Local Association for the Education of Young Children (AEYC) Chapter
- ❑ Child Care Coordinator
- ❑ Anemia Task Force
- ❑ Child Care Food Program
- ❑ Regional Center
- ❑ School District
- ❑ AAP Representatives
- ❑ Health and Safety Trainers
- ❑ Local Planning Council
- ❑ Injury Prevention Council
- ❑ Community College ECE Department
- ❑ Local First 5 Commission
- ❑ CalWORKs Child Care
- ❑ WIC
- ❑ Behavioral Health Specialists
- ❑ Family Resource Centers
- ❑ Pediatric Health Providers
- ❑ Family Homeless Shelters
- ❑ Playground Inspectors
- ❑ Car Seat Technicians
- ❑ Resource and Referral Agencies
- ❑ Other _____
- ❑ Other _____

ACTIVITY 3: BUILDING SUCCESS

You will be assigned one of three categories: advocacy, coalition-building, or professional development.

Think about one or two of the most fruitful early care and education or health relationships or activities you have engaged in, and share the experience with the group.

Think about:

- What made this relationship/activity work?

- Where did this relationship/activity lead you?

- What made this relationship/activity enjoyable?

Take notes on the ideas others shared that you would like to take home and consider further:

Consultation, Communication and Problem-Solving Skills

WHY ARE CONSULTATION, COMMUNICATION AND PROBLEM-SOLVING SKILLS IMPORTANT?

There is no doubt that a CCHC must have appropriate knowledge, skills and experience. However, the CCHC who is most effective—the one who is able to create lasting changes in ECE programs—functions not as an expert or diagnostician, but as a facilitator or helper (Palsha, Wesley, Fenson & Dennis, 1997). Problem solving is the heart of the consultation process. It is the "major goal of virtually all approaches to consultation and an essential determinant of consultation outcomes" (Zins, 1993; p. 185).

WHAT THE CCHC NEEDS TO KNOW

The Consultation Process

According to Meyers, Parsons, and Martin (1979), consultation is a structured series of interactions or problem-solving steps with six characteristics:

- It is a helping or problem-solving process.
- It occurs between a professional helpgiver and a helpseeker who has responsibility for the welfare of another person.
- It is a voluntary relationship.
- The helpgiver and helpseeker share in solving the problem.
- The goal is to help solve a current work problem of the helpseeker.
- The helpseeker profits from the relationship in such a way that future problems may be handled more sensitively and skillfully.

Collaborative Versus Expert/Medical Modes of Consultation

Although consultation is egalitarian by definition, during consultation the CCHC may need to shift temporarily between collaborative and expert modes. The collaborative mode refers to an interactive problem-solving process with the twofold intent to address the concern at hand and develop expertise in the consultee (for

example, the ECE provider) so that when a similar concern arises in the future the consultee will be able to handle it independently. This mode of consultation is preferred by both teachers and consultants (Buysse, Schulte, Pierce & Terry, 1994; File & Kontos, 1992) and is encouraged, because active collaboration in problem solving on the part of the consultee is more likely to insure the success of consultation.

At times, however, CCHCs may need to shift to an expert/medical mode where they must diagnose a problem and prescribe a solution. This type of mode refers to advice-giving or expert-to-novice communication in which CCHCs have certain knowledge and skills that consultees needs to achieve their goals. Expert consultation would most likely arise in an emergency or crisis situation in which the consultee (ECE provider) needs immediate expert assistance, such as an acute outbreak of diarrheal illness. While occasionally necessary, consulting in the expert mode for long periods is considered harmful to consultees since it precludes them from developing skills needed to solve problems independently.

Note that the above descriptions of consultation do not include the terms supervision, regulation or solving the consultee's personal problems (Conoley & Conoley, 1992). CCHCs should be careful not to provide such services for the following reasons:

Supervision

Supervision implies giving advice and expecting its acceptance, being responsible for the supervisee's work, and making decisions about the worker's career. If CCHCs assume the role of supervisor, it will become more difficult for them to form a positive relationship with the ECE provider and to collaborate as co-professionals in the consultation process.

Licensing and Regulatory Activities

These are not the responsibility of the CCHC according to Standard 9.009 of *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition* (CFOC) (American Academy of Pediatrics [AAP], American Public Health Association, & National Resource Center for Health and Safety in Child Care, 2002). Every state should have a statute that identifies the regulatory agency responsible for licensing and regulation of all regular full-time out-of-home care of children (AAP et al., 2002, Standard 9.001). This agency should also formulate, implement, and enforce regulations that reduce risks to children in out-of-home care. Without assuming an enforcement role, the CCHC should, however, coordinate activities among various agencies and government offices (including state health departments, regulatory agencies, child protection agencies, law enforcement agencies, community service agencies, and local government) to ensure health and safety in ECE programs (AAP et al., 2002, Standard 9.044).

The Child Care Health Consultative Relationship

This relationship deals only with professional problems that are relevant to the health and safety of children in the ECE program. It is, therefore, not the responsibility of the CCHC to act as therapist to the ECE provider or others involved in the consultation process.

Who Is Included in the Consultation Process?

Consultation is a triadic helping process (Kurpius & Lewis, 1988). Triadic refers to the fact that consultation between the consultant and consultee provides indirect services to third parties (clients). In child care health consultation the clients, consultees, and consultants will most likely include the following:

- **Clients:** the children and families who are the recipients of the services provided by the consultees, or ECE providers.
- **Consultees:** directors, teachers, or assistants who provide direct services to children in the ECE program.
- **CCHC:** a health professional who has a broad and general understanding of many issues related to child health, safety, development, and care, and should be able to respond to problems presented by the ECE provider and recognize problems that might go undetected by the provider or families. When appropriate, the CCHC may also invite other experts to assist in the consultation process.

To be effective, CCHCs must know the needs and strengths of the consultees and clients with whom and for whom they are consulting.

Stages of the Child Care Health Consultation Process

The following description of consultation stages is adapted from Dettmer, Thurston and Dyck (1993), Brown, Pryzwansky and Schulte (1998), and Evers (2002).

Stage 1 - Preparation for Consultation

Make arrangements to meet at a convenient time and space, ideally when and where there will be few or no interruptions.

Stage 2 - Initiation of Consultation

- Develop an introductory statement explaining who you are and what you are offering.
- Begin building work relationship.
- Learn about the philosophy of the ECE program, about staff roles and relationships, and about the types of families served.
- Gather information about relationships with other health professionals.
- Gather information about Community Care Licensing requirements.
- Set agenda based on perceived needs.

Stage 3 - Assessment

- Focus on (tentatively) defined concern.
- Collect information through discussions, observation and record review (using the CCHP Health and Safety Checklist-Revised, the Child Care Evaluation Worksheet or the ECERS, ITERS and FDCRS, if appropriate).
- Assess and summarize data.
- Recognize strengths and weaknesses in the program.

Stage 4 - Identify Problem

- Identify and analyze the problem(s).
- Listen to concerns and frustrations of all parties.
- Prioritize and reach consensus on problem(s) to address.
- Remain focused on the problem.

Stage 5 - Select Strategy

- Use collaborative problem solving to generate options and discuss consequences of each.
- Select most feasible and potentially successful strategy that can also be implemented with minimal guidance from the CCHC.
- Incorporate evaluation into the strategy.

Stage 6 - Implementation

- Implement strategy identified.
- Assist consultee in implementing the strategy.

Stage 7 - Evaluation

- Evaluate progress and process.
- Evaluate the effectiveness of the strategy upon completion.
- Reassess periodically.
- Provide positive reinforcement for changes.
- Adjust plan as needed or bring closure to consultation process.

Communication Skills

Each request that a CCHC receives requires excellent communication skills and strong problem-solving skills. These are skills, knowledge and techniques that will be used on a daily basis, and will be effective tools to use whether educating a group, persuading a coalition, or explaining an issue to a parent.

Active Listening Skills

Listening consists of four steps: receiving the message, paying attention to the message, understanding the message, and reacting appropriately to the message. Active listening skills will help the listener understand what the speaker is trying to communicate and let the

speaker know that the message is understood. The characteristics of active listening are described as:

- attentive
- non-evaluative, non-judgmental
- conveys understanding or desire to understand
- feedback must have a respectful tentativeness—or questioning tone which leaves the sender room to clarify or correct the listener (see Table 1 for further information.)

(Adapted from Palsha et al., 1997)

Avoiding Barriers to Effective Communication

The following are examples of barriers to effective communication:

- giving orders
- giving solutions
- judging
- labeling
- invading privacy
- distracting
- diagnosing
- threatening
- taking responsibility
- moralizing
- criticizing
- denying reality
- using jargon
- showing disrespect
- belittling
- lecturing
- false praising
- using clichés
- personalizing
- interpreting

(Adapted from Young, Downs and Krams, 1993)

The Problem-Solving Process

Problem Solving at Each Stage of the Child Care Health Consultation Process

Each stage of the child care health consultation process requires different problem-solving tasks.

TABLE 1: EXAMPLES OF FEEDBACK

FEEDBACK	PURPOSE	EXAMPLE
Minimal encouragements to continue	Shows you are interested	"Mm-hm"
Restating	Shows you are listening	"You said you felt frustrated"
Clarifying	Helps you get facts straight	"As I understand it…."
Reflecting	Helps other person recognize and express feelings and attitudes	"I sense that you feel…" "Your voice sounds…" "You seem a little…"

TABLE 2: PROBLEMS AND NEEDS	
Stage of Problem	**Consultee Needs**
Development	Consultee needs help at an early stage of a new program or problem. Seeking intervention at this stage may indicate signs of consultee insightfulness and openness.
Maintenance	Things have become stagnant and/or are falling behind and need improvement. Seeking help at this stage usually indicates the consultee's desire and motivation to improve.
Decline	Things are getting worse, and the consultee recognizes that s/he cannot solve the problem without help. Seeking help at this stage may indicate that the consultee wants a quick fix and will have high expectations of the consultant's ability to provide an immediate solution.
Crisis	The consultee is badly in need of help. Seeking help at this stage may indicate that the consultee is desperate and wants immediate assistance.
Kurpius, et al. (1993)	

Problem-Solving Tasks to Consider at the Stage of Identifying the Problem

Identification of the Problem. Accurate problem identification is considered essential for problem resolution. In reviewing a series of studies, Brown, Pryzwansky and Schulte (1998) report that a major difference between novice and expert CCHCs in their response to a problem-solving situation is that experts spend considerably more time in problem identification. For example, in comparing the responses of school psychology practitioners to that of school psychology graduate students, Pryzwansky and Vatz (1988) found that the practitioners spent more time evaluating the quality of the information provided by the consultee in defining the problem. They also spent more time probing their own role in the solution process and the expectations of the consultee. The graduate students, on the other hand, tended to accept the problems as defined by the consultee at face value.

The message in this for the CCHC is that adequate conceptualization and identification of a provider's problem often requires a considerable amount of time and effort.

In most cases, the CCHC will probably be consulting with a provider who has already tried numerous solutions to the presenting problem. In order to successfully conceptualize the presenting problem and obtain information on how s/he can be of help, the first task for the CCHC is to ask the right questions. The following questions have been proposed to facilitate successful problem identification:

- Tell me briefly about your situation.
- Who is the client in this problem?
- How long has it been going on?
- When did it happen last?
- Who else is involved?
- What have you already tried?
- Why do you think previous interventions failed?
- How will things be different when the problem is solved?
- What will happen if the problem is not solved?

- How will you know when the problem is solved?

(Adapted from Kurpius, Fuqua, and Rozecki, 1993)

Stage of the Problem. Knowing the stage of the problem may help CCHCs to form better questions about the need for help and also provide them with information about the level of help needed. Kurpius, et al. (1993) propose that presenting problems tend to fall into one of four stages and each stage is characterized by unique consultee needs and reactions. The stages they propose with accompanying consultee needs are presented in Table 2.

The Importance of Consensus in Defining the Consultation Problem. In order to define/identify the problem, the collection of good (valid and reliable) information is essential. In gathering such information (through observation, interviews, record reviews, etc.), the CCHC should make sure to involve the provider(s), and in many cases the client, in both the collection and interpretation of the data. The best predicator of success in consultation is an accurate problem definition that is understood and accepted by consultee and client as well as consultant.

Problem-Solving Tasks to Consider at the Pre-Consultation Stage

Self-Assessment of Personal Expertise and Problem-Solving Skills. Rarely can a CCHC solve a problem single-handedly. Prior to consultation, CCHCs should assess their own strengths and weaknesses both in terms of professional expertise and interpersonal skills, and also assess how these abilities mesh with the ways a particular ECE program typically causes, solves, or avoids problems. To facilitate this self-examination, CCHCs should ask themselves:

- How do I listen and respond to people at various levels in the ECE program, for example, the director versus staff members or parents?
- What are my special competencies or areas of expertise?
- How do I think and feel when providers disagree with me and confront me on my ideas?
- How do I conceptualize my primary mode of helping: collaborative? expert?
- How do my words and actions exemplify this mode?
- To what degree do I act as evaluator and judge of the providers/ECE programs?
- How do I conceptualize my role as CCHC?
- How do I conceptualize the roles of the provider and client?
- To what degree do I involve the provider and client as equal partners in the problem-solving process?

(Adapted from Kurpius, et al. 1993)

Kurpius, et al. (1993) recommend that CCHCs engage in self-assessment frequently as their competencies, skills and beliefs will continually grow and develop.

A CCHC team approach to consultation holds several advantages over individual consultation at this (pre-consultation) stage. The primary advantage is that the team may decide which member (or members) possesses the unusual insights and knowledge to best define and facilitate the solution in a specific instance, and through working together, CCHCs can receive objective feedback from each other and learn from each other's experiences.

Problem-Solving Tasks to Consider at the Selecting Interventions Stage

Once a problem has been defined and accepted by consultee, client and CCHC, the consultant's task is to assist in the selection of an intervention strategy. Since they have often been dealing with the problem for some time, there is a natural tendency for consultees to desire a quick, easy solution. However, the CCHC, consultee, and often the client, need to take time and decide together the best intervention(s) for solving the particular problem.

Although many categories of interventions are available (Kurpius, et al. 1993), in child care health consultation the most relevant types are:

Human Interventions: Interventions focused on changing knowledge, beliefs, feelings, motivation or behavior, and

Structural Interventions: Interventions focused on changing policies, procedures, environmental features, etc.

In most child care health consultation it is likely that both kinds of interventions will be needed.

Enhancing the Problem-Solving Skills of ECE Providers

A goal of consultation is to improve the problem-solving skills of providers so that they are better able to independently address similar problems in the future. Zins (1993) contends that it is not enough to "consult and hope" that consultees will develop the skills necessary to resolve the presenting problem, and also somehow be able to apply this knowledge towards the resolution of similar situations in the future. Instead, the transfer and generalization of skills must be incorporated directly into consultation by training consultees directly in relevant problem-solving, communication and intervention techniques (which should include the introduction of important issues such as confidentiality, treatment integrity, unbiased information collection, and so forth).

Group Problem-Solving Skills

Group problem solving is at the core of the consultation process, and there are several structured techniques, including brainstorming, lateral thinking, and mind or concept mapping, commonly used to solve group problems.

Brainstorming. Brainstorming is a creative problem-solving technique used to explore a wide range of possible solutions. Brainstormers generate multiple ideas for solving a problem, offering solutions ranging from practical to far-fetched. Discussion is not allowed until all solutions are recorded, and no solutions are judged or criticized when first suggested.

How to use brainstorming techniques with a group:

- The leader defines the problem to be solved, introduces the criteria that must be met (for example, it should be cost effective, must be finished by the spring, etc.), and sets a time limit for the brainstorming session.
- The leader assigns a record-keeper to write the ideas on a flip chart or white board for all to see.
- Participants may introduce original ideas or develop associations from the ideas of others, and are encouraged to go as far as possible with any one solution. A seemingly crazy and impractical suggestion may inspire practical, creative solutions.
- Without appearing critical, the leader must keep the participants on the subject, ensure that no train of thought is followed for too long, and steer the group toward reasonable solutions.
- When the time limit expires, the participants must reach agreement on the five ideas they like best.
- The leader reminds the group about the criteria set for judging the responses, and the participants score the solutions to the problem on a scale of 0 to 5 for each criterion.
- The recorder tallies the scores and posts the group's best solution to the problem. The leader should keep a record of all of the ideas for future reference.

Lateral Thinking. Lateral thinking is a way of generating novel solutions to problems by approaching them from a different perspective. The conventional method of thinking is vertical thinking, in which one moves forward mentally by sequential and justifiable steps. Vertical thinking is logical and single-purposed, digging down more deeply into the same mental hole. Lateral thinking, on the other hand, digs a "thinking hole" in a different place. It moves out at an angle, so to speak, from vertical thinking to change direction, attitude, or approach so the problem can be examined in a different way (DeBono, 1971).

Example: Granny is sitting knitting and 3-year-old Susan is upsetting Granny by playing with the wool. One parent suggests putting Susan into the playpen. Another parent suggests it might be a better idea to put Granny in the playpen to protect her from Susan. A lateral answer!

How to use lateral thinking:

- State your perception of a problem.
- Identify a different way of perceiving the circumstances surrounding the problem.

- Relax rigid control of your thinking.
- Think about low-probability ideas, which are unlikely to occur under the normal conditions in which the problem occurs.

Mind Mapping. Mind mapping is a problem-solving technique and organizational tool which uses words, lines, colors and images to stimulate thought. Mind mapping may be used individually or in groups as a method of visualizing and relating components of a problem or solution, as a way of organizing thoughts, or as a means of note-taking. The resulting "map" allow the creators to see spatially how concepts and information may relate in ways that traditional outlining does not allow.

How to use mind mapping with a group:

1. Represent the problem or subject by selecting a central word, concept or image.
2. Draw five to 10 major branches radiating from the central idea. Label with related ideas.
3. Draw five to 10 minor branches from each of the major branches. Label with related ideas.
4. Highlight common features in the map. For example, ideas involving ECE programs might be underlined in red, ideas needing outside funding denoted with a green dollar sign, ideas about staffing circled in yellow, etc.).

Problem-Option-Consequences-Solution (POCS). POCS is a traditional problem-solving method.

How to use POCS:

- Collect information from multiple sources to successfully identify the problem.
- Generate a list of options from the people who must support the changes or decisions.
- With honest and open communication, discuss the merits, drawbacks and consequences of each option.
- Reach consensus on the solution to the problem with the people the decision will impact so they will more readily accept the changes and new ideas.

WHAT THE CCHC NEEDS TO DO

Prior to consultation, the CCHC should assess the request being made and decide on the best mode of consultation: collaborative or expert. Before and during the consultation process, the CCHC should gather as much information as possible regarding the specific needs and expertise of the consultees and clients participating in the consultation. The CCHC should maintain a registry of other consultants or experts in the community, and invite these experts to assist in the consultation process when appropriate.

CCHCs should model the type of listening, communicating and creative problem solving that they hope the ECE community will adopt. This should be accompanied by an accepting, understanding approach. Child care health consulting, as in any public health position, requires working with people of many races, religions, education levels, economic strata and temperament. CCHCs will need to communicate with each and be successful at problem solving when there is a barrier to the goal.

Consultation Tips

What to do:

- Have materials and thoughts organized before consultations.
- Develop a list of questions that will help ferret out the real problem.
- Be prepared for the meeting with a checklist of information typically needed.

- Be comfortable saying that you do not have the answer.
- Have strategies and materials in mind that may be helpful to the situation, but do not try to have all the answers. This discourages involvement by others.
- Make it a habit to look for something positive about the provider, the room, and the children, and comment on those things.
- Use feedback as a vehicle that can provide positive information, not just negative comments.
- When a provider asks for advice about a child, first ask what the provider has already observed. This gets the provider involved in the problem and encourages ownership. Whenever possible, use the terms we and us, not I.
- Maintain contact. You may find that the ECE provider has detected an improvement that is directly related to your work, and this reinforcement will be valuable for you and your own morale.
- Involve others in setting goals and in the technical assistance process.
- Be aware of your own motives.
- Be professional and courteous at all times.
- Remember that minds, like parachutes, work best when they are open.

What to avoid:

- Offering suggestions that conflict with policies.
- Being definite, dogmatic, unyielding.
- Sulking when your advice is not taken.
- Using ambiguity to your own advantage.
- Emphasizing your professional status and ignoring others' roles and qualifications.
- Conspiring to cause unwanted, unsanctioned change.
- Trying to fix it if it is not broken.
- Waiting for the ECE provider to make the first move.
- Minimizing the time to establish rapport and mutual trust—just come in like gangbusters.
- Failing to identify the norms and values of the organization or, once identified, ignore them.
- Using jargon and abbreviations that others do not understand.
- Offering technical assistance in areas in which you lack knowledge and skills. Never refer persons to other resources.
- Expecting immediate results, getting mad when you don't see change, and failing to acknowledge the hard work and accomplishments of others.
- Being unreliable, disorganized, inarticulate, and appearing to be eager to end the consultation and leave.
- Finishing without a plan for closure. Surprise people by announcing, "Today is the last time we will meet!"

(Adapted from Conoley and Conoley, 1992; and Dettmer, et al. 1993; Schulte and Wesley, 1997)

WAYS TO WORK WITH CCHAs

CCHCs should model and offer training in effective communication and problem-solving strategies for CCHAs, who will need these skills when working with staff, administrators and parents to advocate for change or explain policies.

ACTIVITY 1: NEEDS OF PARTICIPANTS IN THE CONSULTATION PROCESS

Fill out the following and discuss in small groups:

The client (child/family) needs:

- ❑ Quality care for children
- ❑ Access to services to help meet special needs
- ❑ Linkage with community resources
- ❑ _____
- ❑ _____
- ❑ _____

The consultee (ECE provider) needs:

- ❑ Technical assistance
- ❑ Training for staff and parents
- ❑ Help in developing and enforcing facility policies
- ❑ Linkage with community resources
- ❑ Substitutes who can relieve consultees from their responsibilities so they are available to participate fully in the consultation process (Palsha et al., 1997)
- ❑ Resources (personnel, financial and community) available to help implement the changes identified during the consultation process (Palsha et al., 1997)
- ❑ _____
- ❑ _____
- ❑ _____

The CCHC needs:

- ❑ A consultee who is willing to be an active partner and assume joint responsibility for all aspects of the consultation process
- ❑ _____
- ❑ _____
- ❑ _____

ACTIVITY 2: WHAT PARTICIPANTS BRING TO THE CONSULTATION PROCESS

Fill out the following and discuss in small groups:

The client (child/family) provides:

- ❑ Support to the provider and ECE program by being knowledgeable about and adhering to practices (e.g., nutrition, passenger safety) and policies (e.g., exclusion, payment schedule) adopted by the program
- ❑ Information and insight into the child's history, family and any special needs
- ❑ _____
- ❑ _____

The consultee (ECE provider) provides:

- ❑ Training and experience in the field of early childhood education
- ❑ Information and insight into the children's history, their families, and any special needs of which s/he is aware
- ❑ Information about the ECE program, the staff, and the history of the problem(s) to be addressed
- ❑ Information and insight into the child's history, family and any special needs
- ❑ _____
- ❑ _____

The CCHC provides:

- ❑ Knowledge, skills, and experience needed to assess the environment for health and safety problems and subsequently identify and help implement strategies to solve the problems
- ❑ Technical information and skills to offer assistance, training, and support to those who provide direct services to the children and their families
- ❑ Knowledge and skills to assist development of facility policies on health, safety, and child development
- ❑ Knowledge and skills to assess the quality and appropriateness of health education curriculum materials for providers, children and parents
- ❑ Knowledge and skills to link ECE programs to appropriate community resources
- ❑ Knowledge and skills to act as an advocate, and work with ECE providers, families, communities, and politicians at the local, state and federal levels to improve the quality of ECE programs for all children
- ❑ Information and insight into the child's history, family and any special needs
- ❑ _____
- ❑ _____

ACTIVITY 3:
ACTIVE LISTENING

Using the following sentences, practice active listening techniques. Write a sentence that reflects each technique listed.

1. Repeat speaker's main words that express her feeling.

Example: A provider says: "I'm afraid about caring for a child with such extreme medical needs."

CCHC might say:

_____

_____

_____

2. Avoid close-ended (yes/no) questions.

Example: CCHC says: "Are you having some problems with maintaining the playground equipment?"

Better:

_____

_____

_____

3. Listen for emotional meaning.

Example: A provider says: "Another parent tried to drop off a child with a fever today."

CCHC might say:

_____

_____

_____

4. Listen for more than facts.

Example: A provider says: "Some children still seem hungry after lunch."

CCHC might say:

_____

_____

_____

5. Accept the speaker's feelings—as his/hers, not yours.

Example: The provider says: "I've decided to screen more carefully children with disabilities and other special needs who want to attend my center."

CCHC might say:

_____

_____

_____

6. Offer a chance to elaborate.

Example: CCHC says "There must be more to this situation."

Better:

_____

_____

_____

7. Avoid premature conclusions and interpretations.

Example: CCHC says "I can see right away that one of the children in your program needs special care from an early interventionist."

Better:

_____

_____

_____

8. Be alert for your own negative feelings.

Example: A CCHC might think "I'm afraid this ECE provider is not very responsive to the children's needs."

Better:

_____

_____

_____

9. Give broad openings.

Example: CCHC says "I've been thinking about what we talked about."

Better:

_____

_____

_____

10. Watch for openings in conversation or pauses.

Allow time for pauses. Pauses often mean the person is experiencing a feeling, but isn't able to put it into words. Why else might a provider or parent be pausing:

_____

_____

_____

11. Listen for contradictions.

Example: A provider in a new center says: "I know this is probably not anything to worry about, but can you tell me all the things I would need to do if I accept a child who is medically fragile?"

CCHC might say:

_____

_____

_____

12. Avoid implicating "you" statements.

"You" statements make it sound as if you know what the provider is experiencing better than s/he does. Example: CCHC says "You don't want to do that." "That's not what you really think."

Better:

_____

_____

_____

Adapted from Young, Downs and Krams, 1993

ACTIVITY 4:
COMMUNICATION BARRIERS

The following sentences are examples of things people say that create a barrier to effective communication. Re-write the sentence in ways that promote clear communication, not barriers.

1. Ordering

Example: "Contact the early intervention specialist about this immediately."

Better:

_____

_____

_____

2. Threatening

Example: "If you don't take care of this, I'll contact the child's doctor myself."

Better:

_____

_____

_____

3. Moralizing

Example: "You should be able to control the spread of illness in this classroom better than this. The problem has occurred too many times this year."

Better:

_____

_____

_____

4. Giving solutions, taking responsibility

Example: "This child needs to be evaluated by a mental health professional. I'll call for an appointment."

Better:

_____

_____

_____

5. Lecturing

Example: "I know operating an ECE program is very demanding. You simply have to be more organized."

Better:

_____

_____

_____

6. Judging, criticizing

Example: "You really should have taken care of this problem a long time ago."

Better:

_____

_____

_____

7. False praising

Example: "You are doing a much better job of controlling infection in this classroom even though this is the third outbreak of this kind in the last nine months."

Better:

_____

_____

_____

8. Labeling, name-calling, stereotyping

Example: "This is the snobbiest ECE program in town."

Better:

_____

_____

_____

9. Denying reality, false assurance

Example: "Don't worry. I'm sure everything will be just fine."

Better:

_____

_____

_____

10. Invading privacy, interrogating

Example: "Did you have this many problems in the last center where you worked?"

Better:

_____

_____

_____

11. Diagnosing

Example: "The problem seems to be inadequate supervision on the playground."

Better:

_____

_____

_____

12. Clichés

Example: "It's for your own good."

Better:

_____

_____

_____

13. Belittling

Example: "It's taken three consultation visits before you took action to solve this problem. All other center directors I work with take immediate action."

Better:

_____

_____

_____

14. Interpreting

Example: "So when you say you have problems with some parents, I guess you feel frustrated."

Better:

_____

_____

_____

15. Disagreeing with the client

(May put provider on the defensive and anger her.)

Example: "You're wrong about the amount of bleach to make a disinfecting solution."

Better:

_____

_____

_____

16. Disapproving

(Indicates that you have not accepted the provider's feelings and actions as valid.)

Example: "I wouldn't have done it that way."

Better:

_____

_____

_____

17. Using jargon

Example: "Your children need to be cohorted immediately to minimize the impact of this communicable disease outbreak."

Better:

_____

_____

_____

18. Show disrespect for differing opinions, beliefs, attitudes, or practices

Example: "That's a silly idea."

Better:

_____

_____

_____

ACTIVITY 5: COMMUNICATION SKILLS SELF-ASSESSMENT

1. Complete the Communication Skills Self-Assessment below. Respond to each sentence by placing a check mark under the appropriate response.
2. When you have completed the assessment, select two areas in which you would like to improve.

How often do I...	Never	Rarely	Occasionally	Frequently	Always
Use active listening skills (attention, reflection, summarization)?					
Use non-judgmental language?					
Invite others to talk with me when there is a difference of opinion?					
Avoid jargon, explain terms?					
Offer opinions as suggestions, but not as the only options?					
Answer questions directly if I can, or say "I don't know"?					
Avoid patronizing language and tone?					
Consider that people may interpret information differently?					
Clarify mutual expectations?					
Clarify next steps?					
Clarify or realign roles?					
Appreciate contributions made by people of other cultures?					
Recognize time and resource constraints?					
Pay attention to nonverbal cues (e.g., body posture, tone, eye contact)?					
Refrain from judging a family who resists seeking care for their child with special needs?					
Consider an ECE provider's education level when forming an opinion about him/her?					
Consider the average family's socio-economic status when forming an opinion about the ECE program?					
Consider the number of children a family has when forming an opinion about them?					
Consider an ECE provider's appearance when forming an opinion about him/her?					
Feel uncomfortable or defensive when an ECE provider is very direct or assertive?					
Avoid monopolizing the conversation?					
Create an environment for open communication?					

ACTIVITY 6: SKILLS ASSESSMENT

AAP et al. (2002, Standard 1.041) lists 13 skills CCHCs should be able to perform (see below).

For each skill, rate your perceived competence level, on the following 3-point scale:

Very good at this skill (VG)

Fairly good at this skill, but could improve (FG)

Not good at this skill, need to improve greatly (NG)

"The skills of the child care health consultant shall include the ability to perform or arrange for performance of the following activities:

CCHC Skills		Rating
a)	Teaching child care providers about health and safety issues	
b)	Teaching parents about health and safety issues	
c)	Assessing child care providers' needs for health and safety training	
d)	Assessing parents' needs for health and safety training	
e)	Meeting on-site with child care providers about health and safety	
f)	Providing telephone advice to child care providers about health and safety	
g)	Providing referrals to community services	
h)	Developing or updating policies and procedures for child care facilities	
i)	Reviewing health records of children	
j)	Reviewing health records of child care providers	
k)	Helping to manage the care of children with special health care needs	
l)	Consulting with a child's health professional about medication	
m)	Interpreting standards or regulations and providing technical advice, separate and apart from the enforcement role of a regulation inspector."	

(AAP et al., 2002; Standard 1.041)

Discuss your strengths and weaknesses in small groups. In what areas would you like to improve and why? How do you plan to improve upon these skills?

ACTIVITY 7: CONSULTATION PROCESS

Choose a partner and work with that person to apply the consultation process to the situation you are assigned by the trainer.

1.

2.

3.

4.

5.

6

7.

8.

ACTIVITY 8: GROUP PROBLEM-SOLVING SKILLS

Break up into groups. Utilize a group problem-solving technique such as brainstorming, lateral thinking or mind mapping to solve the problem of what to serve at the ECE program potluck of which you are in charge.

ACTIVITY 9: CONSULTATION SCENARIO PRACTICE

Break into small groups. The group task will be to consult with an ECE program on one of these topics using the skills and knowledge you have already gathered.

- Policy development for a large chain of for-profit infant/toddler and preschool programs
- Training staff on infant/toddler health and safety
- Establishing a CCHA position
- Accommodating a child with special needs in a program operating in the Sunday school room of a church
- Working with the local planning council to include health and safety in their school readiness plan

The group should develop a plan of approach and strategies.

Policy Development

WHY IS POLICY DEVELOPMENT IMPORTANT?

Policies in ECE programs are critical to guarantee the safety and health of the children. Without them, children might arrive at the facility with an infectious disease and infect other children; an unauthorized person might be allowed to pick up a child from the center; and/or staff might be inadequately trained in emergency care procedures. CCHCs can be instrumental in helping staff and parents establish and follow site-specific policies (Young-Marquardt, 2005).

Policies are developed to: promote and protect the health and safety of children and staff; help families and staff understand ECE as a business; help programs keep compliance with regulations and standards; ensure consistent practices; and encourage open communication between and among staff and families.

WHAT THE CCHC NEEDS TO KNOW

State child care regulations are the minimal operating requirements established for licensure (State of California, 2001). Policies are a program's interpretation of state regulations and determine how they will comply. An ECE program's policies may be stricter than state regulations.

CFOC (AAP et al., 2002, Standard 8.004) recommends that ECE facilities establish policies in the following areas:

- Admissions
- Supervision
- Discipline
- Care for children with disabilities and other special needs
- Health history for children and providers
- Current health plan
- Safety surveillance
- Emergency illness and injury plan

- Care of acutely ill children
- Medication administration
- Evacuation plan, drills and closings
- Authorized caregivers
- Transportation and field trips
- Hygiene and sanitation
- Food handling and feeding
- Sleeping and nap time
- Smoking, prohibited substances and guns
- Staff health
- Review of policies
- Design and maintenance of facility
- Use of health consultants
- Child health services
- Health education

Two publications, *Model Child Care Health Policies, 4th Edition* (American Academy of Pediatrics, Pennsylvania Chapter, 2002) and *Caring for Our Children: National Standards for Out-of-Home Child Care Programs, 2nd Edition* (American Public Health Association and American Academy of Pediatrics, 2002), can serve as guidance documents in developing and writing child care policies. Each publication includes examples of recommended policies that can be easily adapted to suit the needs of an individual program. Online sources include other Healthy Child Care America grantees listed at the HCCA Web site at www.healthychildcare.org.

WHAT THE CCHC NEEDS TO DO

CCHCs can help providers and parents determine which topics are appropriate to include in the facility's policy protocols. Early in the policy-setting process, CCHCs might find it helpful to meet with the provider and parents to read through the policies, clarify any issues, and explain what will happen if the policies are not followed. CCHCs may find different kinds of policies located in different places, including personnel policies, parent handbooks, and miscellaneous memos or postings. One goal of policy development would be to gather all directives in one place for review. Consult and collaborate with all those who are affected by the policy. Implementation of policies is easier if all parties are involved in creating them, are educated regarding the policies, and understand the necessity and importance of adhering to them.

CCHCs are often called upon to assist in writing policies. Components of good written policies include:

- Statement of the policy
- Intent statement
- Background
- Procedure/practice
- Applicability (to whom, when, where)
- Communication
- References
- Review
- Effective date
- Subsequent review date(s)

The cost of implementing certain policies is also an important consideration. Without sufficient funds some standards may be more difficult to implement than others. Implementing policies without adequate funding may cause high staff turnover, low wages and unsafe environments—all of which can lead to poor quality ECE programs. Even though the desired financial resources may not be available, CCHCs, staff

and parents must continue efforts to create a healthy, safe and nurturing environment for all children.

In *Model Child Care Health Policies, 4th Edition* (American Academy of Pediatrics, Pennsylvania Chapter, 2002) it is recommended that "a health professional and an attorney who works with the facility should review the completed, site-specific, health policies." These professionals can check whether the final policies are legally appropriate and consistent with current child health practices and Community Care Licensing regulations (State of California, 2002).

It is important that all persons concerned review administration policies periodically in order to evaluate their effectiveness in assuring the safety and health of children in ECE programs. Copies of the ECE program's policies should be made available to families, staff and consultants at least annually. When changes are made to a specific policy, all relevant parties should receive a copy of the revision and be asked to sign an acknowledgement that they agree to adhere to it. CCHCs should review the policies at least annually and when revisions are made (AAP et al., 2002, Standard 8.041).

WAYS TO WORK WITH CCHAs

CCHCs can help CCHAs and parents through the process of developing and maintaining ECE program policies by checking that:

- Sufficient resources (equipment, supplies and staff) are available to make policies work.
- The facility is organized to support the policies.
- Proper procedures are used to support the policies.
- Lines of communication are kept open.
- Everyone involved is educated regarding the recommended standards for policies.

ACTIVITY 1: POLICY PRACTICE—INFECTIOUS DISEASE

What specific policies can CCHCs support for positive change to prevent the spread of infectious disease in an ECE program? Complete the questions below to develop a plan of action.

Overall objective(s):

Steps to take to accomplish the objective(s):

How will you know you have achieved your objective?

Who will you ask for help?

How will you evaluate whether or not the policy is comprehensive and effective?

ACTIVITY 2: POLICY COMPONENTS

Select one practice to reduce infectious disease and develop a policy using the following 10 components:

- Intent statement
- Background
- Procedure/practice
- Applicability (to whom, when, where)
- Communication
- References
- Review
- Effective date
- Subsequent review date(s)

Consultation Plans and Documentation

WHY ARE CONSULTATION PLANS AND DOCUMENTATION IMPORTANT?

Consultation plans define the relationship and activities of the CCHC for employers and funders as well as for clients and consultees. The plan provides guidance to define and implement goals and outcomes and adherence to the scope of work. A Child Care Health Plan for a particular program is a written document that describes emergency health and safety procedures, general health policies and procedures, program policies and procedures, and policies covering the management of mild illness, injury prevention and occupational health and safety (AAP et al., 2002). Having a plan that is mutually developed prevents misunderstandings and builds trust among all parties involved. Good documentation provides evidence and accountability that the goals and activities in the plan have or have not been achieved.

WHAT THE CCHC NEEDS TO KNOW

Planning

Since child care health consultation is an emerging field, the role of the CCHC may be unfamiliar to ECE providers and perhaps to CCHCs themselves. Planning an approach to consulting will facilitate the path to success. Whether CCHCs provide their services solely through phone consultation, via direct services or exclusively through training, planning will be essential to keeping the CCHC and program administrators involved and on track.

Planning requires collaboration, goals, timelines, and an evaluation method. When planning daily activities, CCHCs should leave time for documentation and for satisfying the evaluation criteria. There are many ways to develop and share this plan so those who work with CCHCs will understand and embrace their roles. Possibilities include collaborating on the development of:

- Needs assessments, questionnaire and survey results
- Memos of understanding
- Interagency agreements

- Contracts
- Work plans or scope of work plans
- Measurable outcome data

Documentation

Clear and consistent documentation is a primary avenue to demonstrate that activities have been completed. It is also an important way to decrease professional liability. When there is a question about what has been done or the outcome of a task, CCHCs will find it comforting to open a binder or a file, review a piece of paper that describes specifically what was done, when, by whom and any resulting outcome.

Consultation plans and documentation of consultation/training visits or other services should be given to the ECE program and a copy maintained in the CCHC's files. Plans and documentation can include: the nature of the consultation request and service provided; safety checklists with inspection results and recommendations; training requests; training provided to whom and length of time; and certification given, if any. The documentation should include the name and credentials of the CCHC, and when, where and how the consultation or training took place. Other ways to document consultation activities include:

- Written results of observations with recommendations
- Agendas and minutes of meetings

TABLE 3: RESPONDING TO A REQUEST FOR TRAINING

Topic: Excluding children for Illness	
Consulting Opportunities	**Ways to Document**
"I'd suggest that you to stick with the existing policies on including and excluding children for illness before speaking to the parents and giving the wrong information."	Copy of policies and procedures.
"If you don't have written policy covering that I'd be happy to send you a sample policy so you can see what is recommended by the AAP."	Sample policy.
"Is the sample policy different than yours? Does it seem like it could work for you? Would it be okay if I came to a teacher meeting first and talked about how this might work better for you?"	Workshop "Infection Control and Excluding Children for Illness," date, time, sign-in sheet. Article from Child Care Information Exchange on the evils of excluding too quickly.
"Would you like me to look at the rest of your policies? I can probably offer you some handouts and posters that reinforce your policies once I know what they are."	Policies as received and policy suggestions.
"All policy changes have to go before the board? Can I help you develop an approach for you to take with the board? I'd be happy to meet with your board."	Date, time and agenda of board meeting. Copy of presentation to the board.

- Photos and videos
- Anecdotal recording
- Memos
- Progress reports
- Evaluation and self-assessment tools (using the CCHP Health and Safety Checklist-Revised, the Child Care Evaluation Worksheet and the ECERS, ITERS and FDCRS)
- Quarterly or annual reports
- Data summaries, pre and post intervention
- Activity or journal logs
- Time studies
- Child Care Service Encounter Forms (ECELS, 2002)

See Table 3 for some ideas of how to respond when asked to provide training on excluding children for illness.

WHAT THE CCHC NEEDS TO DO

- Assess the needs of the program, then jointly formulate an objective that meets the needs of the program and develop a plan to meet those needs. Observe for further needs and suggest them to the program staff. Then, develop an extended plan.
- Review existing plans, commentaries on approaches and forms that will meet the needs of this consultee to benefit the client. Work with the consultee to customize the plans and forms so they are appropriate to the ECE program's mission.
- Collaborate with the program staff to implement corrections. Bring in resources and experts when needed. Document when barriers are encountered which keep the CCHC from meeting an objective or staying within a timeline.
- Evaluate the success of the plan and the CCHC's work goal(s) by using documents and forms which indicate work completed, outcomes and benefits derived.
- Write a final report that ties the assessment, collaboration, research, plan, work, timelines and evaluation to the outcome for the program. Use documentation of barriers to recommend an improved approach in the future.
- Work with the CCHA to set objectives and timelines and evaluate processes. The CCHA can use them as guidelines when talking to staff one-on-one or presenting at meetings.

WAYS TO WORK WITH CCHAs

The CCHC and CCHA can work closely to develop a plan to meet the needs of an ECE program. Since the advocate is involved daily with staff, families and children, they can provide valuable information not apparent to the CCHC. The CCHA can provide useful data to document health needs such as injury and illness reports, health and safety checklists; monitor child and staff records for immunization status; special care plans, training needs and compliance; review medication administration records, emergency preparedness items and plans; and plan health education for staff, parents and children.

ACTIVITY: CONSULTATION PLAN

Develop a simple plan for a consultation request you have received in the past.

What was the problem?

What was your objective?

What did you recommend to remedy the problem?

What steps did you take?

What was your timeline?

How did you document your plan?

Community and Family Resources

WHY ARE COMMUNITY AND FAMILY RESOURCES IMPORTANT?

An important part of the work of CCHCs is linking families and programs to community services. While CCHCs may focus on improving child and family access to health services, it is important that they be aware of the broader service delivery system for children and families in their communities. CCHCs should take advantage of their relationships with families and ECE providers by educating them about or referring them to education, employment development and social services opportunities. Families may be unable to address a pressing health issue until other basic survival issues, like income support or housing, are resolved.

WHAT THE CCHC NEEDS TO KNOW

ECE Provider Knowledge of Community Services

In a 2001 focus group study of ECE and mental health providers conducted in California by Health Research Systems of Washington, D.C., center-based ECE providers demonstrated extensive knowledge of the community resources available to address children's individual needs. Participants frequently mentioned seeking the assistance of health providers, specialists and health consultants. However, providers noted that there are usually long waiting periods for assessment services and that intervention services are scarce. Family child care providers, on the other hand, were much more unlikely to take advantage of these resources. They indicated that their knowledge of existing community resources and relationships with other professionals were limited and that they therefore did not have a similar commitment to locating services for the children and families with whom they work.

ECE programs, especially those that are subsidized by state and/or federal funds, may have large numbers of children in their care who have outstanding social, emotional and physical needs. These needs can manifest themselves in behavior problems, chronic absenteeism, chronic health problems, lack of parent involvement, or the inability of families to remain qualified to receive their child care subsidy. Coping with these behaviors is difficult due to the daily stresses placed on ECE staff. Poor compensation, high staff turnover, and a shortage of qualified child development professionals are major obstacles to addressing the underlying causes of challenging behavior. For these reasons, ECE staff may not have the time or knowledge to refer families to community services.

Therefore, CCHCs must have knowledge of community resources in order to assist in making appropriate referrals for children, families and staff in need of services. The CFOC standards (AAP et al., 2002) related to accessing and utilizing community resources are:

- Child care centers and large family child care homes should help families locate a health care provider (medical home) if they do not have one. CCHCs should discourage emergency room use for routine or non-emergent care.
- Families should be linked with a well-child clinic, public health department, private physician, etc. If this is impossible, the family should know how to access the emergency response system, the closest emergency room, or urgent care center when needed.
- Public and private resources in local communities should be used to develop resource and referral (R&R) agencies. These agencies can help provide information to parents, ECE providers and CCHCs about resources and services, and function as a mechanism to coordinate services.
- All ECE programs should have access to a community resource file. This file should include information about eligibility criteria for services, hours of operation, costs of services, insurance coverage, and languages spoken by the agency staff. It should be updated annually and should be accessible to parents. The information should be printed in the parents' language or translated by interpreters. Even small family child care homes should maintain a list of community resources.

The Healthy Child Care America Web site at www.healthychildcare.org/hccapartners.cfm includes a list of major programs for children and families funded by the federal and state government; where possible, the local or state agencies to be contacted for information about a particular program are included as well. Many federal programs require a state match and are delivered as block grants to the appropriate state agencies to administer. All health departments and child care resource and referral agencies have local resource lists appropriate for ECE programs. The CCHP Web site at www.ucsfchildcarehealth.org also has links to critical services for families.

The Internet as a Resource

The Internet is one of the easiest and fastest means of acquiring up-to-date information. In most cities and counties, Internet access is free to the public through public libraries.

However, CCHCs must ensure that the information they obtain via the Internet is safe, pertinent, and accurate. The Health Summit Working Group convened by Mitretek Systems (2000) established the following seven criteria for evaluating Internet health information. (More information on each of the criteria is provided on the Mitretek Web site, listed in the references section at the end of this module.)

Credibility

To determine the credibility of Internet health information, one must consider its source, level of currency, relevance/utility, and editorial review process.

Content

The content of health information on the Internet must be accurate and complete; an appropriate disclaimer should also be provided. Given that accuracy of content is based on evidence and its verification, the site should identify the data that underlies the conclusions presented. Clinical or scientific evidence that supports a position should be clearly stated.

Disclosure

Web sites should provide appropriate disclosures, including the purpose of the site, as well as any profiling/collecting of information associated with using the site, so users can understand the intent of the organization or individual in providing the information.

Links

Especially critical to the quality of an Internet site are its external links - connections to other internal pages or to external sites that form the web-like structure of information searches within and among sites.

Design

The design or layout of the Web site, including graphics and text, as well as links, is important to the effective

delivery and use of any web-based information, even though it does not directly affect the quality of the information. The design of Web sites can be evaluated in terms of accessibility, logical organization (navigability), and internal search capability.

Interactivity

Web sites should include a feedback mechanism for users to offer their comments, corrections, and criticisms, and raise questions about the information provided. This makes the Web sites accountable to its users. If a site provides a chat room, allowing information to be exchanged among many individuals, an indication of whether a moderator is present should be provided, together with a warning that the information may not be accurate. If a moderator is present, his/her expertise and affiliations, as well as the source of his/her compensation should be identified.

Caveats

The sites that market services and products have different agendas than those that are primary content providers.

Brandt (1996) also recommends the following general guidelines for increasing Internet accuracy and credibility:

- Check reliability and credibility by verifying the author, his or her affiliation, date, and the source of publication.
- Check perspective by assessing biases presented in the information or its source.
- Check the purpose by determining its scope, coverage, and level.

WHAT THE CCHC NEEDS TO DO

CCHCs should establish a link between the ECE program and community resources by maintaining a record of contacts, agencies and organizations in the local community. This includes helping ECE programs develop and maintain community resource files, and urging that resources are kept up-to-date. Organizations, government agencies and other sources should be contacted at least once a year to update information and make certain that they are still available, as it can be very discouraging for staff or families if they are referred to sources that are inappropriate or no longer available. In addition to checking basic facts, CCHCs should check that the file also adheres to CFOC standards (AAP et al., 2002), such as including information about the resources' eligibility criteria for services, hours of operation, costs of services, insurance coverage and languages spoken by the agency staff.

CCHCs should keep in mind that the means of researching services or resources in one state, city or county might not work in another. In researching local and state resources and services, CCHCs should check first with places in their community that might already have an established network of services or resources for families and children, such as the local/state resource and referral agency, libraries, schools, churches, health clinics and community centers.

WAYS TO WORK WITH CCHAs

The CCHA and CCHC can work closely to link the program, families and children to resources that improve their lives. The CCHA can define the particular characteristics of their program to the CCHC to assure the linkages are representative. The CCHA can advocate for meeting the needs of all children especially those children and families with special needs. CCHCs and CCHAs can work together to develop, update, and disseminate community resource lists to families at the time of enrollment and annually thereafter. The CCHC can provide training and support for the CCHA in assessing the needs of families and children and in making referrals to address those needs.

ACTIVITY 1: BRAINSTORMING COMMUNITY SERVICES

Brainstorm the categories of services to include on a resource list for ECE programs. What differences might there be for programs in rural and urban settings?

ACTIVITY 2: COMMUNITY SERVICES CONTACTS

Fill in your local service contacts for the following federal and state programs.

Who are your contacts for TANF/CalWORKs?

_____

Who are your contacts for Medicaid?

_____

Who are your contacts for Early Start?

_____

Who are your contacts for nutrition assistance programs?

_____

Who are your contacts for the Children's Health Insurance Program?

_____

Who are your contacts for Head Start?

_____

What are your other local contacts for children and family services?

_____

ACTIVITY 3: COMMUNITY AND FAMILY RESOURCES SCENARIOS

Divide into groups and role-play or discuss the scenarios below. Spend three minutes presenting the situation and your solutions to the group.

1. Two-year-old Jeremy has just entered an ECE program where you consult as a CCHC. You are reviewing the child's health record, which includes the Physician's Report (form #701) and the Parent's Report (form #702). The doctor has indicated that the child is anemic and overweight. The parent indicates that he doesn't like solid food and loves his bottle so much that he drinks about six times during the day and once at night. What do you think this parent needs? What evidence do you have? What resources and routines in the center or community could improve the situation? How do you present your recommendations to the parent?

2. The Physician's Report also indicates that Jeremy has dental caries in his baby teeth. What do you think the problem is? What routines or resources do you have in your center or community to help this situation? How do you present your recommendations to the parent?

3. The Physician's Report indicates frequent ear infections and possible speech problems. The Parent's Report states that he acts as if he doesn't hear his mother sometimes. What action do you need to take to address the concern? Where could you refer the family if the doctor confirms a hearing loss?

4. The parent reports feeling overwhelmed with all of her child's health needs, since she is also 3 months pregnant and her husband just lost his job and the health insurance that came with it. She has to work while she can and he needs to look for a job. What can you say to determine if she is under medical care for her pregnancy and for her 2 year-old? What can you say to her about her smoking? How can you help her find the support she needs?

5. The Physician's Report indicates that Jeremy has a food allergy and asthma. The parent states that sometimes he experiences serious wheezing. What information do you need about these conditions and where can you get it?

6. Jeremy has been in care for six months and his speech has not improved. His behavior is also causing problems since he frequently bites, scratches and hits other children and has frequent temper tantrums. His mother finds him difficult to manage at home, and has no solutions to managing his behavior. She confides that there is a lot of "fighting" in the house as her husband is still out of work. What are your concerns with this child and family? What assistance can you provide to address the concerns?

Training Skills and Health Education

WHY ARE TRAINING SKILLS AND HEALTH EDUCATION IMPORTANT?

Training of ECE staff improves the quality of their health-related behavior and practices. Good quality training with imaginative and accessible methods of presentation, supported by well-designed materials, will facilitate learning.

WHAT THE CCHC NEEDS TO KNOW

Training and Health Education: What's the Difference?

Training is designed to improve the skills and knowledge related to job performance. Health education is meant to improve health seeking behavior and healthy development.

Training

In the ECE field, training can take place through continuing education programs, in structured classrooms or workshops, or during on-the-job training. On-the-job-training includes many opportunities: the initial job orientation, during the first three months, and when a particular need arises, such as the enrollment of a child who has a special health need, or when an employee needs coaching or corrective action to improve performance.

Training content for ECE professionals is well described in the CFOC regulations and standards. Orientation content also is detailed in the CFOC standards (AAP et al., 2002, Standards 1.023, 1.024, 1.025). The director of any center or large family child care program should provide this orientation with assistance from the CCHA, a mentor teacher, or with support from a CCHC. Documentation of orientation, along with a written documentation of training received by or provided for staff should be kept on file as proof that staff is in compliance with training requirements per state regulations and other legislation such as OSHA.

Community Care Licensing regulations (State of California, 2002) require training in CPR and first aid. Health professionals who deliver this training must comply with these requirements outlined by the Office of Emergency Medical Services Authority (EMSA), which can be found at www.emsa.cahwnet.gov/emsdivision/child_care.asp.

Health Education

For young children, health and education are inseparable. Children learn about health and safety by experiencing risk taking and risk control, supported by adults who are involved with them. Whenever opportunities for learning arise, ECE programs should integrate education to promote healthy behaviors. Health education should be seen not as structured curriculum, but as a daily component of a planned program that is part of child development (AAP et al., 2002, Standard 2.061). Health education for children and staff should include physical, oral, mental/emotional, nutritional and social health topics. Additionally, staff should model healthy behaviors such as eating nutritious food, abstaining from tobacco use at the site, and following hand washing policies.

Parent education topics should be individualized and can also address routine developmental or seasonal topics. Parent education topics related to health promotion are described along with adult learning styles in CFOC (AAP et al., 2002, Standards 2.065-2.067).

There are many community organizations that can provide resources or help with training or health education. Some are listed in the standards. Others are specific to ECE programs such as the California Childcare Health Program, Healthy Child Care America, National Resource Center for Health and Safety in Child Care, and the American Academy of Pediatrics-Early Childhood Linkages System. Local health departments and child care resource and referral agencies can also provide assistance.

CCHCs Must Be Effective Educators

- Trainers must understand how adults learn and fashion their approach to get optimum impact.
- Trainers must be able to deliver an understandable message in the time allowed and be assured that the trainee has received the message.
- Trainers and health educators must have a repertoire of skills and techniques that they can choose from when educating others.
- Training can take place in a formal classroom setting, planned, scheduled and anticipated or it can be an impromptu couple of minutes of on-the-job training.

Techniques to Use in Trainings

Effective opening activities should (Pike, 1994):

- Break participants, preoccupation, so they are not only physically present but both emotionally and mentally present during the training.
- Facilitate networking.
- Be relevant to the training content.
- Be set up so all participants can have success.
- Create curiosity among the participants.
- Be fun!

Adult Learners Have Specific Needs

- Adult learners are highly pragmatic. They have a need to apply what they learn to their own realm and environment. Adults want to feel that the training content is meaningful, worthwhile and applies to their life situation.
- Trainers of adult learners should adapt their materials to the specific audience. Adults bring some knowledge and experience to the table. Trainers who honor and build on this will be more successful.
- An ideal environment for adult learning is one that encourages participation and interaction. Trainers should develop dynamic interactive exercises which promote knowledge and skill development. See Table 4 for a list of various formats that can be used in training sessions.

Seven Conditions of Learning

Adult learners learn more when:

1. They feel a need to learn.
2. The learning environment is characterized by physical comfort, mutual trust and respect, mutual helpfulness, freedom of expression, and acceptance of differences. Successful learners feel supported, never judged or threatened.

TABLE 4: HOW ADULTS LEARN	
Format/Technique	**Lecture (or Mini Lecture)**
Strengths	Efficient means of transmitting facts. Mini-lectures of a few minutes work better in an adult learning setting.
Limitations	Participants may lose interest; no immediate feedback; difficult to verify if facts were understood; minimizes participation.
Format/Technique	**Large Group Discussion**
Strengths	Establishes group identity, so well suited for groups that will meet for training more than once. Allows question and answer participation.
Limitations	Consumes time; difficult to manage; has potential to compromise leadership; excludes shy participants.
Format/Technique	**Small Group Discussion**
Strengths	Allows in-depth discussion; skills practice; exploration; active participation. Good for shy people.
Limitations	A leaderless group may become lost; valuable feedback may not reach the whole group.
Format/Technique	**Role Plays and Real Plays**
Strengths	Simulates real-world situations; generates discussion; allows skills practice; can be entertaining and stimulate interest.
Limitations	Requires a degree of trust among group members; need processing to tie role plays back to the learning objectives of the training; need monitoring and sometimes assistance staying on track.
Format/Technique	**Group Games and Exercises**
Strengths	Stimulate relaxed atmosphere for learning; can make dry facts fun and build camaraderie.
Limitations	May drift off point; must be processed effectively to relate to the learning objectives of the training.
Format/Technique	**Audiovisuals: slides, film/video, filmstrips, models**
Strengths	A good way to demonstrate new skills or illustrate facts; stand in when real-life observation is not possible; taping of participants can also be used as feedback in skills development.
Limitations	Interactive methods (e.g, taping of performance) should be used sensitively.
Format/Technique	**Demonstration/Modeling Behavior**
Strengths	Provides motivation and standards for participant performance; enhances assimilation of skills and correction of mistakes.
Limitations	May cut off creativity. In some instances, may be appropriate following, rather than preceding, role playing by participants.
Format/Technique	**Reading**
Strengths	Can be done without trainer's supervision; allows absorption of large amounts of material.
Limitations	Must be discussed or acted upon for maximum retention.
From Zimmerman, et al, Qualitive Research for Program Development: A Training Curriculum, PATH (Program Appropriate Technology in Health), Washington, D.C., 1991	

3. They perceive the goals of a learning opportunity to be the same as their goals.
4. They accept a share of the responsibility for planning and participating in a learning experience, and therefore have a feeling of commitment toward it.
5. They participate actively in the learning process.
6. The learning process is relevant to and makes use of their experiences.
7. They feel they are progressing toward their goal.

(Knowles, 1984)

Recognize Differing Learning Styles

- Trainers can speak to each of the individual learning styles by varying their techniques. Most individuals learn best when their learning style is acknowledged and the training style addresses it.
- Trainers can use techniques that teach utilizing visual, auditory, or kinesthetic means.

Points to Remember

- You are dealing with peoples' attitudes about the health and medical community.
- You are teaching "about" health, not giving medical advice.
- Health care is a constantly changing field and you need to stay current.
- There are few black and white issues.
- It is necessary to link with health resources at the national, state and local levels.

Issues that Arise in Training and Health Education

- CCHCs will be educating on a routine basis. Assume that formal, planned training for the ECE providers will be a regular duty.
- CCHCs will also be educators on health and safety in ECE programs for children, parents, community, policymakers and funders.
- In many instances, CCHCs will need to effectively deliver a message during a very short period of time, for example, as in on-the-job training for ECE providers and in testimonials in the three-minute time allotment at legislative meetings.
- Many opportunities for teaching come about as the result of the trainer observing situations that need correcting or coaching to improve performance.
- Skilled trainers with relevant field experience are often the most effective trainers.

What the Research Tells Us

Adults learn best when they participate actively in the training process. Effective facilitation skills encourage involvement by showing interest in the participants and making them feel comfortable to comment and ask questions. There are four basic interpersonal communication skills that are used in conducting effective training: attending, observing, listening and questioning.

Attending (non-verbal)

- Face the trainees.
- Maintain appropriate eye contact.
- Move toward the trainees.
- Avoid distracting behaviors.

Observing (non-verbal)

- Look at the person's face, body position and body movements.
- Formulate an inference of the person's feeling based on what you have observed.

Listening (verbal)

- Listen to the thoughts or feelings being expressed.
- Listen to the tone of the voice as well as the words; are participants bored, enthusiastic, uncomfortable, angry?

- Paraphrase what was said to ensure understanding.

Questioning (verbal)

- Ask open-ended questions.
- Respond positively to trainees' answers to questions.
- Respond to trainees' questions by enlisting input of others.
- Always use participatory techniques.
- The more you involve the learner, the more they learn.

(From Zimmerman, et. al., Qualitative Research for Program Development: A Training Curriculum, PATH (Program for Appropriate Technology in Health), Washington, D.C., 1991).

WHAT THE CCHC NEEDS TO DO

Provide Training

The CCHC can assess ECE staff training needs by interviewing the ECE director, surveying staff, observing staff to determine if proper health and safety procedures are used, and reviewing policies related to training. The critical times for training recommended in CFOC are at orientation, three months after orientation, annually, and routinely thereafter every three years (AAP et al., 2002).

The health and safety topics at orientation should include:

- any adaptation required to care for children with disabilities and other special needs
- any health or nutritional needs of children assigned to the ECE provider
- acceptable methods of discipline
- nutrition, food service and food handling
- prevention of occupational health hazards
- emergency health and safety procedures including first aid and disaster preparedness
- illness prevention, including handwashing; diapering; toileting; reducing the transmission of illness; recognizing illness and exclusion of ill children; measures to prevent the exposure to blood; and cleaning and sanitizing the environment
- teaching health promotion concepts to children
- reducing injuries to children, including putting infants to sleep positioned on their backs

CCHCs should assure that staff have up-to-date training materials and resources on the above topics. Coaching staff in correct procedures can be practical for on-the-job training if that is part of the CCHC's role at the ECE program. Otherwise a review of concerns and suggestions for follow-up by the ECE director is useful, especially if tools such as the CCHP Health and Safety Checklist-Revised (CCHP, 2005) are used.

Integrating Health Education into ECE Programs

Assist ECE Providers in Providing Health Education for Children

ECE programs should provide health education to children on a daily basis. It should be integrated into other program activities included in the curriculum. For example, hand washing, tooth brushing, nutrition and exercise are everyday activities for children. These are opportunities for the ECE provider to introduce and reinforce health information, attitudes and behaviors. Because family child care programs may not have a formalized curriculum, their health education activities can be implemented in a more informal way.

Assess the Children's, Staff's and Parents' Health Education Interests and Needs

Help the ECE provider select or develop health

education materials to address these specific health topics.

Provide Health Education for Parents

Parent education will occur primarily through personal contacts between the parent and ECE provider, and between the parent and the CCHC. This may involve consultation sessions, additional support, and/or making referrals to community resources. In addition to personal contacts, CCHCs can help ECE providers design regular health education programs for parents. Parents' attitudes, beliefs, fears, and educational and socioeconomic levels are some of the factors to consider when health education materials and/or programs are planned and implemented for families.

Provide Health Education for Staff

ECE staff should also be provided with health education on physical, oral, mental and social health. Staff often act as role models for children and parents regarding healthy behaviors and attitudes (e.g., eating nutritious foods, not smoking, washing hands, etc.).

The CCHC can play a critical role by providing staff education about health-related topics and/or referring the ECE director to community resources that can provide speakers and materials. Staff education can be offered through many different venues: staff meetings, discussions, workshops, guest speakers, newsletters, site visits (e.g., hospital, emergency room), newspaper and magazine articles, posters, pamphlets, and other audiovisual materials (Kendrick et al. 1995).

Help ECE Providers Chose Health Education Topics

Several CFOC standards list possible health education topics for children and parents. Aronson (2002) suggests that health education efforts for children, parents, and staff can focus on the same topics. This way the adults can reinforce health information the children are learning while simultaneously expanding their own health and child development knowledge. The CCHC can assist in determining priorities among the health education topics so topics can be designated as immediate or long-term concerns. The CCHC can review health education topics the ECE program has selected to include in their program activities. The CCHC can support ECE staff in planning a yearly health education schedule.

A selection of health education topics from CFOC are listed below (AAP et al., 2002, Standard 2.061):

For children:

- body awareness
- emergencies, dialing 911
- environmental concerns
- families (including cultural heritage)
- feelings (including how to express them)
- fitness
- hand washing
- taking medications
- nutrition
- oral health
- personal hygiene
- personal/social skills
- physical health
- rest and sleep
- safety (home, car seats and belts, playground, bicycle)
- self-esteem
- special needs

For parents (AAP et al., 2002, Standard 2.067):

- advocacy skills
- behavior of children (typical/atypical)
- child development
- emergencies—how to handle
- exercise
- first aid

- hand washing and diapering procedures
- prevention and management of infectious disease
- nutrition
- oral health promotion and disease prevention
- parental health (pregnancy care, drugs, alcohol)
- safety (home, vehicular, bicycle, etc.)
- special needs
- stress
- HIV/AIDS
- substance abuse prevention

WAYS TO WORK WITH CCHAs

The CCHC should promote the integration of health education into ECE programs by helping CCHAs to:

- Assess the children's, staff's and parents' health education interests and needs.
- Design health education programs for children, staff, and parents.
- Determine priorities among the health education topics and designate as immediate or long-term concerns.
- Encourage ECE providers to offer educational programs at convenient times and places for parents and staff.
- Support ECE staff in planning a yearly health education schedule.
- Review health education topics the ECE program has selected.
- Develop health education materials to address specific health and child development topics.
- Access appropriate community resources that can provide health education programs and/or materials.
- Assist ECE programs with the development of health education policies and procedures.

(Aronson, 2002)

ACTIVITY 1: DEVELOPING A TRAINING GROUP

Break into small groups and then follow the instructions below.

1. Each group will decide on a relevant educational message and develop a training session to deliver it.
2. For the purpose of this activity, we will assume you are training a group of ECE providers.
3. Plan your presentation on the worksheets provided.
4. After your allotted training time is up, your group will present your training plan to the larger group, who will offer feedback at the end.

Training topic: _____

Training session time: _____

Training audience: _____

Learning Objectives	Materials Needed	Activities

ACTIVITY 2: PARTICIPANT FEEDBACK FORM

Please evaluate the small group presentation using this participant feedback form. Answer each question on a scale from 1 to 5 with a 1 being the lowest rating (negative feedback) and a 5 being the highest (most positive feedback).

Topic:_____

How relevant was the topic?	1	2	3	4	5
Were the objectives realistic?	1	2	3	4	5
Were the materials accessible?	1	2	3	4	5
Did the activities promote the key messages?	1	2	3	4	5
Was the training respectful to adult learners?	1	2	3	4	5
Was the training enjoyable?	1	2	3	4	5

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank You.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

Child Care Health Consultation

1.021	Qualifications for Health Advocates
1.041	Knowledge and Skills of Health Consultants
8.073	Documentation of Health Consultation/Training Visits
9.001	Regulation Of All Out-Of Home Child Care
9.010	Community Participation in Development of Licensing Rules
9.11	Collaborative Development Of Child Care Requirements and Guidelines
9.12 9.024	Child Care Advisory Body
9.13 9.026	Written Plans for Health Department Role
9.14 9.029	Sources of Technical Assistance to Support Quality Child Care
9.15 9.037	Networking
9.040	Program Development

Policy Development

8.004	Content of Policies
8.005	Initial Provision of Written Information to Parents and Caregivers
8.040	Availability of Policies, Plans and Procedures
8.041	Health Consultant's Review of Health Policies
8.044	Written Personnel Policies

Community and Family Resources

8.075	Community Resource Information
9.034	Development of List of Providers of Services to Facilities
9.035	Resources for Parents of Children with Special Needs

Training Skills and Health Educations

1.009	Preservice and On-going Staff Training
1.023	Initial Orientation for All Staff
1.024	Orientation for Care of Children with Special Health Needs
1.025	Orientation During Initial Employment
1.027	Topics Covered in First Aid Training
1.029	Continuing Education for Directors and Caregivers in Centers and Large Family Child Care Homes
1.031	Training of Staff Who Handle Food
1.033	Training on Occupational Risk Related to Handling Body Fluids
1.034	Training Records, Training and Performance Monitoring of Licensing Inspectors
1.060	Health Education for Children
2.061	Health Education Topics for Children
2.064	Health Education Topics for Staff
2.066	Methods for Health Education of Parents
2.067	Parent Education Plan

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

Child Care Health Consultation

None

Policy Development

California Regulations

101173 Plan of Operation

101218	Admission Policies
101217	Personnel Records
101619	Admission Policies (Child Care Center for Mildly Ill Children

Policy Development

None

Community and Family Resources

None

Training Skills and Health Education

None

RESOURCES

Building An Infrastructure: Advocacy and Professional Development

Organizations and Resources	
Organization and Contact Information	**Description of Resources**
Action Alliance for Children 1201 Martin Luther King Jr. Way Oakland, Ca 946125 (510) 444-7136 www.4children.org	Action Alliance for Children exists to inform, educate, and inspire a statewide constituency of people who work with and on behalf of children by providing the most reliable information on current issues, trends, and public policies that affect children and families.
California Children and Families Commission (First 5 California) 501 J Street, Suite 530 Sacramento, CA 95814 (916) 323-0058 www.ccfc.ca.gov	The California Children and Families Act of 1998 was designed to provide, on a community-by-community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services.
Child Development Policy Institute 870 Market Street, Ste. 343 San Francisco, CA 94102 (415) 362-4812 www.childlinkca.org	The mission of the Child Development Policy Institute Education Fund (CDPI Education Fund) is to create a mandate for sound public policy that responds to the diversity of California's children and families.
Child Welfare League 440 First Street NW, Third Floor Washington, DC 20001 (202) 638-2952 www.cwla.org	CWLA is an association of more than 900 public and private nonprofit agencies that assist more than 3.5 million abused and neglected children and their families each year with a range of services.
Children NOW 1212 Broadway, 5th floor Oakland, CA 94612 (510) 763-2444 www.childrennow.org	Children Now is a national organization for people who care about children and want to ensure that they are the top public policy priority. Children Now's Health Policy Program works to ensure that all children have access to high-quality affordable health care, including oral care.
Children's Defense Fund 25 E. Streets, NW Washington, DC 20001 www.childrensdefense.org	CDF provides a strong, effective voice for all the children of America who cannot vote, lobby, or speak for themselves. CDF focuses particular attention to the needs of poor and minority children and those with disabilities.
Children's Defense Fund-California 101 Broadway, First Floor Oakland, CA 94607 (510) 663-3224 phone (510) 663-1783 fax www.cdfca.org	The mission of the Children's Defense Fund is to Leave No Child Behind®, and to ensure every child a Healthy Start, a Head Start, a Fair Start, a Safe Start, and a Moral Start in life and successful passage to adulthood with the help of caring families and communities.

On the Capitol Doorstep 926 J Street # 1007 Sacramento, CA 95814 (916) 442-5431 www.otcdkids.com	Providing information on California and federal legislation affecting young children since 1971, OTCD focuses on child care and development ECE programs. OTCD also follows current legislative efforts relative to child protection; child safety; education; health, mental health and disabilities; nutrition and public assistance.
Parent Voices 111 New Montgomery St., 7th floor San Francisco, CA 94105 (415) 882-0234 www.parentvoices.org	Parent Voices is a parent-led grassroots organization fighting to make quality child care affordable and accessible to all families.

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Consultation, Communication and Problem-Solving Skills

Organizations and Resources	
Organization and Contact Information	**Description of Resources**
National Child Care Information Center (800) 616-2242 www.nccic.org	The National Child Care Information Center is a national clearinghouse and technical assistance center that links parents, providers, policy-makers, researchers, and the public to early care and education information.
National Resource Center for Health and Safety in Child Care (800) 598-KIDS http://nrc.uchsc.edu	The NRC's primary mission is to promote health and safety in out-of-home child care settings throughout the nation.
National Training Institute for Child Care Health Consultants (919) 966-3780 www.sph.unc.edu/courses/childcare	Supports the health and safety of young children in child care settings through the development of a national child care health consultant training program. NTI has developed a state-of-the-art national train-the-trainers approach that includes both face-to-face and self-study components.

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Policy Development

Organizations and Resources	
Organization and Contact Information	**Description of Resources**
National Network for Child Care/ Parent-Provider Contracts and Policies www.nncc.org/Business/p.contracts.policies.html	NNCC unites the expertise of many of the nation's leading universities through the outreach system of Cooperative Extension. Their goal is to share knowledge about children and child care from the vast resources of the landgrant universities with parents, professionals, practitioners, and the general public.

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Community and Family Resources

Organizations and Resources

Organization and Contact Information	Description of Resources
African American Health www.aahn.com	This Web site provides information on a variety of cultural, and health related issues for African Americans.
Association of American Indian Physicians www.aaip.com	AAIP is dedicated to pursuing excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing practices and restoring the balance of mind, body, and spirit.
Centers for Disease Control and Prevention www.cdc.gov	CDC, as the sentinel for the health of people in the United States and throughout the world, strives to protect people's health and safety, provide reliable health information, and improve health through strong partnerships
Closing the Gap: Office of Minority Health www.omhrc.gov/ctg/rh-17.htm	A Newsletter of the Office of Minority Health. Lists links to Web sites for rural minority health.
Healthfinder www.healthfinder.gov	healthfinder® is an award-winning Federal Web site for consumers, developed by the U.S. Department of Health and Human Services together with other Federal agencies. Since 1997, healthfinder® has been recognized as a key resource for finding the best government and nonprofit health and human services information on the Internet. healthfinder® links to carefully selected information and Web sites from over 1,500 health-related organizations. On-line health library.

Healthy People 2010 www.healthypeople.gov	Healthy People 2010 is a set of health objectives for the Nation to achieve over the first decade of the new century.
Immunization Action Coalition 1573 Selby Avenue, Ste. 234 St. Paul, MN 55104 (651) 647-9009 phone (651) 647-9131 fax http://immunize.org	501(c)3 nonprofit organization, works to increase immunization rates and prevent disease by creating and distributing educational materials for health professionals and the public that enhance the delivery of safe and effective immunization services.
Indian Health Service www.ihs.gov	The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.
Inter-Face International 3821 East State St. Suite 197 Rockford. IL 61108 USA (815) 282-2433 fax (815) 282-5417 www.inter-faceinter.com	Inter-Face International helps healthcare organizations reach out to patients and staff of other cultures.
Minority Health Network www.pitt.edu/~ejb4/min	The Minority Health Network (MHNet) is a world wide web based information source for individuals interested in the health of minority groups.
National Academy of Sciences www.nationalacademies.org	(NAS) is a private, nonprofit, self-perpetuating society of distinguished scholars engaged in scientific and engineering research, dedicated to the furtherance of science and technology and to their use for the general welfare.
National Center for Complementary and Alternative Medicine (NCCAM) www.nccam.nih.gov	The National Center for Complementary and Alternative Medicine (NCCAM) is 1 of the 27 institutes and centers that make up the National Institutes of Health (NIH). The NIH is one of eight agencies under the Public Health Service (PHS) in the Department of Health and Human Services (DHHS). NCCAM is dedicated to exploring complementary and alternative healing practices in the context of rigorous science, training complementary and alternative medicine (CAM) researchers, and disseminating authoritative information to the public and professionals.
West Side Health Center/La Clinica www.westsidechs.org	The mission of West Side Community Health Services is to improve the health of the community by providing comprehensive primary care, education, and advocacy for those who are experiencing cultural, economic, and other barriers to health care.

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Handouts from Other Sources

CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes

Maintaining Confidentiality in Child Care Settings

CHILDCARE HEALTHLINE

What is confidential information?

Confidential information is personal details from our lives which we may not want to share with others. It can include our address, phone number, birth date, employment history or other personal information. It may also include information about our past or present health and development. Individuals have the right to keep information of this type private.

Child care programs routinely handle confidential information about enrolled children, families and staff. When managing sensitive information, it is important for child care directors, administrators and staff to be aware of their ethical and legal responsibility to protect the privacy of individuals and families.

Legal requirements

California Community Care Licensing (CCL) Regulations for Child Care Centers require that licensed providers ensure the confidentiality of all records pertaining to enrolled children (CCL, 2002). Files containing confidential information should be accessible only to program staff who must know the information in order to care for the children. Each child's records must also be made available to that individual child's parent/guardian, CCL personnel, or police officers upon request. CCL further requires that programs must inform the parents/guardians of enrolled children that their information will be kept confidential. Programs must explain to enrolled families that their records will be shared only as described above, unless the family gives the program written consent to disclose specific information to others (CCL, 2002).

Confidential contents of records in child care settings

Programs keep individual files for each enrolled child, including but not limited to the following:

- enrollment forms
- family's health insurance information
- health screenings and records, including immunization records
- emergency contact information
- contact information for those authorized to pick up child
- emergency care consent forms
- consent forms (permission slips) for outings or special activities
- names of regular medical or dental providers who know the child
- nutritional restrictions
- progress reports
- child observation logs
- parent conference logs
- medication logs
- documentation of medical, behavioral or developmental evaluations, referrals or follow-ups, addressing issues relevant to the child's participation in the program
- documentation of any injury occurring at the program site and the steps taken to address the situation

How can child care programs ensure confidentiality?

Caring for Our Children, National Health and Safety Performance Standards (2002) recommends that programs create and abide by a written policy which describes how confidential information should be documented, stored and handled. All staff should be familiar with this policy, which should cover all of the specific types of confidential information kept at the program site. Below are some examples of how a program can protect confidential information while providing quality care.

Notification of communicable illnesses. When any child in care is diagnosed with a communicable illness or condition, such as chicken pox, impetigo, head lice and many others, programs are required to

notify the program staff and the families of any children who may have been exposed. Notified families should be instructed to monitor their own children for the development of any symptoms, and to seek medical attention if symptoms do occur. This type of notification can and should be done without mentioning the identity of the diagnosed child.

Children with special needs. Enrolled children may have special needs due to disabilities or chronic health conditions. To ensure their safety, programs often institute policies that have an effect on all of the families in the program. A common example of such a policy is one that prohibits families from bringing some types of food to the program site, to accommodate the restricted diet of another child. A program may institute a peanut-free policy, to protect a child with a life-threatening reaction to peanuts. Or, a program may create a policy prohibiting sugar-laden cakes and cookies at birthday celebrations, to accommodate a child with diabetes, for whom such foods are dangerous.

When creating such policies and notifying other families, keep the affected child's right to confidentiality in mind. Notifications of policies should explain that there is a child in the program whose serious health condition makes the policy necessary. The notification need not mention the affected child by name.

When is it appropriate to disclose personal information?

While the rights and desires of families to keep their personal details private are important, there are also some circumstances under which identifying information should be shared.

Program staff and the "need to know." To ensure the health and safety of children with special needs, teachers, caregivers, and other program staff who interact with the children should be informed of the identities of children with special health concerns on a "need to know" basis (AAP, 2002).

For example, staff who prepare and serve food should be fully aware of which children have food allergies and what each affected child is allergic to. Staff members who monitor the children in the playground should be aware if any children are allergic to bee stings, or if any children have a chronic condition which warrants especially close monitoring during play (such as poorly controlled epilepsy, or diabetes treated by insulin injection). Primary caregivers and back-up staff need to know if any children in care have been prescribed medications, for what reasons, and what the possible side effects are, since they are likely to be administering the medications and monitoring the reaction. Program directors and teachers need to know if there are any un- or under-immunized children in care, so that appropriate measures can be taken in the even of exposure to a vaccine-preventable illness.

Outbreaks of reportable illness. Community Care Licensing Regulations provide a list of certain serious infectious diseases which are reportable in California (CCL, 2005). This means that a child care program *must* report to both the local Public Health Department and to Community Care Licensing whenever there is a known or suspected outbreak of any of these illnesses. During such reporting, identifying information about the affected child, including name, age, and how to contact the family, should be reported.

Known or suspected child abuse. Licensed child care providers are mandated reporters of child abuse. If a child in your care shows evidence of abuse or neglect, you must call Child Protective Services and report the situation. The CPS intake process requires disclosure of the child's name, address, parents or guardian's names, and possible additional details. In this situation, the child's safety and welfare come before the family's right to confidentiality.

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Child Care Health Consultation
Daily Encounter Form **Version 7/10/2002**

Consultant's Name: _____Consultant's ID #: __ __ - __ __ __ __

Today's Date: __ __/__ __/__ __ __ __ (m m d d y y y y)

Day of Week:
Mon Tue Wed Thu Fri Sat Sun

In the designated spaces below, please
(u) list each of the activities you performed today using the Activity Codes provided,
(v) indicate whether the activity was a new (N) or a continuation (C) of a previous consultation (Activity Status),
(w) indicate the ID number of the program, facility, or service site,
(x) indicate how much time, in hours and minutes, you spent performing each activity, and
(y) list the NHS Code(s) applicable to each activity (as many under Additional as apply).

Activity Codes

Must have Activity Status, Service Site ID# & Primary NHS Code

OSC	On-Site Consultation
OSO	On-Site Consultation, Other
TLC	Telephone Consultation
TLO	Telephone Consultation, Other
IEC	Internet/Email Consultation
IEO	Internet/Email Consultation, Other

Must have Activity Status, Service Site ID # & Primary NHS Code

HED	Health Education
TRC	Training-Contact Time
TRO	Training, Other

May have Activity Status and/or Service Site ID # **May** have Primary NHS Code

CDV	Community Development
PDV	Professional Development
POR	Portfolio
RFI	Requests for Information
ADC	Administrative-Child Care
NOT	Non Child Care, Other
DHS	Direct Health Services

Activity Code	Activity Status	Service Site ID #	Time Spent		# Children 0 – 5 yrs @ service site	National Health and Safety Codes NHS codebook you used: ☐ 1992 ☐ 2004	
			Hrs	Min		Primary	Additional
	N C						
	N C						
	N C						
	N C						
	N C						
	N C						
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Total travel time for the day					Record the time, in hours and minutes, you spent physically traveling for child care health consultation purposes. If you did not travel today for child care health consultation purpose please record 0. Do not leave blank.		

Child Care Health Linkages Project
Advocate Daily Encounter Form (ADEF)

Health Advocate's Name: _____ ID #: __ __ - __ - __ __ __

Today's Date: __ __/__ __/__ __ __ __
m m d d y y y y

Day of Week (please circle one):
Mon Tue Wed Thu Fri Sat Sun

For the columns below:

(1) List one activity code (H, R, C, I, A, P, O) that corresponds with the activity you did today. Use a separate line for each activity code.
(2) Write the name of the service site and code the type of facility (H = home, C = center, O = other).
(3) Choose one or more recipient codes to describe who received your services (C, P, S, I, O).
(4) Write the number of children age 0-5 served or affected by your activity.
(5) Indicate how much time, in hours and minutes, you spent performing each activity.
(6) Choose **one** content code to describe the activity.
(7) **Optional:** List additional content codes or notes in the "additional" column.

Activity Codes	**Recipient Codes**	**Content Codes**
H = Health Education R = Referral C = Coordination I = Identification A =Administration P = Professional Development O = Other (Explain)	C = Group of Children P = Parent(s) S = Child Care Staff I = Individual Child O = Other (Explain)	1. Child Development 2. Behavioral Health 3. Special Care Needs 4. Health Promotion 5. Inclusion/Exclusion For Illness 6. Health Records 7. Safety 8. Infection Control 9. Childhood Illness 10. Community Resources 11. Environmental Safety 12. Emergency Procedures 13. Injury Prevention 14. Nutrition 15. Oral Health 16. Staff Health 17. Policy Development 18. Other (Explain)

(1) Activity Code	**(2) Service Site Name and Type**	**(3) Recipient Code**	**(4) # of Children 0-5 Yrs. Served**	**(5) Time Spent**		**(6) Primary Content Code**	**(7) Additional Content Codes and Comments**
				hrs	**min**		
				hrs	**min**		
(8) **Travel Time:** Record the time, in hours and minutes, that you spent traveling. If you did not travel today, record 0. Do not leave blank.							

90/20/8 RULE

90 Minutes

Theory: Average length of time an adult can listen with **understanding**

Practice: Each module should run approximately 90 minutes

20 Minutes

Theory: Average length of time an adult can listen with retention

Practice: Change the pace of the instruction every 20 minutes (e.g., lecture, small group activity, overhead transparency, video, etc.)

8 Minutes

Theory: Learners will retain more of the information if interactive techniques are used

Practice: Try to involve people in the training material every 8 minutes (filling in a worksheet, answering questions, reviewing notes, etc.)

Adapted from Pike RW, 1994

CHERRY'S SEVEN PERCEPTUAL STYLES

A Print-Oriented Learner

- Often takes notes
- Remembers quickly and easily what is read
- Learns better after seeing or writing something
- Grasps important concepts on first reading of material

An Aural (Auditory) Learner

- Tends to remember and repeat ideas that are verbally presented
- Learns well through lectures
- Is an excellent listener
- Can learn concepts by listening to tapes

A Visual Learner

- Learns by seeing or watching demonstrations
- Likes visual stimuli such as pictures, slides, graphs, demonstrations, etc.
- Needs something to watch
- Becomes impatient and drifts away when extensive listening is required

A Haptic (Tactile) Learner

- Involves the sense of touch in learning
- Likes to piece things together
- Is successful with tasks requiring manipulation

An Interactive Learner

- Learns best through verbalization
- Likes to use other people as a sounding board
- Finds small group discussions stimulating and informative
- Prefers to discuss things with others

A Kinesthetic Learner

- Learns by doing – direct involvement
- Tries things out
- Likes to manipulate objects
- Learns better when able to move during learning

An Olfactory Learner

- Learns best through the sense of smell and taste
- Associates a particular smell with a particular past memory
- Finds that smells add to learning

(Adapted from Cherry, 1999)