Research Brief:

National Status of Child Care Health Consultation 2012

National Training Institute for Child Care Health Consultants

UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

Introduction:

The National Training Institute for Child Care Health Consultants (NTI) has been actively engaged since 1997 in preparing Child Care Health Consultant Trainers to enhance the health and safety of young children in child care settings. In 2007 the Education Development Center compiled state profiles providing a comprehensive picture of child care health consultation systems nationally. However, in the past five years information shared by contacts with NTI indicates significant changes to many state and territorial child care health consultation systems. In 2011, in response to an identified need for up-to-date information, NTI developed a national questionnaire to gather data about the current status of state-based child care health consultation systems across the country.

The objectives of compiling this information were to:

I. Support information sharing and collaboration among stakeholders

II. Increase awareness about the challenges facing child care health consultation programs

III. Enhance NTI's ability to provide the highest quality support to state child care health consultation programs and training to Trainers of Child Care Health Consultants

IV. Inform appropriate and targeted advocacy efforts to promote the benefits of child care health consultation at the state and federal levels

Abstract:

Purpose. *The goal of this study was to gain specific state-level data to inform an accurate and comprehensive picture of the status of child care health consultation systems in the United States.*

Design and Methods. *A questionnaire was sent electronically to one contact from each of the 50 states, the District of Columbia, and Puerto Rico.*

Results. *Forty three contacts responded. There are active Child Care Health Consultants serving early care and education programs in 34 states.*

Practice Implications. *By utilizing a wide variety of resources, states are providing health consultation to child care facilities to support healthy and safe environments for young children.*

Methodology:

A questionnaire was developed that included both qualitative and quantitative questions related to child care health consultation program structure, training, funding, state support, and professional associations and directories. Through Qualtrics™ survey software, the questionnaire was sent to one contact from each of the 50 states, the District of Columbia, and Puerto Rico. Forty three contacts (83%) completed the questionnaire. Data were collected in the aggregate and compiled to identify key trends and similarities while respecting anonymity of the respondents.

Findings:

National Presence of Child Care Health Consultants (CCHCs)

Of the 43 contacts that completed the questionnaire, 34 reported CCHCs actively working in the role (*Figure 1*). The nine contacts who reported that CCHCs were not working in their state did not answer subsequent questions.

Components of a Coordinated CCHC System

The 34 states with CCHCs were asked to identify existing structural supports for CCHCs among NTI-named components of a coordinated system including training, resource and referral, networking, mentoring, and funding. Responses with multiple selections were possible (*Figure 2*). Ten respondents reported that each of the five components existed in their state. Four states reported training and resource and referral, and, four others reported having all components except funding. Seven states reported that none of these components existed. Six states reported various combinations of these components of a coordinated system, and three states reported only one component (training).

Collaboration with other agencies was reported in 25 (74 percent) of the 34 states. Collaborators provided/offered information, training and technical assistance, funding, resources, referrals for child care health consultation, inclusion of CCHCs in QRIS, planning and guidance, promotion and advertisement of trainings, invitations to present at conferences, and appointments to steering committees and councils.

State Support for CCHCs

Contacts were asked to indicate how CCHCs were supported other than funding, with the option to select multiple responses. Networking, continuing education and job training were the most common types of support reported by respondents (*Figure 3*).

Participants were asked whether their state had a Quality Rating and Improvement System (QRIS) for child care facilities. A QRIS was reported in 27 of 34 responding states. Six of 27 reported that the utilization of child care health consultation services was included in the calculation of the facility's QRIS rating score.

Figure 1

National Presence of CCHCs N=43

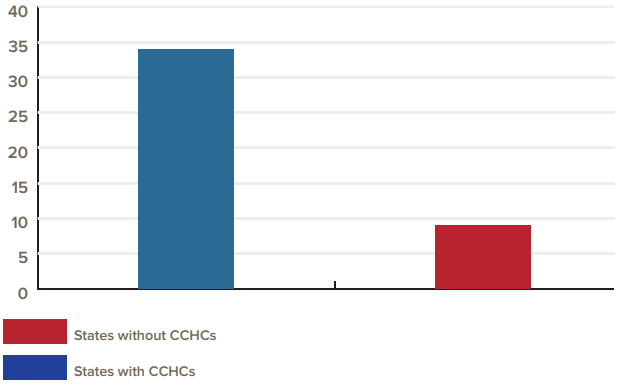
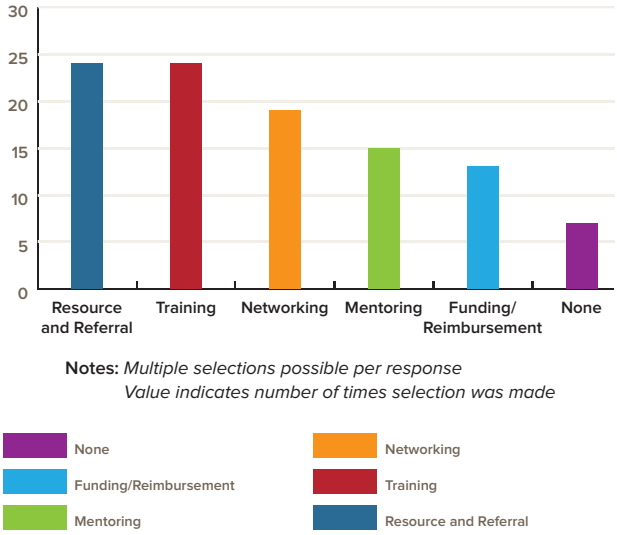


Figure 2

Child Care Health Consultation Systems N=34



Notes: *Multiple selections possible per response*
Value indicates number of times selection was made

In Their Own Words: Collaboration

- "[We] work together to promote CCHC despite the fact that we do not have an organized, funded system...Share current information on outbreaks, evidence based practices, etc. Help share resources like CFOC 3rd ed."

Findings (cont.):

Funding

Data regarding funding streams used to support child care health consultation services were provided by 32 responders with the possibility of selecting multiple sources of funding (*Figure 4*).

It was noted that seven contacts reported their state received no funding or didn't know the source of their funding. The two most commonly reported sources of funding for CCHCs, at least partially, were Title V (15 states) and the Child Care Development Block Grant Fund (14 states).

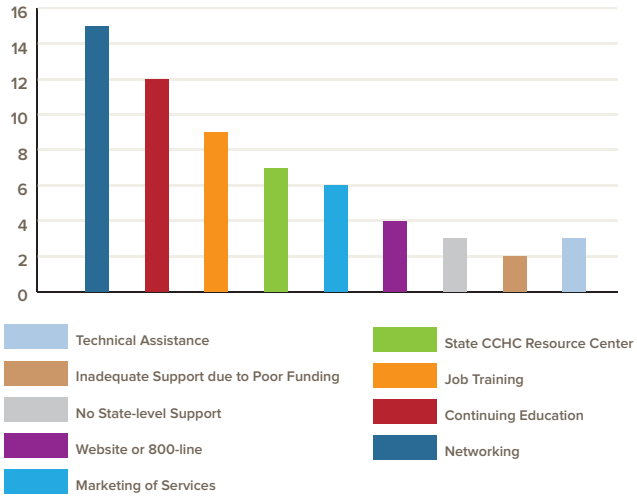
Challenges and Barriers to Success

Key themes in short-answer responses were identified. Some responses contained multiple themes elucidating the complex nature of the challenges facing child care health consultation programs (*Figure 5*).

Insufficient funding was the most commonly mentioned theme, appearing in nearly all responses. Staffing inadequacies were reported by 11 respondents. This included insufficient staffing, high turnover, and a lack of standard requirements for CCHC qualifications and training. A lack of structural and systemic support for CCHCs was reported by nine states. Poor collaboration among stakeholders in child care health and safety was reported in seven responses. A lack of supportive policy and political will was described as a challenge to child care health consultation programming by nine respondents. In seven states, the cost of CCHC services to child care programs was identified as a barrier to utilization of services and program sustainability. Inadequate advocacy for child care health consultation services and insufficient reporting of benefits was reported in seven responses. This included the need for political advocates to prioritize funding for child care health consultation services as well as local supporters to encourage the utilization of child care health consultation services by child care programs.

Figure 3

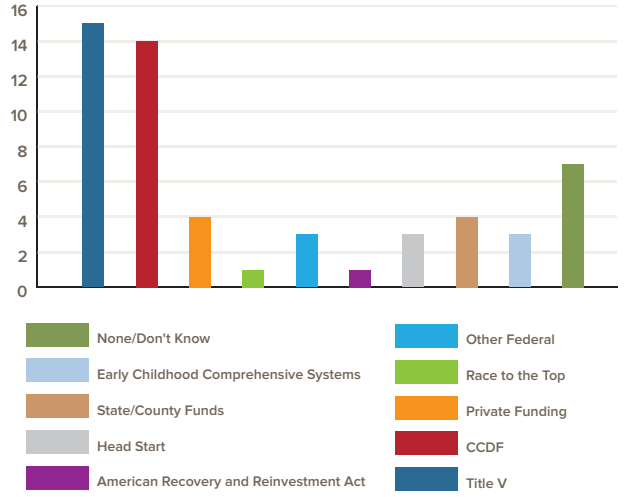
Other Support for CCHCs N=26



Notes: *Multiple selections possible per response*
Value indicates number of times selection was made

Figure 4

Child Care Health Consultation Funding Sources N=32



Notes: *Multiple selections possible per response*
Value indicates number of times selection was made

Findings (cont.):

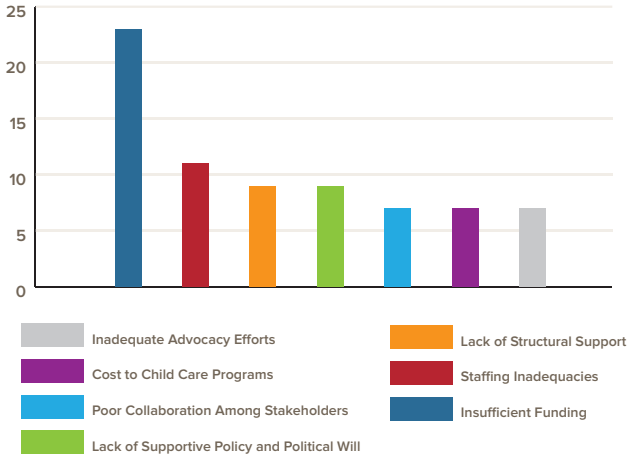
Training

Of 34 states in which CCHCs are actively working, 22 (65 percent) reported that training was being provided for new CCHC recruits. Data indicate this training is exclusively face-to-face in eight states while the remaining 14 states employ a training model that includes a combination of face-to-face and distance learning (*Figure 6*).

- An online training component was reported in eight states.
- The cost for trainees completing CCHC training varied greatly from state to state. Eleven states reported training was held at no cost to the trainees. (In one state this was contingent on being a state-funded CCHC, and in another state, trainees paid an up-front fee of $200 with reimbursement upon completion.) Other states reported costs ranging from $10 to the cost of a three credit college course ($630–$2,631).
- Regarding training duration, two respondents reported having a one-day training, nine respondents reported a training lasting between two to seven days, three states reported training lasting between eight days and one month, and eight contacts answered having a training duration of more than one month.

Figure 5

Challenges to Child Care Health Consultation Programs N=34



Notes: *Multiple selections possible per response*
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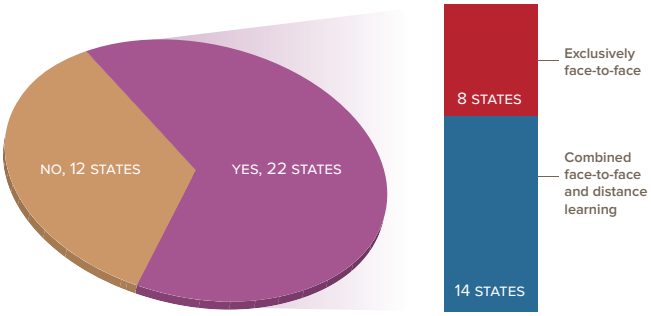
Figure 6

State Training of New CCHCs N=34



Theme	Challenges in their own words...
Insufficient funding	• "Programs have to pay for services on their own and therefore want to limit the time the [CCHC] spends."
Staffing inadequacies	• "Local health jurisdictions (County Health) have many competing priorities for spending health funding."
Lack of structural support	• "Failure to appreciate the role of health and safety in early care and education settings as it related [sic] to school readiness."

Promising Practices:

"*We rely heavily on technology. We have a quarterly email newsletter for CCHCs with resources and information; online training modules during the CCHC training process; and a website with a searchable directory for CCHCs and a secure area for CCHC and NTI trainers to share information, resources, events, etc.*" —Manager, State MIECHV Program

"*I believe the state support from licensing has helped so much. Licensing consultants recommend us to their providers as they see assistance is needed and sometimes even require our visit for approvals of plans of correction.*" —Program Director, Child Care Health Consultants

"*Highlighting the services and approaches of independent CCHCs — We just presented an audio-conference 'Experiences from the Field' that highlights CCHCs in three different parts of the state. We plan to post feature stories from this event on our website and in our quarterly newsletter.*" —Director, AAP State Chapter Child Care Project

"*The CCHC program is unique in that is* [sic] *provides face-to-face training/consultation with a 'hands-on' approach. This allows for a dialogue between trainer/trainee, offering an enriched learning environment. These nurses are the frontline people who take calls from their local child care providers when there is a communicable disease outbreak, or even something small. These relationships have been built over time...so the network has been established and firmly in place.*" —Manager, Child Care Health Consultation Program

"*The state is engaged in a process to look at all consultation/mentoring services. There may also be a shift of training funds to more mentoring and TA [technical assistance]. CCHC would be part of that system. There will also be a registry for these individuals.*" —CCHC

Discussion and Recommendations:

Conclusions

While child care health consultation programs may vary in the resources provided, funding received, challenges encountered, and adaptations made in response to these challenges, there are trends and similarities among states that advocates at the federal, state and local levels would benefit from understanding.

Key themes identified through data collection include:

- Child care health consultation has a significant national presence.
- States with coordinated systems of child care health consultation overwhelmingly recognize that multiple components are necessary to support these services.

Networking, continuing education, and job training are the most commonly offered resources provided to CCHCs.

- QRIS is present in 27 states; however, only six include child care health consultation as part of the rating system.
- Funding streams supporting child care health consultation services are varied and complex, resulting in over two thirds of states recognizing funding as a major challenge to the success and sustainability of these programs.

Discussion and Recommendations (cont.):

The challenges relate directly and indirectly to inadequate staffing and staff preparedness, a lack of supportive resources and policies, and difficulties around utilization of services by child care facilities, among others.

Limitations

The goal of the questionnaire was to obtain data to provide a comprehensive picture of the status of child care health consultation across the United States and its territories. Unfortunately, nine of 52 representatives contacted did not complete the questionnaire. Nonetheless, it was determined through a review of NTI's database that a significant portion of states with active CCHCs responded, providing a representation of child care health consultation programs nationwide.

Only one representative from each state was contacted. Each was asked to compile all necessary data from other sources. Still, because there was no other source from which to cross-reference the data given, NTI cannot be absolutely certain these data reflect a full and accurate representation of the state system.

Recommendations

Based on the results of this nationally distributed questionnaire, the National Training Institute for Child Care Health Consultants makes the following recommendations for future action to strengthen child care health consultation programs across the country:

1) Incorporate, at the very least or require at best, utilization of CCHCs in the calculation of a facility's QRIS rating scores. This would help stabilize child care health consultation programs, increase demand for child care health consultation services, and encourage development of the structural supports necessary to sustain child care health consultation services, which have been shown to improve the overall child care environment and the health and safety of young children in child care[1–7].

2) Improve collaboration among child care health and safety stakeholders to reduce overlap and maximize the benefits of collective efforts.

3) Develop advocates at the local and state levels to promote the benefits and utilization of child care health consultation services within child care facilities and increase financial and policy support for child care health consultation programs within state systems.

4) Increase information sharing among state child care health consultation programs. This will provide an avenue for leaders in the field to benefit from the experiences, lessons learned, and problem solving strategies developed by other states.

5) Devote funding to child care health consultation. One possible option would be to include a percentage of the quality set-aside dollars from the Child Care Development Block Grant to support child care health consultation programs and services.

6) Develop a federal mandate for the inclusion of child care health consultation in Title V Performance Measures. The uncertainty and fluctuation of support for child care health consultation inhibits system development and quality improvement efforts for these programs. Including child care health consultation in Title V Performance Measures would increase sustainability and result in the development of a public health model for supporting child care health consultation.

Discussion and Recommendations (cont.):

7) Provide training and technical assistance to child care health consultation programs. With federal funding, training and technical assistance could be provided to identify program strengths and weaknesses, build state and community capacity, and achieve state program goals. Similarly, the establishment of a coordinated system for training and technical assistance would ensure that resources are in place at all levels to provide the highest quality of child care health consultation possible.

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