Building Consultation Skills
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Training Module

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NOTE TO TRAINERS

This Module represents the combination of NTI's two previous Modules on consultation skills, *Building Consultation Skills Part A* and *Building Consultation Skills Part B*. Learning activities can be found in the six *Building Consultation Skills* Trainer's Toolkits. Each Toolkit includes a Trainer's Guide to leading training sessions, PowerPoint slides, and materials for participants' packets.

For more information about using the NTI materials, please read "Guidelines for Using the NTI Curriculum Materials," available in the "Curriculum" section of the NTI Resources Website (accessed by entering your NTI username and password at http://sakai.unc.edu).

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LEARNING OBJECTIVES

After reading this Module, Trainers will be able to:

Child Care Health Consultation
- Describe the need for and qualifications of a child care health consultant (CCHC)
- Explain the process of effective consultation
- Delineate the seven stages of problem-solving

Cultural and Linguistic Competence
- Develop skills for cultural self-assessment
- Define "cultural competence" and "linguistic competence"
- List strategies to achieve cultural and linguistic competence in the child care setting
- Identify components of effective communication with diverse audiences

Policy Development
- Recall steps for developing child care health and safety policies
- Discuss cost, resource, and review considerations for policy development and implementation

Health Education
- Provide examples of how to incorporate health education topics into daily activities
- Describe guidelines to consider when designing health education materials
- Describe guidelines to consider when developing policies related to health education

Advocacy
- Review the CCHC's role as an advocate for health and safety in the child care setting
- State techniques for being an effective advocate

The Medical Home Model & Home Visiting
- Define "medical home"
- Define "home visiting"
- Discuss the role of the child care facility in supporting medical home and home visiting programs
- Describe the role of the CCHC in supporting medical home and home visiting programs

Resource and Referral
- Identify three different sources for researching available community and state resources
- Name and describe the major federal programs for assisting families and children

INTRODUCTION

The proportion of children in out-of-home childcare has doubled in the past 30 years as more parents return to work and school. Approximately 60% of children who are younger than 5 years in the United States are in some form of child care for at least part of the day. (NCES, 2005) Studies published over the past 25 years demonstrate that participation in child care poses both risks, such as an increased rate of communicable diseases and injuries (Bradely & National Institute of Child Health and Human Development Early Child Care Research Network, 2003; Waibel & Misra, 2003), and benefits to children's health and safety, such as up-to-date health visits and immunizations (Williams & Sadler, 2001).To improve the overall health and safety standards in child care settings, health professionals are being trained as child care health consultants to work with ECE staff and parents to address health and safety issues for children attending child care programs. Consultation is defined most often as a voluntary and time-limited process in which the consultee seeks assistance from a consultant regarding a problem and seeks options for resolution. Child care health consultation involves specific activities, such as health assessment, parent education, and injury control through environmental surveillance. [1.6.0.1] Numerous studies to date (Hanna et al, 2011; Alkon et al., 2009; Crowley & Sabatelli, 2008; Kotch, 2007) have demonstrated a positive effect of health consultation on improving staff understanding of health issues, quality of written policies and attainment of medical homes.

       To date, health consultation has been described as a role focused primarily on improving children's health and safety within the child care environment. The current field of consultation in child care settings has moved to more of a focus on collaboration and the recognition of the influence of outside entities and resources on the traditional relationship between the child care consultant, child care program and family of a young child. The role shift from direct to indirect service in the field of early care and education has resulted in many practitioners graduating from universities without adequate preparation in consultation (Dinnebiel & McInerny, 2000). The interdisciplinary nature of consultation and the wide range of activities involved with this role suggest that many consultants will often not fall under one specific set of guidelines or core principles. In order to address the new direction of the field, this Module will take a holistic approach to the discussion of basic skills needed to perform the duties of the child care health consultant and provide context for how the role fits into the larger early care and education environment. This discussion will begin with a thorough examination of the stages of consultation and the relationship of the consultant to various local and national regulations and standards. The Module will continue with a look at the need for CCHCs to become culturally competent in their interactions with facilities and how an understanding of culture will also impact policy development and health education activities. The final sections of the Module will explore the various forces that impact child care settings from outside the walls of the facility and will include discussions specifically around the CCHCs role in participating in advocacy, providing support to medical homes and home visiting services and making referrals to community resources and services.

This standard states the facility should enroll children who reflect the cultural and ethnic diversity of the community, and provide cultural curricula that engages children and families and teaches multicultural learning activities.

2.3.3.1 – Parents'/Guardians' Provision of Information on Their Child's Health and Behavior, p.80
This standard states all facilities should ask parents/guardians for information regarding the child's health, nutrition, level of physical activity, and behavioral status upon entrance into or after an extended absence from a program.

2.4.1.1 – Health and Safety Education Topics for Children, p. 81
This standard lists possible health education topics.

2.4.1.2 – Staff Modeling of Healthy and Safe Behavior and Health and Safety Education Activities, p. 82
This standard explains how staff members can model healthy and safe behaviors and how health education activities should take place.

2.4.2.1 – Health and Safety Education Topics for Staff, p. 83
This standard lists possible topics for staff health education.

2.4.3.1 – Opportunities for Communication and Modeling of Health and Safety Education for Parents/Guardians, p. 84
This standard states parents/guardians be provided with opportunities to observe staff members modeling healthy and safe behavior and facilitating child development.

2.4.3.2 – Parent/Guardian Education Plan, p. 84
This standard states the facility should develop family-focused education plans, including the consideration of cultural values and beliefs.

3.1.2.1 – Routine Health Supervision and Growth Monitoring, p. 89
This standard states all facilities should require that each child have routine health supervision by his/her primary care provider.

4.4.0.2 – Use of Nutritionist/Registered Dietician, p. 176
This standard states that a local nutritionist/registered dietician with specific early childhood experience should work with the food service staff and contractors.

9.2.1.1 – Content of Policies, p. 348
This standard provides a list of topics for which all facilities should have policies.

9.2.1.2 – Review and Communication of Written Policies, p. 349
This standard states all written policies should be reviewed and updated at least annually.

9.2.3.6 – Identification of Child's Medical Home and Parental Consent for Information Exchange, p. 356

This standard states that as part of the enrollment, the family should be asked to identify the child's primary care provider, his/her medical home, and other specialty health care professionals.

9.2.3.17 – Child Care Health Consultant's Review of Health Policies, p. 364
This standard states all facilities should obtain input and a review of the policies from a child care health consultant.

9.4.1.19 – Community Resource Information, p. 386
This standard explains how facilities should make information about community resources available to families.

9.4.2.4 – Contents of Child's Primary Care Provider's Assessment, p. 389
This standard states that the file for each child should include an initial health assessment completed and signed by the child's primary care provider.

9.4.2.5 – Health History, p. 390
This standard states that the file for each child should include a health history completed by the parent/guardian at admission.

10.2.0.1 – Regulation of All Out-of-Home Child Care, p. 397
This standard states all child care facilities (full- and part-time) be regulated by a state agency.

10.3.4.1 – Sources of Technical Assistance to Support Quality of Child Care, p. 402
This standard explains who should provide technical assistance and what that assistance should address.

10.3.4.4 – Development of List of Providers of Services to Facilities, p. 405
This standard states local regulatory or resource and referral agencies assist facilities in creating and maintaining a list of community resources.

10.7.0.1 – Development of Resource and Referral Agencies, p. 416
This standard explains that states encourage the development of resource and referral agencies to provide specific assistance to child care facilities and others.

Appendix B – Major Occupational Health Hazards, p. 426
This appendix lists occupational health hazards common to the child care environment.

CHILD CARE HEALTH CONSULTATION

What the CCHC Should Know: Standards and Training

The Need for Health and Safety Standards in Child Care
All 50 states and the District of Columbia impose varying degrees of regulation on child care facilities through licensing procedures. These regulations, however, impose only *minimum* health and safety requirements for compliance, or "the floor below which no agency or program should operate" (*CFOC* 3rd ed., 2011, p. xxi). According to Azer et al. (2001), the intent of the state licensing regulations is "to ensure that the care provided is good enough to do no harm to children" (p.1).

In 1990, the National Research Council Report of the National Academy of Sciences recommended that the United States push for higher than the bare minimum standards for health and safety in out-of-home child care facilities. They recommended the adoption of:

> …uniform national child care standards—based on current knowledge from child development research and best practice from the fields of public health, child care, and early childhood education—as a necessary…condition for achieving quality in out-of-home child care (p. 310-311).

In contrast to licensing and regulation, child care standards define a goal of practice that is "legitimized or validated based on scientific or epidemiological data, or when evidence this lacking, it represents the widely agreed upon, state-of-the-art, high-quality level of practice" for child care facilities (*CFOC* 3rd ed., 2011, p. xxi). They are not rigid criteria against which actual child care programs are to be evaluated, but instead represent the level of practice child care programs voluntarily seek to attain.

Recently, many states have sought to provide a bridge from child care licensing regulations to national standards in the form of quality rating and improvement systems (QRIS). QRIS is a system that measures, collects, and disseminates information about the quality of child care settings. Many states supplement their rating systems by providing technical assistance and financial incentives—such as grants and teacher scholarships—to reward and encourage quality improvements. QRIS is a consumer guide, a benchmark for program improvement, and an accountability measure for funding (Mitchell, 2005). It often uses a simple three- or four-star rating to summarize information on quality in multiple domains, such as child/staff ratios and teacher credentials, and presents it in formats, such as interactive Web sites, that parents (the consumers) can easily access and understand. By raising parents' awareness about the importance of quality in early childhood care and education, and helping them identify quality child care programs, QRIS creates incentives for child care programs to improve their services.

Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs: The *CFOC* standards are the highest health and safety standards for child care facilities available in the United States.

Accompanying the standards are specific guidelines or instructions for achieving best practice.

The *CFOC* standards address many of the same issues as state regulations and have the same intended audience—the general child care system in the United States, including both public and privately-funded facilities. The *CFOC* standards, however, go well beyond minimum requirements for health and safety. They emphasize the conditions needed to produce the most favorable outcomes in healthy and safe child care.

The Child Care Health Consultant
To achieve the goal of safer and healthier child care, the *CFOC* standards propose that a facility should identify and engage/partner with a child care health consultant (CCHC) who is a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation.[1.6.0.1] According to *CFOC,* the consultant should be knowledgeable in several areas including the following:

- Indicators of quality early care and education,
- Day-to-day operations of child care facilities,
- Community health and mental health resources for child, parent and staff health and
- The importance of serving as a healthy role model for children and staff. [1.6.0.1]

In addition to the key areas listed above, the Administration for Children and Families (ACF) recently released a guide to core knowledge and competencies, developed by a Region 1 workgroup, for all consultants supporting infants and toddlers in child care settings. This guide aligns with early care and education quality improvement efforts within ACF Region I (the six New England states) and nationally, including state and local QRIS initiatives. The entire guide can be found at this site:
http://transition.acf.hhs.gov/sites/default/files/assets/2011_effective_consultation.pdf

State or local health and child care agencies should support the recruitment of licensed health professionals who meet these qualifications. In recruiting CCHCs, state agencies should also bear in mind ethical guidelines of all consulting associations (e.g., American Psychological Association, 2008; American Association for Counseling, 2005) suggest that consultants provide only those services for which they are qualified.

Nationally, the field of child care health consultation has received tremendous support from the Healthy Child Care America Campaign (HCCA). Launched in 1996 by the Child Care Bureau and Maternal and Child Health Bureau, the campaign developed three priority areas and ten steps for communities to implement in order to support quality child care among states; child care health consultation is one of three priority areas and is specifically designated as a strategy to create an infrastructure of support to promote healthy and safe child care (USDHHS, 1996). HCCA, along with the National Resource Center and the National Training Institute for Child Care Health Consultants (mentioned below), provide support for statewide education and service programs to train child care health consultants.

Fifty states were supported by the Healthy Child Care America campaign to establish linkages between the child care and health communities, primarily through health consultation programs. Although consultation programs are now established in many states, consultants assume different roles and responsibilities depending on CCHC training and professional background, children's health needs, ECE program needs, and administrative support. Few states have published descriptions of their child care health consultation programs or the child care health consultation services provided and there are no published articles describing the activities conducted, content covered, or frequency of visits for different models of health consultation. What is known, broadly amongst states, is that health consultation roles can range from employment at a Head Start or center-based program, employment at a local or state public health agency, private, fee-for-service models or consultation provided on a voluntary basis. Some professional organizations include child care health consultants in their special interest groups, such as the AAP's Section on Early Education and Child Care and the National Association of Pediatric Nurse Practitioners (NAPNAP). Even those programs with a designated CCHC may also choose to supplement services offered with a consultation from a specialty provider.

An alternative and perhaps preferable approach to recruiting individual, fully qualified CCHCs is for state or local agencies to recruit teams of professionals representing a mix of areas of expertise, the combination of which qualifies the team to perform all CCHC duties. For example, in addition to a CCHC, an early childhood mental health professional may be able to provide expert advice on child behavior and conflict resolution[1.6.0.3], an early childhood education consultant may be able to observe the program and review the curriculum and written policies[1.6.0.4], while a nutritionist/registered dietician may have expertise in food preparation/storage and nutrition education in child care.[4.4.0.2]

The National Training Institute for Child Care Health Consultants: The National Training Institute for Child Care Health Consultants (NTI) is a cooperative undertaking of the Department of Maternal and Child Health and the Frank Porter Graham Child Development Institute, both of The University of North Carolina at Chapel Hill. NTI is funded by the Maternal and Child Health Bureau of the Health Resources and Services Administration, US Department of Health and Human Services. NTI was founded in 1997 as the national resource for training instructors of CCHCs in the United States. NTI trains state and regional public health and early childhood education professionals to coordinate and train CCHCs in their community who ultimately serve out-of-home child care programs. The target audience for this training program includes child health, mental health, child care, early childhood education, and child development professionals with training and child care experience. Unless they will be acting as CCHCs themselves, NTI Trainers are not required to be health professionals. The NTI curriculum is intended to teach the comprehensive skills and knowledge needed for child care health consultation training.

What the CCHC Should Know: The Consultation Process
Effective consultation relies on a productive and positive relationship between a consultant and one or more consultees through which they identify the focus of consultation; agree on goals for change; and select, implement and evaluate strategies to address the goals (Buysse & Wesley, 2005).

In addition to the above, consultation also includes the following:
- A structured series of interactions
- A voluntary and professional relationship between a consultant and someone seeking help (consultee)
- A process that instructs the consultee to handle future problems more sensitively and skillfully
- suggestions

Who is Included in the Consultation Process?

In the traditional model of consultation the relationships that form relate in a triadic helping process (Kurpius and Lewis, 1988). Triadic refers to the fact that consultation between the consultant and consultee provides indirect services to third parties (clients). In this model the clients, consultees, and consultants will most likely include the following:

- **Child Care Health Consultant**: a licensed health professional who has a broad and general understanding of many issues related to child health, safety, development, and care; and who should be able to respond to problems presented by the child care staff and recognize problems that might go undetected by the child care caregivers/teachers or families. When appropriate, the CCHC may also invite other experts to assist in the consultation process.

- **Consultee**: may include directors, teachers, or assistants who observes and provides direct services to children and understands the policies and practices of the child care program.
- **Client**: the children and families who are the recipients of the services provided by the child care staff and ultimately the most knowledgeable resource for information on their child.

Ecological Perspective & Collaborative Consultation

The advent of the ecological perspective on human development in the 1970s had a significant impact on intervention programs and idea that health professionals need only focus on the direct provision of services to an individual client or young child. Based in part on Bronfenbrenner's seminal work, *The Ecology of Human Development: Experiments by Nature and Design* (1979), this perspective emphasizes the inextricable link between individuals and their environments within the context of cultural beliefs and social policies. Adapting this perspective to the child care experience helps to demonstrate how children, parents, and child care staff all interact and influence their collective development. An ecological model of health consultation promotes sound health policies and practices within a child care program and recognizes the inherent value of quality care for families and the importance of collaboration across systems. For example, health consultants often review children's health records. If a child's history of asthma is noted, the health consultant might explain the diagnosis to the child care caregivers/teachers and actively solicit parents' concerns and strategies. Additionally, the health consultant could seek parents' permission to contact the child's primary care provider in order to clarify management issues at the child care program. In turn, the health consultant can assist with communicating teachers'

observations of a child's chronic illness, which may assist primary care providers in updating the management plan. When parents understand the purpose of the advocacy role, the health consultant can serve as a liaison among primary care providers, teachers, and parents. This role promotes individualized care for all children and facilitates integration of children with chronic illnesses and special needs for whom coordination is vital (Crowley, 2001).

Effective consultation is grounded in interpersonal relationships. One distinguishing feature of consultation is that consultants must operate on two planes simultaneously; they must manage the sequence of consultation tasks while also concentrating on maintaining the interpersonal aspects of a trusting relationship with the consultee (Wesley & Buysse, 2006). Regardless of discipline, collaboration in consultation has emerged as an important construct. According to Friend and Cook (2000) the defining characteristics of collaboration are (a) voluntary participation, (b) parity among participants, (c) mutual goals, (d) shared resources, and (e) shared responsibility for participation, decision making and outcomes.

Benefits of Collaborative Consultation
The rudiments of effective consultation lie in the collaborative, egalitarian interaction between the consultant and the consultee. In almost every case, collaboration is seen as the answer to an enduring and critical question in consultation – how to increase the likelihood that assistance provided by the consultant successfully solved the problem addressed in consultation.

Collaborative consultation is an interactive problem-solving process with the twofold intent to address the concern at hand and develop expertise in the consultee (e.g., child care staff) so that when a similar concern arises in the future, the consultee will be able to handle it independently. This mode of consultation is encouraged because active collaboration in problem-solving on the part of the consultee is more likely to ensure the success of consultation.

What Collaborative Consultation Does NOT Include: The above description of consultation does not include supervision, regulation, or solving the consultee's personal problems (Erchul & Martens, 2010).

- **Supervision:** If child care caregivers/teachers perceive that the CCHC functions as a supervisor, the CCHC will have a difficult time building a trusting relationship. The CCHC should clarify that the consultee is not obligated to accept his/her advice.

- **Licensing and regulatory activities:** Every state should have a statute that identifies the licensing agency and mandates the licensing and regulation of all full-time and part-time out-of-home care of children, regardless of setting, except care provided by parents or legal guardians.[10.2.0.1]This agency should also formulate, implement, and enforce regulations that reduce risks to children in out-of-home care. The CCHC should be able to interpret standards, regulations and accreditation requirements related to health and safety, as well as providing technical advice, separate and apart from an enforcement role of a regulation inspector or determining the status of the facility for recognition.[1.6.0.1]

- **Personal consulting:** The CCHC-caregiver/teacher relationship deals only with professional problems that are relevant to the health and safety of children and staff in the child care program. The CCHC does not provide hands-on health services (such as screening or immunizations) to individual clients, such as children or staff. Rather, she or he may arrange for others to provide such services or make referrals.

Expert/Medical Mode of Consultation: Although all parties in a consultation relationship ideally work together as equals in the collaborative model, there are situations where the CCHC's expertise may strongly influence the decision-making process. Expert consultation would most likely be required in an emergency or crisis situation where the child care staff needs immediate expert assistance, such as during an acute outbreak of diarrheal illness. This expert or medical mode of consultation refers to advice-giving where the consultant demonstrates certain knowledge and skills that the consultee needs to achieve his/her goals.

The need for the expert mode of consultation is usually intermittent, and even in these situations, the consultee is likely to have knowledge that will assist in resolving the problem. The more actively involved the consultee is in the consultation process, the more likely it is that he/she will gain knowledge and skills that will further his/her capacity to independently manage a similar situation in the future.

Keys to Successful Consultation
Several key elements contribute to successful consultation and apply to all stages of consultation. The following are tips for the CCHC:

Be Prepared
- Have materials and thoughts organized before consultations.
- Develop a list of questions that will help understand the real problem.
- Be prepared for the meeting with a checklist of information typically needed.
- Have some strategies and materials in mind that may be helpful to the situation, but also encourage others to offer strategies and materials.

Keep Communication Open
- Use terms everyone will understand.
- Use feedback as a vehicle for providing positive information, not just negative comments.
- When a caregiver/teacher asks for advice about a child, first ask what they have already observed. This gets the caregiver/teacher involved in the problem and encourages ownership.
- Do not be afraid to do additional research when an answer is not immediately known.
- Whenever possible, use the terms "we" and "us", not "I" or "you".

Be Respectful
- Make a habit of offering positive comments about the caregiver/teacher, the room, and the children.
- Maintain contact so that the child care staff can reach you with questions and feedback.
- Be prompt and reliable.

- Maintain flexibility and an open mind.
- Schedule and follow through on all phases of the consultation.
(Adapted from Erschul & Martens, 2010; Dettmer, Thurston and Dyck, 2004; Wesley & Buysse, 2005)

What the CCHC Should Know: Stages of Consultation

To be effective, the CCHC must know both the needs and the strengths of the consultees and clients with whom and for whom she/he is consulting. The following is a guide for the stages of collecting information and implementing effective strategies for change, adapted from Dettmer, Thurston and Dyck (2004); and Dougherty, 2000.

> **Stages of Consultation:**
> 1. **Prepare**
> 2. **Build the relationship**
> 3. **Assess the situation**
> 4. **Identify the problem**
> 5. **Select an intervention strategy**
> 6. **Implement intervention strategy**
> 7. **Evaluate intervention strategy**

Stage 1: Prepare for Consultation

This stage includes the CCHC developing an introductory statement, assessing his/her personal expertise and problem solving skills, and when a member of a team of consultants, determining which team member can best address the consultee's needs if the consultee's needs are known.

The CCHC should make arrangements to meet the consultee at a convenient time and location where there will be few interruptions. Before the first meeting, the CCHC should develop an introductory statement that includes a schedule of times available for consultations, a detailed scope of services provided, a brief summary of his/her experience, and contact information. The goal of this statement is to establish a clear picture of the CCHC's role and how the CCHC may be best utilized by the child care program. Prior to meeting with the child care staff, the CCHC should also familiarize him/herself with the child care licensing requirements that apply to the facility.

Self-Assessment & Communities of Practice: Self- assessment functions both as a mechanism for identifying one's weaknesses and as a mechanism for identifying one's strengths. In daily practice, the identification of one's weaknesses allows the CCHC to self-limit in areas of limited competence. Second, in reflecting on one's practice in general, the ability to identify weaknesses can serve the function of helping the CCHC set appropriate goals for professional development. At the same time, having a clear and accurate sense of one's strengths allows the professional to act with appropriate confidence and may aid with persistence in the face of initial negative feedback. Prior to consultation, CCHCs should assess their own strengths and weaknesses both in terms of professional expertise and interpersonal skills. They should also assess how their abilities might allow them to contribute to a particular child care program. To facilitate this self-examination, it may prove helpful for consultants to ask themselves the following kinds of questions:

- How do I listen and respond to people at various levels in the child care program, e.g., the director, staff members, or parents/guardians?
- What are my special competencies or areas of expertise?
- How do I think and feel when others disagree with me and confront me on my ideas?
- How do I conceptualize my primary mode of helping: collaborative or expert?

- How do my words and actions exemplify this mode?
- To what degree do I act as evaluator and judge of the providers, child care programs, and families?
- How do I conceptualize my role as consultant?
 (Adapted from Eva & Regehr, 2005)

A CCHC team approach to consultation holds several advantages over individual consultation at this pre-consultation stage. Namely, the team may decide which member (or members) possesses the unique insights and knowledge to best define and facilitate the solution in a specific instance. Through working together, consultants can receive objective feedback and learn from each other's experiences. A promising approach to this type of shared inquiry and learning is to build communities of practice based on diverse expertise and designed to scrutinize and improve the way CCHCs work with staff, children and families. According to Wegner et al. (2002), communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. Communities of practice are a more intentional approach to collaboration, which seeks to develop knowledge collectively through shared goals and team guidelines. Communities develop their practice through a variety of methods, including: problem solving, reusing assets, coordination and synergy, discussing developments, mapping knowledge and identifying gaps.

Stage 2: Build the Relationship
At the outset of the consultation, the CCHC should present the introductory statement and make efforts to build a good working relationship. These efforts should include gathering information about:
- The philosophy of the child care program
- Staff roles and relationships
- The types of families served
- Relationships with other health professionals and with regulatory/licensing professionals

The CCHC should then begin to set an agenda with the child care staff that is based on the needs of the program.

The most common barrier to successful consultation at this stage is not putting in the effort to learn about the child care program and the children and families being served. A good faith effort to learn about the program will facilitate relationship-building and will contribute to successful problem-solving. The CCHC should spend ample time establishing rapport and mutual trust.

Stage 3: Assess the Situation
Once the CCHC has established a good working relationship with the caregiver/teacher, he/she can begin focusing on the consultee's specified need. The director or caregiver/teacher may have a particular issue that is brought to the consultant's attention, or the consultant may be asked to review the overall health and safety status of the child care facility. In either situation, the CCHC should take the following steps to assess the situation:

- Collect information through discussions, observation, and record review
- Record, assess, and summarize data
- Recognize strengths and weaknesses in the program

One good strategy is for both the CCHC and consultee to complete the observation assessment tool and then compare notes. This helps build an understanding of each participant's values and perceptions, which is critical to the problem-solving process to follow.

Stage 4: Identify the Problem
Problem-solving is the heart of the consultation process. Steps for problem solving include the following:

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

How to Identify the Problem: Accurate problem identification is essential for problem resolution (Kratochwill & Pittman, 2002). Adequate conceptualization and identification of a program's problem often requires a considerable amount of time and effort.

To successfully conceptualize the presenting problem and obtain information on how she or he can be of help, some questions a CCHC may want to ask include:
- Can you tell me about your situation?
- Who is affected by this problem?
- How long has it been going on?
- When did it happen last?
- Who else is involved?
- What have you already tried?
- For what reasons do you think previous interventions were unsuccessful?
- 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 Dougherty, 2008)

Stage of the Problem: Knowing the stage of the problem may help the CCHC to form better questions about the need for help. Listening to the caregiver/teacher as he/she describes the problem or responds to the CCHC's observations will help determine the stage of the problem. Kurpius, Fuqua, and Rozecki (1993) propose that presenting problems tend to fall into one of four stages, with each stage characterized by unique consultee needs and reactions as presented in Table 1 below.

Table 1: Stages of Consultation Problems

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 she/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, Fuqua, and Rozecki, 1993)

The Importance of Consensus in Defining the Problem: To define the problem, collecting valid and reliable information is essential. The CCHC should involve the child care staff, and in many cases the client, in both the collection and interpretation of the data.

Attempting to cause unwanted or unsanctioned change can interfere with the consultation. The CCHC should make an effort to ensure that all parties involved in the consultation see eye-to-eye on the source of the problem. The CCHC should also take care not to try fixing what isn't broken. The most important skills in consensus building are good listening skills (see the section on "Active Listening Skills" in this Module) and patience not to move forward until everyone agrees.

Stage 5: Select an Intervention Strategy
Once a problem has been defined and accepted by the CCHC and consultee, the CCHC's task is to assist in developing an intervention strategy. Human interventions are focused on changing knowledge, beliefs, feelings, motivation, and/or behavior. Structural interventions are focused on changing policies, procedures, and physical features in the child care environment.

The following are steps to selecting an effective intervention:
- Use collaborative problem-solving to generate possible strategies and discuss consequences of each.
- Select the most feasible and potentially successful strategy, preferably one that utilizes the strengths of the child care program and requires minimal guidance from the consultant.

- When possible, select an intervention with a proven evidence base. This will help to
  ensure that the steps to follow flow from an already proven strategy and will provide an
  additional layer of academic rigor to the consultant-consultee relationship.
- Consider the resources needed to implement the strategy and confirm that they are
  available.
- Incorporate a timeline and evaluation plan into the strategy.

Some common mistakes CCHCs make at the stage of selecting an intervention are to work alone and/or to be ambiguous about the needed intervention. The CCHC should not neglect to involve others in setting goals or in the technical assistance process. To avoid ambiguity, the CCHC should recruit others to assist with developing the best intervention plan. Before the intervention can be implemented, all parties need to be very clear about what steps are involved. The CCHC should also remember that the consultation process is collaborative and he/she must be prepared to accept that his/her advice may not always be taken.

Stage 6: Implement Intervention Strategy
Once an intervention has been selected and agreed upon by all parties, the CCHC should assist with implementing the plan. This includes monitoring the process and progress of the plan for evaluation purposes and providing any technical assistance or links to resources that may be required. An important element of implementation is also having the flexibility to change course if the proposed intervention does not seem to work. It is especially important that the CCHC, consultee, and clients not expect immediate results. The solution may take some time, and the CCHC should make an effort to acknowledge the hard work and accomplishments of others along the way.

Stage 7: Evaluate Intervention Strategy
For effective consultation, the process and progress of the chosen intervention needs to be evaluated. Evaluation provides an opportunity to identify barriers, to adjust the plan with the barriers in mind, and to recognize that often a problem can only be partially resolved. The evaluation is also an opportunity for the CCHC and child care staff to discuss how the intervention could be used in future situations. Evaluation should be ongoing rather than occurring only at the end of the process and should include the following steps:
- Evaluate progress and process of consultation
- Reassess periodically
- Evaluate the effectiveness of the intervention upon completion
- Provide positive reinforcement for changes
- Adjust plan as needed or bring closure to consultation process

Evaluating an intervention strategy is part of a larger activity important to the CCHC, which is reflective practice. Reflective practice is the means by which learning, renewal and growth continue throughout the development of career professionals (Steffy et al, 2000). The shift toward an interest in reflective practice has come about partly as a reaction to a more simplistic view of consultation that dominated the field in the past and which has been replaced with a view that is more reflective of the complex relationships and interdisciplinary nature of consultation as it stands now. Reflective practice allows a CCHC to process

situation-specific dilemmas that come about during the consultation process and can be done individually or through formal/informal communication with a supervisor or colleague.

How to Enhance Problem Solving Skills in Child Care Staff: One of the major goals of consultation is to improve the child care staff's problem-solving skills so that they are better able to independently address similar problems in the future; the transfer and generalization of skills must be incorporated directly into consultation by training consultees directly in relevant problem-solving, communication, and intervention techniques. The integrity in which the consultant-consultee developed intervention is implemented and the relationship formed during the consultation process will greatly affect the success of this transfer of skills. According to Lewis and Newcomer (2002), the efficacy of the transfer of problem-solving skills is also influenced by the consultant's ability to: (a) employ evidence-based decision making, (b) work in teams, and (c) "goodness of fit" between problem and chosen intervention. It is important to highlight this last point and the consistency the consultant is able to employ throughout the consultation process and the effect this has on consultee "buy-in" after termination of the relationship.

The CCHC should always take care to finish the consultation with a formal plan for closure. Child care staff should never be surprised by an announcement that, "Today is the last time we will meet!" Formal closure means returning to the model of consensus building to ensure that everyone is ready to conclude the collaboration. The CCHC may step out of the relationship before the intervention is complete, but she/he should ensure that the consultee is prepared to move forward with a plan for completing the intervention.

Action Items for the CCHC
- Encourage child care staff to implement the *CFOC* standards in order to promote and establish best practice of child care health and safety in their facilities.
- Enhance the ability of the child care program to provide high quality care by acting as a resource to arrange for health services and health education. For example, there may be times when the CCHC and child care staff are unable to solve a problem together. The CCHC should then serve as a link between the program and qualified experts, such as mental health specialists, early intervention specialists, or certified playground safety inspectors.
- The CCHC should make an effort to establish a collaborative mode of consultation, and he/she should also be able to recognize when an expert mode is valuable
- 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 provide community resources and referrals for health, mental health, and social needs.[1.6.0.1]
- Direct the consultation process through the seven stages described above, utilizing the skills outlined in the next major sections including cultural and linguistic competence, policy development, advocacy, health education, and resource and referral.

Cultural and Linguistic Competence
According to the National Center for Infant and Early Childhood Health Policy, "If a[n] [early childhood] service system is to be effective, it must address the culturally diverse needs of *all* the children it is designed to serve" (Sareen, Russ, Vicensio, and Halfon, 2004, p. 5). In addition CFOC states that programs "should educate staff to support the cultural, language, and ethnic backgrounds of children enrolled in the program" and participate in diversity training. [1.4.5.4] Therefore, the CCHC should model cultural and linguistic competence in his/her interactions with child care caregivers/teachers and families, as well as play an important role in ensuring cultural competence within a child care facility.

Camphina-Bacote (2002) lists two of the most critical elements in building cultural competence in the child care setting as cultural self-awareness and knowledge of information specific to other cultures. This section of the module will explore how to achieve cultural self-awareness and begin on a path toward cultural competence, as well as how to communicate effectively with diverse individuals.

What the CCHC Should Know: Cultural Self-Awareness
To fully appreciate the diversity that exists among people with whom she/he works and lives, the CCHC must first understand his/her own culture. The first question to ask is, "What is culture?" A common definition that is used in the field of cultural anthropology says that culture is "a system of shared beliefs, values, customs, behaviors and artifacts that members of society use to cope with their worlds and with one another, and that are transmitted from generation to generation through learning" (Bates and Plog, 2002). Individuals may belong to more than one cultural group, which can be based on such broad categories as ethnicity, gender, geographic area of residence, religion, profession, sexual orientation, socio-economic status, and so on.

Based on work by Jean Moule (2008), the CCHC must follow two sequential steps to achieve understanding of his/her own culture. First, the CCHC must define his/her unique cultural heritage by answering questions about his/her own family, such as their place of origin, when and why they immigrated, where they first settled, and foreign languages that were and still may be spoken. The CCHC can also learn a lot about family if she/he seeks answers to questions about political leanings, jobs, education, social status, and any economic, social, or vocational changes made in previous generations.

The second step is to examine the values, behaviors, beliefs, and customs within the CCHC's own cultural heritage. Only after the CCHC has assessed his/her own attitudes and values toward diversity is she/he able to promote understanding and appreciation of the diversity that exists among everyone.

Characteristics of Cultural Self-Awareness
Cultural self-awareness includes an understanding of the following:
- One's perceptions of other cultures are influenced by one's own world view and are not independent from culture.
- Cultural biases may be at a conscious or subconscious level.
- Values, beliefs, and practices related to health, health care, illness, and well-being are one's own and often influenced by culture as well as societal norms.
- Health and mental health disparities exist among racial and ethnic groups.

- Self-assessment and reflection can have a positive impact on cultural and linguistic competence, for both individuals and organizations.

(Adapted from Goode and Dunne, 2004)

An excellent cultural self-assessment tool has been developed by Tawara Goode of the Georgetown University Center for Child and Human Development (2004). It is called the "Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care." (See "Where to Find More Information" for a link to this tool.)

What the CCHC Should Know: Cross-Cultural Competence

What is Cultural Competence?
Someone who is culturally competent has the values, behavior, knowledge, and skills to work effectively cross-culturally. Alongside those four basic aspects of competence is the respect for all cultures and an understanding that cultural competence is a dynamic process in which there is always room for growth.

While there is no universal definition of cultural competence, some of the key principles of cultural competence for organizations include the ability to:
- Value diversity in families, staff, caregivers/teachers, and communities
- Have the capacity for cultural self-assessment
- Be conscious of the dynamics inherent when cultures interact, e.g. families and caregivers/teachers
- Institutionalize cross-cultural knowledge
- Adapt programs to reflect an understanding of cultural diversity

For individuals, the key elements include the ability to:
- Examine one's own attitudes and values about culture
- Acquire the values, knowledge, behaviors, and skills for working in cross-cultural situations
- Remember that everyone has a culture deserving respect

(Adapted from MCHB, 2005)

Cultural competence develops over time in a process of self-assessment, learning, and acquiring new skills. A helpful chart for thinking about how cultural competence exists on a continuum was developed by the National Center for Cultural Competence and is printed on the following page:

Figure 1: Cultural Competence Continuum[1]

(Goode, 2004)

A culturally competent CCHC is one who helps to design and implement policies and services that meet the unique needs of the children, families, and communities served. The CCHC can learn about other cultures by reading, observing, listening, and asking questions. One possible way to learn is by talking personally with members of another culture, such as friends, colleagues, or neighbors with whom there is an established degree of mutual trust and respect.

Characteristics of Cross-Cultural Competence
A culturally-competent CCHC embodies the following characteristics:
- **Ability to recognize cultural bias**: CCHCs should be aware of their own cultural biases as well as historical and institutional biases that exist in their communities. This includes sensitivity to how potential biases may affect caregivers/teachers , children, and their families, and how biases can best be addressed.
- **Willingness to learn about other cultures**: one should not assume he/she has learned everything about a culture. Respect and openness are critical to culturally-competent relationships.
- **Flexibility**: a culturally-competent CCHC is willing to adapt services in order to honor different cultural values and practices.
- **Sensitivity to power relationships**: CCHCs should always be aware of power relationships between themselves, caregivers/teachers, and families, as well as within families.
- **Cross-cultural communication skills**: CCHCs should be skilled in communicating with culturally diverse groups and individuals. The following section on linguistic competence will explore tips for improving cross-cultural communication.
(Adapted from Sareen, Russ, Vicensio, and Halfon, 2004)

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[1] The characteristics of each of these steps can be found online at the following URL: http://www.ncccurricula.info/framework/B3.html (It is free, but you may have to register in order to have access.)

Please note that when referring to this chart, the term "Cultural Blindness" deserves a bit of attention. The term may appear to some to have a negative connotation, but it is actually at the mid-point of the continuum along with "Cultural Pre-Competence" — neither positive nor negative. It is a term that is current in the field of cultural competency and usually does not cause offense. However, CCHCs should use sensitivity when promoting this continuum model.

The process of becoming culturally competent for a CCHC is similar in some ways to the consultation process itself in that it should ideally involve clear, open communication, recognition of the strengths and background participants bring to a relationship and the flexibility to forgive mistakes when they are made. The use of the word *process* here is key. As with consultation, cultural competence exists on a continuum and the journey to reach the final stages will come with some bumps along the road. The idea is not to prevent mistakes, but instead to use them as teachable moments when they occur and recognize that they are opportunities for child care staff or a CCHC to learn from persons of a different culture from their own.

Cultural Competence and Health Beliefs: For CCHCs, it is especially important that the diverse health beliefs held by different cultures be respected through the consultation process. Health beliefs are the beliefs that people have about the causes, treatment, and prevention of sickness and injury. Health beliefs can also impact feelings and decisions about child development, mental health, and education.

The CCHC should always prepare for differences in health beliefs. A CCHC who has been trained to have a certain understanding of health and health care may end up making recommendations that are not accepted by others because of differences in health beliefs. The CCHC must be open to learning about and respecting health beliefs that differ from his/her own. Some examples of health beliefs that may differ from those of the CCHC include different expectations about toilet training, a preference to receive care from lay or alternative healthcare providers, or a belief in spiritual rather than physiological causes of illness.

Health beliefs particularly come into play when the CCHC and childcare staff create policies and practices that impact the behavior of parents/guardians in the home. For example, many cultures and religions have different perspectives on immunizations and also on dietary requirements and nutrition. It is important for CCHCs and/or child care staff to discuss goals with parents/guardians to ensure that proposed policies and practices align as closely as possible with the health beliefs of the family (Sareen, Russ, Vicensio, and Halfon, 2004). Health beliefs are strongly held and must be dealt with respectfully—even those that are dangerous or counter to the CCHCs recommendations.

Family-Centered Care: The Maternal and Child Health Bureau of the US Department of Health and Human Services (2005, p. 1) offers the following definition of family-centered care:

Family-Centered Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.

Because family-centered care is based on honoring cultural and family traditions by developing family-centered policies and practices, it is consistent with the principles of culturally-competent care. Family-centered care is also "consistent with the medical home model - an approach to providing an entire range of high quality cost-effective health care to

families by a health care provider whom they know and trust" (Sareen, Russ, Vicensio, and Halfon, 2004, p. 9). See page 48 of this Module for a definition of the medical home model.

All of these factors have contributed to a greater recognition of the role families have within child care. This approach recognizes that parents' well-being and sense of self are critical factors in children's long-term outcomes; therefore, the emphasis is on enhancing the development of children and supporting parents. Teachers and parents build a relationship based on mutual respect for each other's expertise. Teachers contribute a broad background and knowledge of child development, while parents share their understanding of their own child and cultural traditions. While teachers continue to be an important source of knowledge, the family-centered child care approach advocates the centrality of parent participation in decision making and policies. The child care program provides comprehensive services specific to the needs of families, and it functions as a link to the community. It serves as a hub for emotional, social, and practical support. Child care health consultation, which focuses on child health within the context of family health, much like a family- oriented approach to early childhood education, recognizes and respects the central role of families in child care and other influences, including primary care providers and other community resources. The health consultant expands the concept of family centered care by empowering families in the area of health (Crowley, 2001).

Some methods CCHCs can use to ensure that family-centered care is being provided to all the cultural groups served by their child care facilities include:

- Remember that *family* is defined differently by different cultures.
- Ask parents/guardians about family-centered care and cultural competence on satisfaction surveys.
- Ask child care staff if they are satisfied with their interactions with families.
- Involve the families of children served in as many decisions as possible, including policy-making, curriculum development, etc.
- Negotiate with families when beliefs and practices differ from those established in the facility.
- Help connect families with community resources.
(Adapted from MCHB, 2005; Sareen, Russ, Vicensio, and Halfon, 2004)

What the CCHC Should Know: Linguistic Competence

The CCHC cannot be effective without the ability to both receive and communicate complex information to audiences that may include child care staff, community partners, families, and children. The purpose of communication may change dramatically from audience to audience, but a strong foundation in basic communication skills and linguistic competence will serve the CCHC in all situations. Some of the different arenas of communication that the CCHC may enter include building personal relationships with individual caregivers/teachers and families, delivering health education messages, collaborating with other service-providers in the community, and engaging in advocacy at the community or government level.

What is Linguistic Competence?

Linguistic competence means the ability to communicate sensitively with a diverse audience. It includes both good communication skills and cultural competence. The following definition, developed by the National Center for Cultural Competence, provides a foundation for determining linguistic competence:

> The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.
> (Goode and Jones, 2004, p. 1)

Communication Skills
The CCHC needs to have effective communication skills to achieve linguistic competence.

Active Listening Skills: Active listening is the cornerstone of effective communication. Listening consists of four steps: (1) receiving the message, (2) paying attention to the message, (3) understanding the message, and (4) 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 the message is understood. The characteristics of active listening are described as:
 - Attentive
 - Non-evaluative, non-judgmental
 - Conveys understanding or desire to understand
 - Feedback has a respectful tentativeness or a questioning tone which leaves the sender room to clarify or correct
(Adapted from McNaughton et al., 2007)

Table 2: Examples of Feedback

Feedback	Purpose	Example
Encouragement 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…"

(Adapted from Young, Downs, and Krams, 1993)

Tips for Effective Communication: The CCHC should remember a few aspects of good communication that apply to all audiences and communication styles:

- **Collaboration**: avoid giving orders or lecturing and make sure all participants have a say in developing solutions
- **Clarity**: avoid clichés, professional jargon, and acronyms
- **Positive outlook**: start the conversation with praise and avoid judging, criticizing, threatening, or belittling
- **Honesty**: don't offer false praise or deny that a problem exists
- **Open-mindedness**: don't assume to have all the answers and avoid moralizing, labeling, and diagnosing or interpreting a situation before all have spoken

(Adapted from Young, Downs, and Krams, 1993)

Bias, Stereotyping, and Derogatory Communication: Health and mental health care organizations and their personnel are not immune to bias, prejudices, discrimination, and the broad range of "isms" (e.g., sexism, ageism, racism) in US society. It is inevitable that CCHCs will encounter bias in themselves, their clients and their families, colleagues, supervisors and administrators, and in the communities they serve. CCHCs need to master two critical skills: (1) monitoring their verbal and non-verbal communication for expressions of bias and stereotyping and (2) intervening in an appropriate manner when biases are expressed by others. The CCHC should make clear statements that such bias and/or stereotyping is unacceptable.

Communication Styles
Communication styles vary across cultural groups. One of the most important distinctions is between the more direct style of some cultures and the indirect style of others. Communication between these two cultural types often leads to misunderstanding and dissatisfaction for both, especially when communication is limited by time-constraints. Direct communicators may come across as abrupt, rude, and insensitive. Indirect communicators may seem uncommunicative, unclear, and evasive.

Cultures which rely heavily on understanding through shared experience, history, and implicit messages are more attuned to nonverbal cues (Knapp & Hall, 2009). For some, fewer words are spoken and less emphasis is placed upon verbal interactions. Other cultures focus on precise, direct, logical, verbal communication and often are impatient with communicators and communications that do not get to the point quickly (Gudykunst, 2003). Body movements (or kinesthetics), such as eye contact, posture, or facial expressions, have different interpretations among different cultural groups. Similarly, cultures differ in the amount of physical distance with which they are comfortable (Gudykunst, 2003).

Of course, these are just generalizations and consultants should enter into communication with as much of an open mind as possible. The key to effective communication is to take the time to learn about the communication style of the audience and adapt as best as possible to that style. For a large and diverse audience, this may mean using more than one communication style to make a point. Also remember that an individual may have a communication style that is different from others within their culture.

The CCHC should also consider how the following might affect communication:

- **Literacy:** A national study completed by the National Association for Adult Literacy (White & Dillow, 2005) demonstrated that 40% of their sample had basic or below basic reading skills and may be unable to read or understand policies, flyers, or posted notices.
- **Communication with people who experience disabilities**: A person's capacity to communicate may be impacted by many factors, including but not limited to: speech or language disorders, hearing loss, low vision or blindness, developmental disabilities, and mental illness.

Action Items for the CCHC
- Engage in cultural self-assessment to learn about his/her own culture and recognize his/her own cultural beliefs and biases.
- Learn about other cultures and cultural beliefs.
- Remain sensitive to cultural power relationships through the consultation process.
- Adapt programs, and curricula to reflect cultural diversity.[2.1.1.8]
- Promote family-centered care in the child care environment.
- Practice linguistically-competent communication skills.
- Assist the child care program in identifying a staff member or consultant to speak with parents/guardians and children, including families whose native language is not English.[2.1.1.7]
- Apply the values and skills of cultural and linguistic competence to all aspects of the consultation process, including policy development, advocacy, health education, and provision of resources and referrals.

POLICY DEVELOPMENT

Written policies in the child care setting are critical to guaranteeing the safety and health of young children in care. The CCHC can be instrumental in helping child care staff and parents/guardians establish and follow site-specific policies.

What the CCHC Should Know: Health and Safety Policies

Standards Related to Child Care Policies

Management Plan: "The child care facility should have policies to specify how the caregiver/teacher addresses the developmental functioning and individual or special health care needs of children of different ages and abilities who can be served by the facility" [9.2.1.1] (*CFOC*, 3rd ed., 2011, p.348).

Statement of Policies: Formal written policies should be developed and implemented for the topics outlined in *CFOC* standard 9.2.1.1. Since the standards are national in scope, it is important the CCHC and others using them to develop policies also take into account any state, county, or city laws and regulations.

In addition to the *CFOC* standards, *Model Child Care Health Policies* (Aronson, 4th ed., 2002) can also guide child care policies. This document includes information on developing and writing policies, as well as examples of recommended policies that can be easily adapted to suit the needs of the individual child care facility. *Model Child Care Health Policies* can be accessed online at the following URL:
http://www.ecels-healthychildcarepa.org/content/MHP4thEd%20Total.pdf

Aronson (4th ed., 2002) recommends that child care facilities establish policies for children and staff in the following areas:
- Admissions
- Supervision
- Discipline
- Care of acutely ill children
- Current health plan for each child
- Medication
- Safety surveillance
- Emergency illness or injury plan
- Evacuation plan, drills, and closings
- Authorized caregivers
- Transportation and field trips
- Hygiene and sanitation
- Food handling and feeding
- Sleeping
- Smoking, prohibited substances, and guns
- Staff employment
- Design and maintenance of facility

- Review of policies

Developing Written Health and Safety Policies

A health policy is a written plan developed by a child care program that includes guiding principles, practices/procedures, and the means for achieving the program's health goals.

At a minimum, written policies must specify how the program intends to comply with the state regulations. Ideally, they support the best practice recommendations found in *Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs* (*CFOC,* 3rd ed., 2011).

Steps of Health and Safety Policy Development: The CCHC is in a unique position to assist child care programs in identifying the need for a written policy, writing the policy, and continually reviewing and revising the policy. Early in the relationship-building process, the CCHC might find it helpful to meet with the child care staff , parents/guardians, and other child health professionals to read through existing policies, consider any issues, and clarify what will happen if the policies are not followed. In most cases, a safety concern may be the primary reason why a policy needs to be written or revised. The implementation of policies is easier if all parties are involved in creating the policies, are educated about the policies, and understand the necessity and importance of adhering to them. The following section outlines specific steps in the development of a child care health policy.

1. **Identify the child care program's perspective**
   - Know what viewpoints the child care directors, staff, parents/guardians, and other health care providers bring to the health or safety-related goal. A program's health and safety policies will need to be understood and followed by the staff and parents/guardians.
   - Consider having a team representative of all viewpoints develop the policy. Future compliance with the policy will be easier to attain when all viewpoints are considered.

2. **Define the purpose**
   - Often policies are written in response to a specific incident or situation that makes it clear a policy needs to be in place to guide caregivers in the future. For instance, a policy on biting would clarify expectations for staff following a biting incident.
   - Many policies are developed to preemptively achieve the health and safety goals of the child care program. For example, to lessen the risk of an allergic reaction, a child care program might have a policy stating that children may not bring food containing peanuts to the facility.

3. **Determine reasonable expectations for the child care program and parent/guardian population**
   - Policies must meet state child care regulations and should ideally comply with *CFOC* standards.
   - Staff and parents/guardians must be able to meet or follow the standards set by the policy.

- The child care program must have the resources to implement and enforce the policy.

4. **Write the policy**

The program director, or a team of people interested in the issue, can write the policy. A CCHC can be a valuable policy team member.

What to include in a health and safety policy:
a. **Title:** specify the health or safety goal covered
b. **Belief Statement:** explain briefly why the facility believes the policy is necessary
c. **Intent Statement:** explain the purpose of the policy
d. **Background:** explain why the policy exists (may not be included in all policies)
e. **Procedure/Practice:** outline the actions necessary to accomplish what the policy recommends
f. **Application:** specify to whom the policy applies
g. **Communication:** state how staff, parents/guardians, and affected community members will be informed about the policy
h. **References:** include your source of information
i. **Review:** include the names of those who reviewed the policy
j. **Effective Date:** state the effective date of the policy
k. **Review Date:** include scheduled policy review dates
(Dail, Garrett, and Quirk, 2004)

5. **Review the policy**

Make sure the policy:
- Fits the purpose
- Makes sense to everyone
- Can be put into practice
- Is accurate and up-to-date with current practices
- Meets *CFOC* standards and state regulations

In *Model Child Care Health Policies* (4th ed., 2002), Aronson recommends 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 practice" (p.i).

When implementing a new or revised policy, the CCHC should work with the child care facility to consider any costs that may be associated with the policy. It may be difficult for facilities with few resources to implement some of these standards. Implementing policies without adequate funding may cause high staff turnover, low wages, and unsafe environments—all of which can lead to poor quality child care. When the desired financial resources are unavailable, CCHCs, child care staff, parents/guardians, and medical care providers "should continually strive for improvement in health and safety processes and policies for the improvement of the overall quality of care to children" (CFOC, 3rd ed., 2011, p. xx).

6. **Implement the policy**
   - Inform all child care staff, parents/guardians, and any other affected community members about the policy and how and when it will take effect.
   - Train staff on and inform parents/guardians about any procedures outlined in the policy.
   - Ensure that any procedures outlined in the policy begin the day the policy is implemented.
   - The facility should provide copies of policies, which include pertinent plans and procedures, to all staff and parents/guardians at least annually, and two weeks before new policies or changes to existing policies go into effect.[9.2.1.2]
   - Everyone who agreed to these policies should provide a written acknowledgement, such as a signature.

Action Items for the CCHC
   - Help child care staff and parents/guardians determine which topics are appropriate to include in the facility's policies.
   - Assist in the institution of culturally competent, family-centered policies and procedures.
   - Guide child care staff and parents/guardians through the process of developing and maintaining child care policies by checking that:
     ▪ equipment and supplies 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 (Aronson, 4th ed., 2002)
   - Encourage the involvement of community health professionals in the development, review, and revision process of health-related policies.
   - Be knowledgeable about what community resources are available to the child care facility in setting and implementing policies that are appropriate and financially feasible.
   - Review the policies at least annually, after an incident or injury has occurred, and when revisions to health policies are made. [9.2.3.17]

HEALTH EDUCATION

What the CCHC Should Know: Health Education Audiences, Topics, and Guidelines

Health Education for Children: The CCHC should empower and support child care facilities in providing health education to children on a daily basis. Child care staff often has the most frequent contact with children, outside of the parent/guardian, and opportunities often exist for integrating health education into other program activities included in the curriculum.[2.4.1.1], [2.4.2.1,] Caregivers/teachers should talk about and model healthy and safe behaviors while they carry out routine daily activities.[2.4.1.2] For example, handwashing, toothbrushing, nutrition, and exercise are everyday activities for children. These are opportunities for the child care caregiver/teacher to introduce and reinforce health information, attitudes, and behaviors. Because small family child care programs may not have a formalized curriculum, their health education can be done on a more informal basis. According to Bailey (2002):

> "A teachable moment is a time during which a child is most receptive to learning from experience, and may be thought of in two ways. From a child's perspective, teachable moments occur when children show that they are motivated to learn something new, either by their behavior, their interests, or their questions."

Teachable moments may also emerge in the context of certain *critical events*, usually times when children are vulnerable or challenged, and thus, more open to an instructive dialogue. For example, when a child has his first serious cold, it may be a good time to teach the child about healthy behaviors such as handwashing. Timely and developmentally appropriate input from an adult at this brief and precise moment could be enormously effective in helping the child learn this skill, much more so than if the teacher tried to teach the skill in a context where it was not needed and the child was not motivated to succeed. Facilities should use developmentally appropriate health and safety education materials and activities in the children's activities and should also share these with the families whenever possible. [2.4.1.2] Caregivers/teachers should also take account children's individual personalities and interests when planning health education efforts.

Health Education for Parents/Guardians: Parent/guardian education will occur primarily through personal contacts between the parent/guardian and the child care caregiver/teacher and/or CCHC. This may involve consultation sessions, additional support, and/or making referrals to community resources (see the "Accessing and Utilizing Community Resources" section of this Module on page). The *CFOC* standards recommend that health departments and licensing/regulatory agencies support these parent/guardian education efforts by providing health education materials on specific health issues.[10.3.4.1]

In addition to personal contacts, child care health consultants and facilities should work together to offer regular health education programs to parents/guardians. The topics for these programs should be determined based on specific needs, as identified through survey or other informal method, or as either a response or preventative measure regarding a particular issue (ex. handwashing education during cold/flu season). Regardless of the program offered, the CCHC should keep in mind parents/guardians' attitudes, beliefs, fears, and educational and

socioeconomic levels when health education materials and/or events are planned and implemented for families.

Health Education for Staff: To ensure that consistent and valid information is being passed on to both young children and their families, CCHCs should also provide child care staff with health education on a wide range of issues including nutrition, injury prevention, safe sleep environments, children with special needs, physical activity, and behavior/discipline, and promoting healthy brain development (please read a more detailed list below).[2.4.2.1] Staff should also be aware of the occupational hazards associated with working in child care facilities. [Appendix B] Staff are in positions where they can act as role models for the children and parents/guardians concerning healthy behaviors and attitudes (e.g., eating nutritious foods, not smoking, washing hands, etc.).[2.4.1.2, 2.4.3.1] Staff education can be offered in many different ways, for instance, staff meetings, discussions, workshops, , newsletters, site visits, newspaper and magazine articles, posters, and other audiovisual materials (Vesay, 2008). (Please refer to NTI's *Promoting the Health and Safety of Child Care Staff* Module for more detailed information regarding this topic.)

Health Education Topics: Several *CFOC* standards list possible health education topics for children and parents/guardians.[2.4.1.1, 2.4.2.1, 2.4.3.2, 2.1.1.1] This way the adults can reinforce health information the children are learning while simultaneously expanding their own health and child development knowledge. Possible health education topics are presented in Table 4 on the following page.

Table 4: Suggested Health and Safety Education Topics, *CFOC*, 3rd ed., 2011

For Children [2.4.1.1]	For Parents/Guardians [2.4.3.2]
▪ Body awareness and use of appropriate terms for body parts ▪ Families (including information that all families are different and have unique beliefs and cultural heritage) ▪ Personal/social skills such as sharing, being kind, helping others, and communicating appropriately ▪ Expression and identification of feelings ▪ Self-esteem ▪ Nutrition, healthy eating ▪ Outdoor learning/play ▪ Fitness and age-appropriate physical activity ▪ Personal and dental hygiene including wiping, flushing, handwashing, cough and sneezing etiquette and toothbrushing ▪ Safety (such as home, vehicular car seats and safety belts, playground, bicycle, fire, and firearms, water safety, personal safety, what to do in an emergency, getting help and /or dialing 9-1-1 for emergencies) ▪ Conflict management, violence prevention, and bullying prevention ▪ Age appropriate first aid concepts ▪ Healthy and safe behaviors ▪ Poisoning prevention and poison safety ▪ Awareness of routine preventative and special health care needs ▪ Importance of rest and sleep ▪ Health risks of secondhand smoke ▪ Taking medications ▪ Handling food safely ▪ Preventing choking and falls ▪ Physical activity ▪ Conflict management	▪ Safety (such as home, community, playground, firearm, seat belts, safe medication administration procedures, poison awareness, vehicular, or bicycle.) ▪ Value of developing healthy and safe lifestyle choices early in life and parental/guardian health (such as exercise and routine physical activity, nutrition, weight control, breastfeeding, avoidance of substance abuse and tobacco use, stress management, maternal depression, HIV/AIDS prevention) ▪ Importance of outdoor play and learning ▪ Importance of role modeling ▪ Importance of well-child care ▪ Child development and behavior including bonding and attachment ▪ Domestic and relational violence ▪ Conflict management and violence prevention ▪ Oral health promotion and disease prevention ▪ Effective toothbrushing, handwashing, diapering, and sanitation ▪ Positive discipline, effective communication, and behavior management ▪ Handling emergencies/first aid ▪ Child advocacy skills ▪ Special health care needs ▪ Information on how to access services (e.g., WIC) ▪ Handling loss, deployment, and divorce ▪ The importance of routines and traditions with a child

Guidelines for Designing Health Education Materials
Designing health education programs, selecting and developing appropriate health education materials, and making references to appropriate health education resources in the community are important responsibilities of a CCHC. In addition to the information provided in the *CFOC* standards, the following are offered as basic health education guidelines.

The CCHC should use a variety of health education materials that involve visual, audio, or participatory learning methods. This can include videotapes, slide shows, models, experiments, visual aids, guest speakers, debates, and dramatic presentations, to name a few. Using a variety of approaches will help ensure that everyone in the audience is able to learn. Health education materials that are designed only for lecturing do not allow the audience to become fully involved and invested in the learning process. (Please refer to NTI's *Building Curriculum Development and Training Skills* Training Module for more information about learning styles.)

Materials should:

- **Include specific information concerning pre-school age children**: It is necessary for selected health education materials to be developmentally specific for preschool age children. Health education materials geared toward adults or teenagers will not identify the same health problems as those that are pre-school age specific.

- **Incorporate information technology**: Consider information technology when selecting health education materials. This can be as simple as providing email addresses and websites to lists of resources, or as complex as demonstrating how to use a mobile application and different search engines to find information. Evaluating or surveying your audience before an event can help determine whether you need to provide educational materials that discuss how to use the Internet. See Appendix D of this Module for more information about how to evaluate information that is available on the Internet.

- **Include up-to-date resources and information**: Make sure that the materials are as recent as possible so that the information is relevant to the current needs of the community.

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.

When developing health education materials, the CCHC must ensure that the information she/he is receiving over the Internet is safe, pertinent, and accurate. Recently the National Library of Medicine and the National Institutes of Health have developed an online tutorial for individuals to learn more about evaluating Internet health information. This tutorial can be accessed here: http://www.nlm.nih.gov/medlineplus/webeval/webeval.html

To ensure that education materials are culturally and linguistically competent, a CCHC should also:

- **Use culturally competent language**: When developing or selecting health education materials, it is critical to address the health needs of the different groups of people who are located within the community. For example, if a community is primarily African-American, then the CCHC must ensure that the health education materials chosen address the health problems of African-American preschoolers. Terms used to identify cultural groups (i.e., Latinos, Hispanics, blacks, African-Americans, Asians, Asian-Americans) should be acceptable to those groups.

- **Translate materials into the dominant language**: Most health education materials in the United States are written in English. If the CCHC is speaking to a predominantly Latino community, distributed materials should be available in Spanish. If this is not possible, a list of sources that may be able to assist in providing or translating the materials in Spanish should be furnished.

- **Ensure materials are written at appropriate informational levels**: Know the audience, particularly when judging materials for literacy and informational levels. For example, health professionals may have a more technical knowledge of health issues than parents/guardians. The materials must be modified for these two different audiences. It is also important not to over-utilize technical information and clinical studies. Designing health materials that emphasize the key points will enable the audience to learn and apply the information more quickly. If requested, the CCHC can then supply more specific research or technical information. See Appendix B of this Module for resources on health literacy.

- **Ensure materials are written at appropriate literacy levels**: To reach the most adults, materials should be written at the level of grades 5-8. Research shows that most people prefer easy-to-read pamphlets, and a single pamphlet aimed at the lowest reading level is appropriate for the general population (Sanders et al, 2009).

Guidelines for Developing Policies Related to Health Education
Aronson (4th ed., 2002) presents information on child care health education, which may be useful to the CCHC in assisting facilities to develop policies in this area. The sample policy Aronson presents addresses the following questions:
- Who will receive the health education?
- What topics might be included in the health education plan?
- What resources for speakers and materials are suggested?

Aronson's answers emphasize:
- Activities and materials need to be developmentally appropriate
- Health practices should be integrated into daily activities
- Topic areas can relate to specific weeks such as Child Passenger Safety Week
- Parents/guardians need to be notified if sensitive topics are included
- Parents/guardians need to notify the child care staff if children are not to be included in specific health education activities

Policies related to health education should also address the need for such education to be culturally and linguistically competent.

Action Items for the CCHC
- Help child care staff assess the children's, staff's and parents'/guardians' health education interests and needs.
- Assist in determining priorities among the health education topics so topics can be designated as immediate or long-term concerns.
- Help child care staff design health education programs for children, staff, and parents/guardians.
- Encourage child care programs to offer educational programs that are scheduled at convenient times and places for parents/guardians and staff.
- Support child care staff in planning a yearly health education schedule.
- Review health education topics the child care facility has selected to include in their program activities.
- Select and/or develop health education materials to address specific health and child development topics.
- Refer child care staff to appropriate community resources (i.e. local clinics, nonprofits, medical home providers, etc.) that can provide health education programs and/or materials.
- Assist child care facilities with the development of health education policies and procedures.

ADVOCACY

"What is advocacy? Advocacy is the act of supporting a cause to produce a desired change" (Save the Children, 2003, p.1).

What the CCHC Should Know: How to be an Advocate

CFOC *Standards Related to Child Advocacy*
The *CFOC* standards differentiate between a health advocate and a CCHC. They recommend that a regular member of the child care facility staff should receive health training and act as a health advocate for individuals connected with the facility. This health advocate should be responsible for policies and everyday issues related to health, development, and safety of children, staff, and parents/guardians. The health advocate should also be the primary contact for parents/guardians when they have health concerns, including health-related parent/guardian/staff observations, health-related information, and the provision of resources. [1.3.2.7] As the CCHC begins to gradually decrease the intensity of services provided based on the needs of the program and transfer responsibilities to the child care staff, the role of the health advocate will take on additional importance. If the child care program does not have a health advocate, the consultant can assist the program in identifying and training a staff member to fill this role.

Guidelines for Effective Advocacy
To ensure that children's needs are met, the CCHC can serve as an advocate in areas such as public awareness, education, and legislation. Each of these areas is further described in this section. Advocating can be accomplished through a variety of channels, not just through legal or legislative means. It is important to note that advocacy, by its very nature, is a political activity and should be approached delicately. Depending on where the CCHC's position is located or how it is funded, certain types of advocacy may not be allowed or could potentially threaten a CCHC's standing. All of this is balanced by the idea that a CCHC is often in an ideal position to advocate around health and safety issues based on their level of involvement and intersection with families, child care staff, young children and community providers.

Public Awareness
- **Network with groups in the community**: The CCHC should identify groups for networking such as local/state advocacy organizations, religious groups, medical home and other health care providers, 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 on his/her behalf and help with local resources and services for children and families.

- **Inform the community about the role of the CCHC**: 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 is one way the CCHC can advocate for the needs of children in out-of-home care.

- **Inform members of the media**: The CCHC should know people in the community who are involved 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
- **Self-education**: CCHCs should learn as much as possible about their community and its resources. They should find out about local health issues, gaps in services, influential community members, funding issues, and the major concerns of the community. A CCHC needs to learn about the requirements for families and children in programs such as Medicaid, State Children's Health Insurance Programs (SCHIP/CHIP), Infant-Toddler Program, and Supplemental Security Income (SSI). Education can be gained through:
  - training sessions offered by community groups or the state and local government
  - listservs or email newsletters offering up-to-date information
  - connecting with health care providers to keep current on community resources related to health, safety, and social services
  - reading newspapers, magazines, journals, studies, and other materials on the health of children or child care

- **Educate parents/guardians and child care staff**: A key role of the CCHC is to transmit knowledge and information to parents/guardians, family members, and child care staff. This transfer 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 special needs.

- **Educate the community**: The CCHC plays an important part in encouraging businesses, employers, legislators, and others to make child care affordable, safe, and healthy for children. A CCHC can encourage these individuals and institutions to become advocates by suggesting they either volunteer time or make financial contributions.

Legislation
- **Learn current legislative agendas**: If it is determined that the funding source for the CCHC position does not restrict government lobbying, a CCHC might become 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 child care, health insurance for children, child maltreatment, public services, affordable housing, etc. The Children's Defense Fund Website (see "Where to Find More Information") can be accessed for information on current legislation related to children's health, children's welfare and mental health, child care and early childhood development, and education and youth development.

- **Contact politicians about child care issues**: The CCHC should be willing to show disapproval of weak public policies as well as 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. For names and addresses of federal, state, and local representatives see the general phone number for state or federal government information located in the blue pages of a local phone directory. The Coalition of National Health Education Organizations maintains a website which provides immediate email access to each congressman in the US House of Representatives (see "Where to Find More Information"). This site also lists national health education priorities requiring urgent action. The Children's Defense Fund Action Council's Website, mentioned above, can also be useful in contacting politicians about child care issues.

Please refer to Table 3 on the following page for some general advocacy tips.

Table 3: Advocacy Tips

Mobilize State and Community Contacts	Tips on calling and/or writing to legislators
Send a mail, fax, or email alert. Set up and activate telephone trees. Get on the agenda for community group meetings and statewide conferences. Work with interested individuals and organizations.	▪ Identify yourself as a constituent. Share other information about yourself that is relevant to the issue. If writing a letter or sending an email, make sure to include your full contact information to confirm your constituency. ▪ State your purpose in the first paragraph. Be specific. If possible, include the name and number of the relevant bill. ▪ Be courteous, brief, and to the point. Pick three strong talking points. ▪ Address only one issue with each call, written letter, or email. ▪ Keep the letter/email to one page if possible. Always type or print. (Send a copy of the letter/email to the editor of a newspaper or magazine if relevant.) ▪ Be confident, but polite. ▪ Use statistics and facts. Make sure the information you provide is accurate. ▪ When addressing a member of Congress or the House of Representatives in a letter, use "Honorable." ▪ Follow up with a phone call, a letter/email, or a visit at the appropriate time.
Educate Members of Congress and the President Find out who your members of Congress are: US Senate Tel: 202/224-3121 http://www.senate.gov US House of Representatives Tel: 202/224-3121 http://www.house.gov The White House Tel: 202/456-1111 TTY: 202-456-6213 http://www.whitehouse.gov/ Visit your Representative and Senators in their district offices. Local contact information can be found using the US Senate and US House links listed above.	
Child Welfare League of America, 2004; Save the Children, 2003	

Action Items for the CCHC
- Assist the child care program in identifying and training a staff member to fill the role of health advocate.
- Support the health advocate.
- Act as an advocate for improved quality in child care throughout the community
- Serve as a liaison between child care staff and community members (e.g., medical home or other health care providers) to assist with the coordination of advocacy efforts.

RESOURCE AND REFERRAL

What the CCHC Should Know: Accessing and Utilizing Community Resources
A CCHC attempting to locate resources available in the community may run across the same barriers and obstacles that a family or child care teacher/caregiver would face; the important thing is that the CCHC is taking on the task of this preliminary research and passing along useful information for the benefit of others. States and localities often have a wide array of available programs for different populations and areas of need, yet determining where these programs are located within a state/local bureaucracy, what eligibility criteria they use and who are the key contacts may take time to determine. If the CCHC is working with a team of other consultants, then he/she should not be afraid to use these contacts in order to develop a comprehensive list of local resources. Consultants must recognize when they themselves need help or additional support and utilize the team approach to consultation as a way to share resources. In addition, a CCHC should keep in mind the concepts and potential avenues of information listed in the following sections. Websites for the resources mentioned below are listed in "Where to Find More Information." Appendix A of this module also lists contact information for child care agencies and related organizations that are valuable resources and may be able to connect a CCHC to additional national, state, and local resources.

Diversify Methods of Research
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, a CCHC should check first with places in his/her community that might already have an established network of services or resources for families and children, such as the local/state resource and referral or information and referral agency, libraries, schools, faith organizations, health clinics, and community centers.

Maintain Local/State Resources
It is not uncommon for organizations to close and government services to be discontinued. A CCHC can perform a valuable service by ensuring that parents/guardians and child care staff are made aware of these changes. Making referrals to inappropriate or nonexistent resources can be very frustrating and discouraging for those referred. This may be especially true for those parents/guardians who are not accustomed to asking for help and/or contacting community resources.

Research Local/State Resources
Local Child Care Resource and Referrals (CCR&Rs) or Information and Referrals (I&Rs) and the National 2-1-1 hotline are useful tools for maintaining up-to-date information on local resources. Child Care Resource and Referrals/Information and Referrals are the "local experts" on child care and related services (NACCRRA, 2004). The goals of these agencies are to help parents/guardians find appropriate child care, support child care staff, and engage the community in the effort to improve the quality of child care (NACCRRA, 2004). These agencies can be contacted about local child care programs, child care subsidies, state licensing requirements, the cost and quality of local child care, and other local or state resources related to child care. Services are often provided via the phone, email, newsletters, face-to-face consultations, and/or training workshops. To locate a CCR&R or I&R in your

community, contact Child Care Aware or Alliance of Information and Referral Systems (AIRS).

Child Care Resource and Referrals/Information and Referrals are the "local experts" on child care and related services (NACCRRA, 2004). The goals of these agencies are to help parents/guardians find appropriate child care, support child care staff, and engage the community in the effort to improve the quality of child care (NACCRRA, 2004). These agencies can be contacted about local child care programs, child care subsidies, state licensing requirements, the cost and quality of local child care, and other local or state resources related to child care. Services are often provided via the phone, email, newsletters, face-to-face consultations, and/or training workshops. To locate a CCR&R or I&R in your community, contact Child Care Aware or Alliance of Information and Referral Systems (AIRS).

National Hotlines: The national 2-1-1 hotline was initially developed by the United Way of Metropolitan Atlanta in 1997 to serve as a starting place for locating community services and volunteer opportunities (211.org, 2000). The 2-1-1 hotline, available 24 hours/day and 7 days/week, refers callers to a variety of human services, from those that will meet every day needs to crisis services. The range and number of agencies available through 2-1-1 will differ between communities. Currently, with the co-sponsorship of the United Way and AIRS, 2-1-1 serves approximately 137 million Americans via 169 active hotlines in 32 states and Washington, DC. Canada and Puerto Rico also have active 2-1-1 hotlines (211.org, 2000). The Calling for 2-1-1 Act (S211 / HR 896) proposes bipartisan legislation that would allocate $150 million annually to states for the implementation and maintenance of a 2-1-1 hotline. States would be required to match the funding, which would be administered by the U.S. Department of Health and Human Services. To learn the status of a 2-1-1 hotline in your state, contact 211.org.

Through the Maternal and Child Health Block Grant, every state is required to maintain a maternal/child health hotline for information and referral services regarding maternal health services. These hotlines help connect women with Medicaid providers and other services.

CFOC *Standards Related to Accessing and Utilizing Community Resources*
Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs (*CFOC* 3rd ed., 2011) contains specific standards related to accessing and utilizing community resources.

The *CFOC* guidelines state:
- States should encourage the use of public and private resources in local communities to develop resource and referral (R&R) agencies. These agencies can help provide information to parents/guardians and child care facilities about resources and services and function as a mechanism to coordinate services. [10.7.0.1]
- Local child care resource and referral agencies should assist child care centers in formulating and maintaining a local list of community resources available to meet the health, dental, and social needs of families. [10.3.4.4]

- All child care centers should obtain or have access to a community resource file. This file should include information about eligibility criteria for services, hours of operation, costs of services, accepted insurance plans, listing of accessible medical home providers, and languages spoken by the agency staff. It should be updated annually and should be accessible to child care staff and parents/guardians.[9.4.1.19] The information should be printed in the parents'/guardians' language or translated by interpreters. Even small family child care homes can maintain a list of telephone numbers of community resources.[9.4.1.19] It would also be helpful to have a list of state resources for small or rural communities that may not have access to certain resources locally.
- CCHCs should provide children and families with referrals to community services.[1.6.0.1]

What the CCHC Should Know: Referring Children and Families to Government Services

Federal Programs for Assisting Families and Children
The following is a list of federal service programs for assisting families and children with a brief description of each program. Website addresses for each program are listed in "Where to Find More Information." Federal programs may be administered solely by the federal government, cooperatively among federal, state, and local agencies, or by states through federal block grants.

Temporary Assistance for Needy Families (TANF): TANF was created in 1996 by the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It went into effect on July 1, 1997, and replaced the Aid to Families with Dependent Children (AFDC) and the Job Opportunities and Basic Skills Training (JOBS) programs. TANF allows states to provide assistance and work opportunities to needy families. TANF also gives states the flexibility to develop their own long-term monetary assistance programs to increase self-sufficiency and personal responsibility. Some examples of assistance might include cash assistance, medical insurance, food programs, and transportation. To find out the requirements of families in your state contact your state administrator of TANF.

Medicaid Program: The Medicaid program became law in 1965. The purpose of the program is to provide medical services to individuals and families with low incomes and resources. Each state, within broad federal guidelines, has the flexibility to establish its own eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment for services; and administer its own program. The Affordable Care Act of 2010, creates a national Medicaid minimum eligibility level of 133% of the federal poverty level ($29,700 for a family of four in 2011) for nearly all Americans under age 65. This Medicaid eligibility expansion goes into effect on January 1, 2014.

Social Security: Social Security benefits are managed by the federal government and are calculated on the basis of income and other information recorded under a person's Social Security number. The benefits are a percentage of each person's income, taken out as payroll taxes, averaged over their working lifetime, and then paid to them by the government if they become disabled or retire. The five major categories of benefits paid through Social Security taxes are retirement, disability, family benefits, survivors, and Medicare (US Social Security

Administration, 2012). For more information about eligibility requirements contact your state or local regional representative or call the National Social Security Hotline.

Supplemental Security Income (SSI): Supplemental Security Income under the Social Security Administration makes monthly payments to those who have a low income and few assets. To qualify for SSI, an adult must be 65 years old, or a child or adult must be disabled. Adults or children who qualify for SSI usually also qualify for other public assistance programs (U.S. Social Security Administration, 2012). For more information about eligibility requirements contact your state or local representative or call the National Social Security Hotline.

Nutrition Assistance Programs: The Food and Nutrition Service (FNS) administers the Nutrition Assistance Programs of the U.S. Department of Agriculture. FNS works in partnership with local and state agencies. The major programs that are administered by FNS are:
   - Supplemental Nutrition Assistance Program (SNAP)
   - National School Lunch, School Breakfast, and Special Milk Programs
   - Team Nutrition
   - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
   - Child and Adult Care Food Programs (CACFP)
   - Food Assistance for Disaster Relief
   - Commodity Supplemental Food Program (CSFP)
   - Food Distribution Program on Indian Reservations (FDPIR)

Different state and local agencies are responsible for each Nutrition Assistance Program (USDA, Food and Nutrition Service, 2012). For information on eligibility requirements of any of these programs, please contact your regional representative.

State Children's Health Insurance Program (SCHIP): The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP): an insurance plan that provides health insurance to low-income children who do not qualify for Medicaid because their family incomes are too high but cannot afford private health insurance. SCHIP is a jointly funded Federal-State program. This program allows states to expand their Medicaid Program, create a separate program, or develop a combination of the two. For more information on your state's SCHIP program get in touch with a state-level SCHIP contact.

Head Start Program (needs to be updated**):** Head Start, a national program created in 1965, provides developmental services for low-income preschool age children (ages 3 to 5) and social services for their families. The four components of Head Start are education, health, parent involvement, and social services. The Head Start Program is administered nationally by the Administration for Children and Families (ACF) in the Department of Health and Human Services. Funding for Local Head Start Programs is provided to local public or private non-profit agencies through grants from the 10 ACF Regional Offices and the Head Start Bureau's American Indian and Migrant Programs Branches. There are almost 1,600 Head Start programs nationwide, with over 2,000 Health Managers and 240,000 staff serving over one million children. In 1994 the reauthorization of the Head Start Program created a new program, Early Head Start (EHS), that provides child development and family support

services for low-income pregnant women and families with infants and toddlers. EHS evolved out of Head Start's long history of providing services to infants and toddlers through Parent Child Centers, Comprehensive Child Development Centers (CCDPs) and Migrant Head Start programs.

Office of Child Care: Formerly known as the Child Care Bureau (CCB), created in 1995, provides a central federal home for child care programs. When the Welfare Reform Act passed in 1996, DHHS recognized that "affordable, accessible and quality child care" was crucial to its success (Child Care Bureau, 2003, p.1). The OCC provides block grants to states under the Child Care and Development Fund (CCDF). These monies provide child care assistance to low-income working families. The vision is to not only support the parents/guardians or caregivers, but to promote children's learning by improving the quality (including health and safety) of early care, education, and after-school programs.

Action Items for the CCHC
- Make sure the agency and services offered are credible and appropriate for the child care population.
- Keep current records of contacts, agencies, and organizations in the local community and state by contacting these sources at least once a year.
- Check that the contacts adhere to *CFOC* standards. For example, include information about the resources' eligibility criteria for services, hours of operation, costs of services, accepted insurance plans, listing of accessible medical home providers, and languages spoken by agency staff.
- Establish a link between the child care facility and community/state resources.
- Assist the child care staff in locating appropriate federal/state/local services for the families served by the facility.

THE MEDICAL HOME MODEL

What the CCHC Should Know: The Relationship Between the Medical Home and Child Care

Defining "Medical Home"
A medical home is not a building, house, or hospital, but rather a partnership approach to providing quality and cost-effective health care services for children (AAP, 2002). There are seven components that define what a medical home should be:
   - **Accessible**: Health care should be provided in the child's community, and at a facility that accepts all types of insurance, including Medicaid. Also, a well-trained primary pediatric health care physician (hereafter referred to as the medical home provider) should be available to speak directly with the parents/guardians when requested.

   - **Family-Centered**: The health care facility should recognize that the parents/guardians are the experts about their child and his/her health care needs.

   - **Continuous**: The medical home provider for the child provides health care throughout childhood. Should a transition be necessary, the medical home provider, the parents/guardians, and the child should all be included in the process.

   - **Comprehensive**: All types of health and dental health care services are provided, including preventive, primary, and tertiary needs. Also, parents/guardians are provided with information about community resources that provide services that the medical home provider is unable to provide.

   - **Coordinated**: The child's health care plan is developed by the medical home provider, the parents/guardians, and other agencies or services that the child or family currently receive (i.e., child care center).

   - **Compassionate**: The child's and family's well-being and the perspective of the child and family are always of concern when providing health care services.

   - **Culturally Effective**: The family's cultural background is incorporated into the child's health care plan. This includes beliefs, rituals, and customs. Efforts are made by the medical home provider and other health care providers to ensure that the child and parents/guardians understand the health care plan and any other medical encounters. This includes the provision of language translators and interpreters.
   (AAP, 2002)

CFOC *Standards Related to Promoting the Medical Home Model*
CFOC (3rd ed., 2011) contains specific standards related to promoting the medical home concept. The *CFOC* guidelines state:

   - Child care centers should request information regarding each child's health, nutrition, level of physical activity, and behavioral status, and each child's primary health care

provider/dentist and medical home on program enrollment forms or during the application process. The parent/guardian should provide consent to enable the caregiver/teacher to establish communication with those providers. The family should also always be informed prior to the use of this permission unless it is an emergency.[2.3.3.1], [9.2.3.6]

- Local agencies should assist child care centers in identifying and maintaining a resource list of community professionals and agencies available to provide health, dental, and social services to families.[10.3.4.4]

- Child care programs should include an initial health assessment, completed and signed by the medical home provider, in each child's file.[9.4.2.4]

- Child care programs should include a comprehensive health history, completed by the parents/guardians, in each child's file.[9.4.2.5]

- Child care programs should require that all children have routine health supervision by a medical home provider. This would include routine screening tests, immunizations, and chronic or acute illness monitoring. Additional requirements exist according to whether the child is under or above twenty-four months of age.[3.1.2.1]

What the CCHC Should Know: The Relationship between the Medical Home and Child Care

It is best for a child's health and development when families, the medical home, and child care programs work together to make sure children are healthy and safe in out-of-home child care settings. Because child care programs frequently establish a close and open relationship with families, they are in a unique position to:

- Assist in documenting all services the child is receiving outside the of the child care center, including developing a health report in a child's file.
- Assist families in obtaining information about resources on accessing care (i.e., Medicaid; Women, Infants, and Children [WIC] Supplemental Nutrition Program; and other family support programs).
- Ask parents to discuss certain concerns/issues with their child's health provider. Program staff can obtain written parental consent to exchange information with the child's medical home to further facilitate the patient- and family-centered medical home and allow staff to talk directly with the medical home practice team for clarification about a child's care or health needs (e.g., asthma, allergies, diabetes). If services are provided within the child care program, they can work to ensure that this information gets back to the medical home (e.g., immunizations, developmental screening, early intervention services). (National Center for Medical Home Implementation, 2011). Families of children with special health care needs may also be in need of services, such as respite care and family counseling (USDHHS, HRSA, MCHB, 2003). The medical home concept is designed to address and provide a variety of coordinated services to meet the needs of children, particularly those with complex special health care needs and their families.

(For more detailed information about issues related to children with special health care needs, please refer to NTI's *Caring for Children with Special Needs* Module.)

Common Barriers to Integrating a Medical Home Model in Child Care
Barriers exist when collaborating with child care staff in the integration of a medical home model. These specific barriers are:
- A difference in perception of who is responsible for the health care of children
- Overburdening child care staff with additional responsibilities
- Navigating health care services and financing
- Availability of pediatric health services

(Aronson SS, Aird, Pickett, Romeo, Gross, and Aronson JM, unpublished material.)

CCHC's are ideally suited to addressing or ameliorating some of these barriers by acting as a liaison between the child care program and medical home. They can act in this capacity by promoting communication among the medical home, child care program, and family. They also can educate families and child care caregivers/teachers about medical home concepts and develop/implement health policies that are family-centered.

HOME VISITING

Home visiting is not a single clearly defined methodology of providing service to children and families. The term "home visiting" is used differently in a variety of contexts. Generally, voluntary home visiting programs pair high need and at-risk families with trained professionals, who provide ongoing information and support services in the families' homes during pregnancy and through their child's first three years. By reaching families in the home environment, providers serve otherwise hard-to-reach families and tailor services to meet families' unique needs. Some programs use professional nurses or masters-prepared professionals as their home visitors; others use trained paraprofessionals who are often members of the target community and culturally linked with the families they visit (Ansfield et al., 2004). Some of the most studied home visiting efforts have a primary focus on the prevention of child abuse and neglect. Home visiting helps connect parents to support and resources, such as medical care, stable housing, and/or mental health or substance abuse counseling. Home visiting also supports parents' development by teaching them to build positive, loving relationships with their children. By focusing on families most at risk, programs seek to diminish disparities in health and developmental outcomes. Findings from recent studies on home visiting suggest:

- Mothers who received home visits were half as likely to deliver low birthweight babies as were mothers of a similar background who were not enrolled in a home visiting program. (Lee et al., 2009)

- Children who participated in a nurse home visiting program were 35 percent less likely to end up in the emergency room, and 40 percent less likely to need treatment for injuries and accidents between the ages of two and four. (Olds et al., 2004)

- Mothers who participated in home visits were more sensitive and supportive in interactions with their children, according to several studies, and they reported less stress than those mothers who did not receive home visits. (Olds et al., 2004)

- By age six, children who participated in a nurse home visiting program had higher cognitive and vocabulary scores than those in the control group. These gains persisted through third grade, with participants posting higher grade-point averages and achievement test scores in math and reading. (Olds et al., 2004)

In 2010, as part of the Patient Protection and Affordable Care Act, Congress established the new Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), a major national commitment—$1.5 billion over five years— to expand and improve home visiting services within states' early childhood comprehensive systems. This initiative mandates that the majority of federal funds be spent only on evidence-based home visiting models. Evidence-based home visiting models are home visiting models that meet designated, rigorous evidentiary standards and are effectively coordinated and monitored. A brief overview of some of these federally approved models is provided in the following table:

TABLE 5: MIECHV Recognized Home Visiting Models

Model	Target Population	Other Info
Child First	- Birth to Age 6 - Families with a child with emotional, behavioral, or developmental concerns or the family faces multiple barriers	Clinician and care coordinator provide services that include comprehensive assessment of child and family needs, observation and consultation in early care and education settings, parent-child mental health intervention, development of a family and a child plan of care, and care coordination/case management
Early Head Start	- Birth to Age 3 - Low-income pregnant women and families, most of whom are at or below the federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act in their state	- EHS programs include home- or center-based services, a combination of home- and center-based programs, and family child care services (services provided in family child care homes) - EHS home-based services include (1) weekly 90-minute home visits and (2) two group socialization activities per month for parents and their children.
Family Connections	- Birth to 5 - Families that are at risk for neglect and exhibit at least two risk factors such as unemployment, parent mental health issues and parent substance abuse issues	- Community-based program designed to improve protective factors and reduce risk factors such as parent depression and child behavioral problems - Core program components are (1) emergency services, (2) comprehensive family assessment, (3) goal setting, (4) home visiting, (5) client advocacy and service facilitation (indirect services), and (6) multifamily recreational and supportive activities
Healthy Families	- Prenatal to 6 - Designed to serve families at risk for child abuse and neglect	- Program model offers weekly home visits, screenings and assessments and may include parent support groups, father involvement programs, and job training - HFA home visitors, called family support workers (FSWs), are selected based on their personal characteristics and willingness to work in culturally diverse communities
Healthy Steps	Birth to 3	- Emphasizes collaboration between health care professionals and parents - Pediatric or family medicine practice must be involved in every Healthy Steps site - Program model is delivered by a team of medical practitioners and a Healthy Steps Specialist - Can be offered at different intensities, ranging from two to five or more home visits between a child's birth and age 36 months
Home Instruction for Parents of Preschool Youngsters (HIPPY)	- Age 3 to 5 - Designed for parents who lack confidence in their ability to prepare their children for	Program model offers weekly, hour-long home visits for 30 weeks a year, and two-hour group meetings monthly or at least six times a year

	school, including parents with past negative school experiences or limited financial resources	▪ Provides parents with curricula, books and other materials designed to strengthen their children's cognitive and early literacy skills and social, emotional and physical development
Maternal Infant Health Outreach Worker	▪ Birth to age 3 ▪ Economically disadvantaged and geographically and/or socially isolated families	▪ Parent-to-parent intervention that is designed to improve prenatal care, birth weight, infant care, family dynamics, parenting skills, child development, life skills, and community development
Nurse-Family Partnership	▪ Prenatal to age 3 ▪ First-time, low-income mothers	▪ One-on-one home visits by a trained public health nurse to participating clients ▪ During visits, nurses work to reinforce maternal behaviors that are consistent with program goals and that encourage positive behaviors and accomplishments ▪ Targets several outcomes, with a focus on maternal and child health and on family self-sufficiency
Parent-Child Home Program	▪ Age 2-4 ▪ Parents with multiple risk factors—such as low levels of education and teen mothers	▪ Program model's approach has home visitors model behaviors for enhancing children's development, rather than directly instructing parents ▪ Families receive two home visits per week for two years, and the program also provides materials, books, and referrals to social and educational services
Parents as Teachers	▪ Birth to age 5	▪ Focus on supporting a parent's role in promoting school readiness and healthy development ▪ Provides information on children's development, teaches parents to encourage their child's learning, provide referrals to community resources and conduct screenings of children's development and health issues
Resources, Education and Care in the Home (REACH)	▪ Birth to 11 months ▪ Low-income teenage mothers, mothers with limited or no access to prenatal care, infants and mothers discharged early from the hospital, and families with psychosocial problems	▪ Multiagency service model designed to prevent and reduce post-neonatal morbidity and mortality in high-need communities ▪ Hospital-based registered nurse case manager coordinates mothers' contacts with participating REACH agencies, makes referrals to social service organizations, and provides counseling ▪ Families typically receive home visits when children are two weeks; six to eight weeks; and 4, 8, and 12 months old, with additional visits as necessary

*Adapted from U.S Department of Health and Human Services (2011). Home visiting evidence of effectiveness. Available at:
http://homvee.acf.hhs.gov/programs.aspx

What the CCHC Should Know: The Relationship Between Home Visiting and Child Care
Meta-analyses (Nievar & Van Egeren, 2005; NGA Center for Best Practices, 2011) of home visiting programs show that the greatest levels of success are achieved by programs with an extended duration. Additionally, the National Academy of Sciences has concluded that family support programs tailored to meet the needs of the *families* involved (such as those home visiting models listed in the above table) produce the longest-lasting, broadest range, and largest magnitude changes when paired with child-focused programs such as high quality child care and preschool. A home visiting program that begins prenatally or in infancy is likely to carry forward to a child's care in an out of home setting. CCHCs are already often asked to work with a variety of professionals, including primary care physicians and early education consultants, in order to ensure that standards, practices and goals for a particular child are integrated comprehensively in an out of home setting. Increasingly this list of professionals has expanded to include home visitors as well. CCHCs can support home visiting in child care by:

- Ensuring that child care facilities understand the nature and goals of home visiting programs, and the need for collaboration;
- Ensuring that facility policies focused on working with outside professionals include language on home visitors; and
- Acting as a member of a team along with parents/caregivers and the home visitor in order to achieve a common goal, such as supporting a child's early intervention needs.

 An awareness of a diverse array of prevention and intervention models and the utilization of effective communication skills is crucial in supporting child care staff to understand new procedures and their role as part of a continuum of services.

Action Items for the CCHC
- Consult with child care facilities to support families of young children in finding a medical home and that the child care caregivers/teachers are active participants in the medical home.
- Assess and/or develop policies that help ensure every child has access to a medical home; for example, these policies may reflect how the facility should ensure that each child has a medical home or how child care staff interact with medical home providers.
- Advocate within the community for greater access to a medical home for every child.
- Educate child care caregivers/teachers and parents/guardians about the medical home model.
- Assist child care programs in maintaining a current local/state list of medical home providers and related resources.
- Serve as a liaison between medical home providers and child care staff to develop child care policies related to medical home, coordinate advocacy efforts, and connect health services to children and families.

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California Childcare Health Program
Health and Safety Checklist-Revised
http://ucsfchildcarehealth.org/pdfs/Checklists/UCSF_Checklist_rev2.0802.pdf

Healthy Child Care America
Work With a Health Professional
http://www.healthychildcare.org/WorkWithHP.html

National Resource Center for Health and Safety in Child Care and Early Education
http://nrckids.org/consultants.htm

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http://www.healthychildcare.org/pdf/BlueprintII.pdf

Where to Find More Information: Cultural Competence

Cross Cultural Health Care – Case Studies
http://support.mchtraining.net/national_ccce/

Early Head Start National Resource Center
http://www.ehsnrc.org/pdffiles/ta5.pdf

Goode TD. National Center for Cultural Competence. Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care.
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http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=d5X%2FOqyqeuY%3D&tabid=185

U.S. Department of Health and Human Services
Administration for Children and Families
http://www.childwelfare.gov/systemwide/cultural/families/

Where to Find More Information: Policy Development

California Childcare Health Program Health and Safety Policies Checklist
http://www.ucsfchildcarehealth.org/pdfs/Checklists/UCSF_Policy_Checklist_rev3.pdf

National Network for Child Care. Parent-provider contracts and policies.
http://www.nncc.org/Business/p.contracts.policies.html

National Resource Center for Health and Safety in Child Care and Early Education (NRC)
http://nrckids.org/

U.S. Department of Justice. Americans with disabilities act: ADA home page.
http://www.usdoj.gov/crt/ada/adahom1.htm

Where to Find More Information: Advocacy

American Academy of Pediatrics (AAP)
http://www.aap.org/

Washington office news releases and press statements
http://www.aap.org/advocacy/washing/wnews.htm

AAP state legislative links
http://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Pages/State-Advocacy-Web-Resources.aspx

Association of Maternal and Child Health Programs (AMCHP)
http://www.amchp.org/

AMCHP Maternal and child health email lists
 http://www.amchp.org/aboutamchp/elist.htm

Child Care Aware
http://childcareaware.org/

Child Care Law Center
http://www.childcarelaw.org

Children's Defense Fund
http://www.childrensdefense.org/

Child Welfare League of America
http://www.cwla.org/

Coalition of National Health Education Organizations
http://www.cnheo.org/

Families USA
http://www.familiesusa.org/

National Association of Children's Hospitals and Related Institutions
http://www.childrenshospitals.net/

National Court Appointed Special Advocate (CASA) Association
http://www.nationalcasa.org

National Early Childhood Technical Assistance Center, State part c coordinators
http://www.nectac.org/contact/ptccoord.asp

Save the Children USA
http://www.savethechildren.org/index.asp

Where to Find More Information: Health Education

Child Care Aware
http://www.childcareaware.org

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Healthfinder

http://www.healthfinder.gov/

National Black Child Development Institute (NBCDI)
http://www.nbcdi.org

U.S. Department of Health and Human Services
Office of Minority Health Resource Center
http://minorityhealth.hhs.gov/

Where to Find More Information: Medical Home and Home Visiting

American Academy of Pediatrics (AAP)
The National Center for Medical Home Initiatives for Children with Special Needs
http://www.medicalhomeinfo.org/

AAP Community Pediatrics
http://www.aap.org/commpeds/

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Family Support America
http://www.familysupportamerica.org

Family Voices, Inc.
http://www.familyvoices.org/

Institute for Family-Centered Care
http://www.familycenteredcare.org/

Maternal, Infant, and Early Childhood Home Visiting Program
http://mchb.hrsa.gov/programs/homevisiting/index.html

National Early Childhood Technical Assistance Center
http://www.nectac.org/default.asp

National Center for Medical Home Initiatives for Children with Special Needs
http://www.medicalhomeinfo.org/about/

Weinberg ST. Pennsylvania Chapter of the American Academy of Pediatrics. WellCareTracker.
https://www.wellcaretracker.org/index1.php

Where to Find More Information: Resource and Referral

211 Hotline
United Way of America, Alliance of Information and Referral Systems
http://www.211.org

Alliance of Information and Referral Systems
http://www.airs.org

Centers for Disease Control and Prevention
http://www.cdc.gov

Child Care Aware
http://www.childcareaware.org

Child Care Bureau
US Department of Health and Human Services
Administration on Children, Youth and Families
http://www.acf.hhs.gov/programs/ccb/

Head Start Program
US Department of Health and Human Services
Administration on Children, Youth and Families
http://www.acf.hhs.gov/programs/ohs/

Kotlas C. Center for Instructional Technology
Evaluating websites for educational uses: Bibliography and checklist
Evaluating Websites

Medicaid Program
US Department of Health and Human Services
Centers for Medicare and Medicaid Services
https://www.cms.gov/home/medicaid.asp

Nutrition Assistance Programs
USDA Food and Nutrition Service
http://www.fns.usda.gov/fns

State Children's Health Insurance Program (SCHIP)
US Department of Health and Human Services
Centers for Medicare and Medicaid Services
https://www.cms.gov/home/chip.asp

Social Security and Supplemental Security Income (SSI)
http://www.socialsecurity.gov

Temporary Assistance for Needy Families (TANF)
US Department of Health and Human Services
Administration for Children and Families
Office of Family Assistance
http://www.acf.hhs.gov/programs/ofa/

US Government's Official Web Portal
Federal Citizen Information Center
 http://www.info.gov/

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APPENDIXES

Appendix A: Resource List of Child Care Agencies and Related Organizations

Appendix B: Health Literacy Resources

APPENDIX A

RESOURCE LIST OF CHILD CARE AGENCIES AND RELATED ORGANIZATIONS

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
Tel: 847/434-4000
Fax: 847/434-8000
Web: http://www.aap.org

Child Care Aware
1515 North Courthouse Road, 11th Floor
Arlington, VA 22201
Tel: 1-800-424-2246
Web: http://childcareaware.org/

Child Care Bureau, U.S. Department of Health and Human Services
Administration for Children, Youth and Families
Switzer Building, Room 2046
330 C Street, SW
Washington, DC 20447
Tel: 202/690-6782
Fax: 202/690-5600
Web: http://www.acf.hhs.gov/programs/ccb/

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
Tel: 202/628-8787
Email: cdfinfo@childrensdefense.org
Web: http://www.childrensdefense.org

Families and Work Institute
267 Fifth Ave., Floor 2
New York, NY 10016
Tel: 212/465-2044
Fax: 212/465-8637
Web: http://www.familiesandwork.org

National Association for the Education of Young Children
1509 16th Street, NW
Washington, DC 20036
Tel: 202/232-8777 or 800/424-2460
Fax: 202/328-1846

Web: http://www.naeyc.org

National Association for Family Child Care
5202 Pinemont Drive
Salt Lake City, UT 84123
Tel: 801/269-9338
Fax: 801/268-9507
Email: nafcc@nafcc.org
Web: http://www.nafcc.org

National Black Child Development Institute
1101 15th Street, NW, Suite 900
Washington, D.C. 20005
Tel: 202/833-2220
Fax: 202/833-8222
Web: http://www.nbcdi.org

National Center for Children in Poverty
Columbia University School of Public Health
215 W. 125th Street, 3rd Floor
New York, NY 10027
Tel: 646/284-9600
Fax: 646/284-9623
Email: info@nccp.org
Web: http://www.nccp.org

National Center for Education in Maternal and Child Health
Georgetown University
P.O. Box 571272
Washington, DC 20057-1272
Tel: 202/784-9770
Fax: 202/784-9777
Email: mchlibrary@ncemch.org
Web: http://www.ncemch.org

National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
Tel: 303/364-7700
Fax: 303/364-7800
Web: http://www.ncsl.org

National Resource Center for Health and Safety in Child Care and Early Education (NRC)
13120 E. 19th Ave., Mail Stop F541
P.O. Box 6511
Aurora, CO 80045
Tel: 800/598-KIDS (5437)
Fax: 303/724-0960

Email: info@nrckids.org
Web: http://nrckids.org

Stand for Children
516 SE Morrison, Suite 206
Portland, OR 97214
Tel: 800/663-4032
Fax: 503/963-9517
Web: http://www.stand.org

Zero to Three
National Center for Infants, Toddlers, and Families
2000 M Street, NW, Suite 200
Washington, DC 20036
Publications: 800/899-4301
Email: 0to3@presswarehouse.com
Tel: 202/638-1144
Web: http://www.zerotothree.org

APPENDIX B

HEALTH LITERACY RESOURCES

Resources for Understanding the Audience
Culture, Health and Literacy
http://www.worlded.org/docs/Culture_Health_Literacy.pdf
A guide to health education materials for adults with limited English literacy skills.

Resources for Writing Health Related Materials
Clear & Simple: Developing Effective Print Materials for Low-Literate Readers
National Cancer Institute
http://www.cancer.gov/cancertopics/cancerlibrary/clear-and-simple/page1

Simply Put
Center for Disease Control and Prevention
Tips for creating easy to read print materials your audience will want to read and use.
http://www.cdc.gov/healthliteracy/pdf/Simply_Put.pdf

Endres J, Montgomery J, Welch P. Lead poison prevention: a comparative review of brochures. J Environ Health. 2002 Jan-Feb;64(6):20-5; quiz 35-6.

Bibliographies
Understanding Health Literacy and its Barriers
Current Bibliographies in Medicine 2004
National Library of Medicine
http://www.nlm.nih.gov/archive/20040830/pubs/cbm/healthliteracybarriers.html
Contains 651 citations from January 1998 through November 2003. Topics covered include background, adherence/compliance, age factors, comprehension readability, usability and other assessment, cultural considerations, decision making, economic and other access barriers, materials development and strategies, toolkits, handbooks and audiovisuals.

General Overview
DeWalt, DA., Berkman, ND., Sheridan, S., Lohr, KN, Pignone, MP. (2004). Literacy and health outcomes: A systematic review of the literature. Journal of General Internal Medicine, 19(12); 1228-1239.

Williams, MV., Davis, T., Parker, RM., Weiss, BD. (2002). The role of health literacy in patient-physician communication. Communicating with Special Populations. 34(5); 383-389.

http://www.readability.info/info.shtml

Testing/Assessing Audience Ability Articles

Horner SD, Surratt D, Juliusson S. Improving readability of patient education materials. J Community Health Nurs. 2000 Spring;17(1):15-23. Available from: PubMed; PMID 10778026

Articles related to Material Development and Strategies
Cotugna N, Vickery CE. Health literacy education and training: a student-professional collaboration. J Am Diet Assoc. 2003 Jul;103(7):878-80. Available from: PubMed; PMID 12830028

Monsivais D, Reynolds A. Developing and evaluating patient education materials. J Contin Educ Nurs. 2003 Jul-Aug;34(4):172-6. Available from: PubMed; PMID 12887228

The Smog Readability Formula [Internet]. Salt Lake City (UT): University of Utah Health Sciences Center; [modified 2011 Sept 9; cited 2004 Apr 30]. Available from: http://aimhieducational.com/InclusionResources/smogreadabilityformula.pdf

Wright P. Criteria and ingredients for successful patient information. J Audiov Media Med. 2003 Mar;26(1):6-10. Available from: PubMed; PMID 12916632