Healthy Futures for Young Children
Implementing the Healthy Futures Curricula to Promote Health and Safety in Early Childhood Settings
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The little girl came into the emergency room wracked with seizures. A common lice infestation had led her there. Thinking the pink anti-louse shampoo prescribed by her pediatrician was an oral medication, the girl’s mother had spoon-fed it to her.

“She [is] a very good mom. She just didn’t understand,” says Laurel Wills, MD, FAAP, who treated the girl in the emergency room that day. “She inadvertently poisoned her own kid.”

Now a staff physician at Gillette Children’s Specialty Healthcare in St Paul, MN, and Minnesota Chapter Child Care Contact of the American Academy of Pediatrics (AAP), Dr Wills tells the story to illustrate how easy it is to make a health-endangering or even life-threatening mistake when caring for children.

And as someone who has dedicated herself to promoting children’s health and safety wherever they are, she adds a hypothetical, “What if the adult in the scenario were a day care teacher?” It’s not hard to imagine what the possible outcomes might have been.

Millions of children in the United States spend as many waking hours in early education and child care settings as they do at home. As caring and competent as child care providers may be, many do not have a great deal of training in health and safety. Nor do they have the direct contact with pediatricians and other health care professionals that parents do.

“It’s up to us physicians to educate people, especially child care providers.”

Need for Information

Conveying a child’s health care needs can turn into a game of telephone, with key information lost en route from pediatrician to parent to child care staff, says Laura Jana, MD, FAAP, Nebraska Chapter Child Care Contact.

In addition, child care providers may not be aware of best practices for health and safety at early education and child care facilities. These practices include standards to prevent infections, decisions about when a child is too sick for care, and the proper administration of over-the-counter and prescription medications.

“It’s up to us physicians to educate people, especially child care providers,” says Noreen Womack, MD, FAAP, Idaho Chapter Child Care Contact. “It is our job to inform them of the set guidelines.”

In other words, early education and child care providers need accurate, accessible training on health and safety and assistance putting best practices in place at their facilities. Physicians can provide that training and assistance.
Support for Healthy Futures Training

The AAP Healthy Futures implementation grants enable state AAP chapters to do just that. Funded by McNeil Consumer Healthcare and administered in cooperation with the Healthy Child Care America program, these grants fund AAP chapters to use AAP-developed curricula for training early education and child care professionals on 2 important topics: administering medication and managing infectious diseases.

The AAP and McNeil Consumer Healthcare believe pediatricians play an important role in training early education and child care professionals. Since 2010, 25 chapters in 25 states have received 1 or more Healthy Futures implementation grants. This report features the experiences in 10 of those chapters.

Differing child care regulations, requirements for professional development, geography, demographics, and other factors mean implementation of the curricula differs in each state. But, in every case, the Healthy Futures implementation grants offered an important method to improve collaboration among pediatricians, early childhood systems, and early education and child care providers.

“It really represents an opportunity to bring capacity to promoting health in child care,” says Dina Lieser, MD, FAAP, Child Care Contact for New York’s Chapter 2, which received a grant to implement the medication administration curriculum and an expansion grant to build on the chapter’s original project. “There are so many issues to collaborate on between medicine and child care, but obviously there’s regulation around medication administration, … and it’s an area that resonates with child care. It’s an amazing stepping stone to much broader collaboration.”

This report looks at the 3 stages of implementing the Healthy Futures curricula: (1) getting projects off the ground, (2) training child care providers, and (3) putting new knowledge in place at child care centers once staff members are trained.
Nearly Two Decades of Promoting Collaboration Between Pediatricians and the Early Childhood Field

The Healthy Futures curricula are part of a broad effort by the AAP and its partners to promote early education, health, and safety of children in child care centers, preschools, and other out-of-home child care facilities. These initiatives aim to increase access to preventive health services and safe physical environments and to promote a medical home for every child, with care coordinated by the child's primary care provider.

One program—Healthy Child Care America, Child Care and Health Partnership—strives to increase pediatrician participation and effectiveness in providing high-quality care and promoting children's early education, health, and well-being. Pediatricians do much of the work of Healthy Child Care America, including introducing programs like the Healthy Futures implementation. These pediatricians volunteer their time as Chapter Child Care Contacts. Appointed by the AAP in all state chapters, Chapter Child Care Contacts lead a network of pediatric child care experts who mobilize efforts to improve the health and safety of children in early education and child care and engage parents in discussions about care quality and options. Each volunteer is a member of the AAP Council on Early Childhood.
Chapters arranged trainings in unique ways depending on the state’s training and licensing requirements and its system for providing professional development for child care providers. In addition, Chapter Child Care Contacts had different visions for how to start their projects, depending on their backgrounds, connections with state systems, and sense of what would work best in their states.

**Close Working Relationships**

Partnerships have proved to be a key ingredient to success for most states.

“You have to have a close working relationship with the other early childhood systems,” says Dr Womack. “I cannot do anything without enlisting the help of partners, such as the Idaho Association for the Education of Young Children [AEYC].”

The Arkansas Chapter worked with the Department of Human Service’s Division of Child Care Early Childhood Education to hold a large train-the-trainer session that included Head Start representatives, licensing specialists, Arkansas Better Chance programs, and community health nurses from the Department of Health.

“The success [of the training] is largely because we had the Division of Child Care and Early Childhood Education’s support,” says Maya Lopez, MD, FAAP, associate professor at the University of Arkansas for Medical Sciences and the Arkansas Chapter Child Care Contact. “They were part of the program. … We were able to make sure that everyone would come.”

In Michigan, Chapter Child Care Contact Andrew Hashikawa, MD, FAAP, set up a series of lectures by working with the Michigan Head Start Association, the Michigan AEYC, community colleges, and the Child Care Network’s Great Start Collaborative, a southeast Michigan nonprofit that supports parents and child care providers.

State Head Start Associations (the membership network for the government-funded early childhood programs) and regional child care resource and referral agencies, which support the professional development of child care providers and help parents find child care, were common partners for the AAP chapters implementing the Healthy Futures curricula.
Getting on the Calendar

In Illinois, 7 of 16 regional child care resource and referral agencies collaborated with the AAP chapter on its Healthy Futures implementation. Multiple trainings were held in Cook County, where much of the child care that occurs in Illinois is concentrated.

“All of the agencies have training calendars,” says Rachel Sacks, manager of early childhood development for the Illinois Chapter. “Some trainings are set up very far in advance because of how the training calendar works. They send out their schedule 3 months in advance. So it’s a little bit of a challenge. It’s sometimes hard to get trainings on the schedule.”

But Ms Sacks says dealing with resource and referral agencies’ timeframes was worth the effort. The referral agencies worked with the Illinois Department of Health and Human Services to ensure credentialing, which is a very important benefit to early education and child care providers.

“We gained significant value from our partnerships with the referral agencies,” she says. “This was a fantastic approach. They’re already set up to organize these trainings, they have a training coordinator whose role it is to schedule and coordinate. They have publicity and ways to communicate with providers, evaluations, sign-in sheets. They’re perfectly set up to serve this very population. Going straight to the folks who train child care providers and saying we have a curriculum and a physician to provide it was very valuable for them. We listened to their expertise and if they said, ‘We’d like to do it on a Saturday morning,’ we looked for a physician who could do it.”

Integrating the AAP curricula into the professional development system for child care providers proved more complicated in some states than in others. Minnesota’s “career lattice” enables child care providers to acquire certificates for 12 steps of training. To support the career lattice, the state-funded Minnesota Center for Professional Development maintains a registry of approved trainings and trainers. To be included in the lattice, the AAP curricula had to be approved by the state and presented by approved trainers, says Dr Wills. For Minnesota’s first medication administration grant, she enlisted a child care health consultant who had knowledge and experience in health and safety practices in child care to train regional health consultants and provided 1 training session herself to statewide Head Start center health consultants. During the chapter’s expansion grant, which began in 2014, Dr Wills will contract with a nursing college professor from central Minnesota who is already an approved trainer with the state.

“We got to that list [of approved trainers] was huge because it allowed us not to have to reinvent the wheel,” she says.

Chapters with expansion grants have found that putting additional trainings in place is made easier by the partnerships and knowledge they gained through their first grants.

“We listened to their expertise and if they said, ‘We’d like to do it on a Saturday morning,’ we looked for a physician who could do it.”

Piece of a Bigger Picture

The connections established to get Healthy Futures projects off the ground serve a broad purpose. Collaborating with the state and regional associations of child care providers increases their knowledge of the ways the AAP can assist child care providers and influence early childhood policy, says Kris Morrissey, executive director of the Nebraska Chapter.

“They have a mission through federal grants to do work like this, so they are enthusiastic and excited about partnering with us,” Ms Morrissey says of her chapter’s partners. “It’s nice to let them know we have this chapter, we have resources, [and] we’d like to get them out there.”
Four Tips for Launching a Successful Healthy Futures Project

The Chapter Child Care Contacts interviewed for this report offered advice on how to successfully launch projects in which pediatricians train, or facilitate training of, early education and child care providers:

1. **Be involved with child care policy.** Having an AAP member on the state's child care or early childhood advisory council is helpful and will familiarize you with the players in your state.

2. **Know who's involved.** Common partners for AAP chapters included the state agency in charge of early education and child care, the state Head Start Association and other professional membership groups for child care providers, and regional child care resource and referral agencies. These groups often have training schedules, conferences, training instructors, and popular communication vehicles (eg, Web sites and newsletters) through which to market trainings.

3. **Know your state's professional development system for certification of child care providers and ongoing training.** In some states, courses must be approved by the state before they can be offered to providers for formal credit toward their professional development requirements or certification. In several states, only approved instructors can be used for trainings.

4. **Plan ahead.** In some states, training calendars are set months ahead of time. Conference schedules are also set far in advance.
In Idaho, a mountain pass can be an obstacle to professional development.

“Some regions of Idaho are not very densely populated and roads are difficult,” says Dr Womack. “Having [trainers] who reside in those areas is helpful.”

Idaho has had 2 Healthy Futures implementation grants: infectious diseases awarded in 2011 and medication administration currently under way in the 2013–2014 fiscal year.

In both cases, the AAP chapter and its partner, Idaho AEYC, have used a two-tiered training model that includes training of trainers and regional trainings for providers.

To attract providers to the free regional trainings, which are conducted by trained and state-approved child care health consultants, the chapter and the association offered food and refreshments, scheduled trainings in the evenings, and offered 3 IdahoSTARS (Idaho State Training and Registry System) training hours to apply to state licensing requirements or professional development.

Hands-on Training

Dr Womack says the free Healthy Futures trainings made possible by the implementation grants build trust and relationships among the child care health consultants and child care providers. “Once child care providers get to meet the child care health consultants through these trainings, they are less hesitant to reach out for help in the future,” she says.

For example, with other funding, Daleen Nelson, manager of Idaho AEYC’s Child Care Health Consultant Program, visited ABCs and 123s Child Development Center in Nampa, ID. Ms Nelson and another consultant educated 15 staff members and 140 children about infectious disease prevention right in the classroom.

“They taught the kids songs to make sure they were washing their hands the right way,” says Becky Jordan, the center’s owner and director. “That was the best part of it, that they were able to come out during the day with the kids here, because … the best way to learn is hands on, and for them to see if we are doing it properly and for them to step in to help.”

At the time, Ms Jordan was readying the center for its quality rating and improvement system assessment, which rates facilities on a scale of 1 to 5.

“A big part of assessment is about hand washing and germ control and health and hygiene,” Ms Jordan says.
Creativity and Collaboration

The Healthy Futures trainings were welcome in a state that ranked dead last in Child Care Aware’s 2013 ranking of state child care center regulations and oversight.¹

“In Idaho, we don’t have very much money for early childhood,” says Larraine Evans Clayton, executive director of the Idaho Department of Health and Welfare’s governor-appointed Early Childhood Coordinating Council. “Small grants can really help us achieve some milestones in terms of developing quality training and engaging folks from different disciplines and putting people together to find creative solutions. … We do a lot of work creatively with very little money. These grants really are critical for us.”

Dr Womack says the Healthy Futures grants have helped strengthen the AAP chapter’s relationships with Idaho’s early childhood systems. This year, Dr Womack is collaborating with the coordinating council on a home visiting program for families with young children. With Ms Clayton, she developed a video on early brain and child development and toxic stress that will be the first training viewed by all child care providers who participate in IdahoSTARS.

“You form these relationships and they start building on each other until you feel you are part of a team of like-minded people who all share your vision,” Dr Womack says. “I find myself spending more and more hours doing this because I learn so much and enjoy the interactions. It is encouraging to feel you aren’t alone in striving to overcome seemingly insurmountable obstacles.”

“Small grants can really help us achieve some milestones in terms of developing quality training and engaging folks from different disciplines.”

All the chapters used the same curricula for their implementation projects, but each determined how it would deliver the trainings. States took 3 approaches to delivering trainings:

1. Direct training for early education and child care providers
2. Training for trainers (usually nurses or certified child care health consultants), who in turn train child care providers
3. A combination of direct training and train-the-trainer

In some states, pediatricians delivered the trainings. In others, pediatricians coached or trained other health professionals (eg, nurses, child care health consultants, pharmacists) to deliver trainings to child care providers or other trainers.

Most states have delivered in-person trainings, but a few (eg, Washington) are experimenting with online delivery.

The training approach the chapters took depended on several factors including the needs and preferences of the state’s child care providers and the state’s professional development system for providers (if one was in place). These factors also influenced modifications that many chapters made to the curricula.

“Child care providers felt more comfortable with the medical community after [the trainings].”

When Pediatricians and Child Care Providers Meet

Dr Hashikawa has delivered more than 40 presentations of the Healthy Futures medication administration curriculum in Michigan since 2010. “I started out doing train-the-trainer,” he says. “But ultimately, providers wanted it from a medical provider. Questions come up that relate to medical issues. … I really feel that when physicians give [the training], it can be more powerful.”

The Illinois Chapter also veered from its original intent to use a train-the-trainer model. Instead, 5 pediatricians and 2 nurses gave presentations of the medication administration curriculum to groups of child care providers at libraries, hospitals, and other locations.

“One of the big things that came out of some of the feedback was that child care providers felt more comfortable with the medical community afterwards,” says Ms Sacks. “For health and safety practices, that’s incredibly valuable. People said they would feel comfortable talking to a pediatrician about whatever questions or concerns they had.”
The information sharing went both ways, Sacks says, with pediatricians gaining greater understanding of the day-to-day challenges and requirements at child care facilities. “The pediatric providers got a better sense of where child care providers are coming from,” she says. “There were a lot of questions on EpiPens. That may help us in the future develop something on this topic. We’re not fully doing our job if we’re only training [child care providers] on Tylenol or eye drops.”

Three chapters interviewed for this report—Arkansas, Michigan, and New York—have enlisted pediatric residents to train or consult with child care providers as part of their medical education. “Developing physicians who are comfortable interacting with child care providers is hugely important,” Dr Hashikawa says.

### Modifying the Curricula

Most chapters modified the curricula in some way. For example, they tailored content to reflect state policies, added topics they considered useful for child care providers, or condensed the information because of time considerations.

In Georgia, the Department of Early Care and Learning reviewed the Healthy Futures training manual for the AAP chapter. Department staff noted places to embed state policies to which providers must adhere, says Fozia Eskew, the chapter’s early intervention coordinator.

Michigan’s Dr Hashikawa added to the medication administration training content on anaphylaxis, allergies and EpiPens, asthma, and emergency medicines (eg, seizure medicines).

Several states condensed the curricula to save time for busy child care providers, many of whom can complete trainings only after working hours. “We have to leave out some of the activities,” says Idaho AEYC’s Ms Nelson. “[Providers] basically want an evening training from 6:30 to 8:30.”

But Jaci Foged, director of the University of Nebraska Children’s Center, says she would have attended a training lasting 3 or more hours. “We had lots of questions and everybody had stories. You can learn a lot from stories,” Ms Foged says.

“Developing physicians who are comfortable interacting with child care providers is hugely important.”

### Approved Trainers

In several states (eg, Idaho, Washington), trainers were required to be approved or certified, meaning that physicians could not be trainers. To meet this requirement, Chapter Child Care Contacts trained child care health consultants or found approved trainers with expertise in a curriculum’s topic.

In Washington, even online courses must be conducted by a State Training and Registry System–certified trainer who maintains contact with course participants, says Cathe Paul, a private child care health consultant contracted by the Washington Chapter.

“You have to have a forum for people taking the course to communicate with each other,” Ms Paul says. “I set up an e-mail list, and every time they take the course, they have to send their certificate to me and submit 1 question about the training.”
Even as a state trainer interacting with students only electronically, Ms Paul says using an AAP curriculum lends her credibility. “I’m not just any nurse giving a response to a question,” she says. “I’m using a training approved by AAP. This isn’t just something somebody just pulled out of the woodwork and set up. This just has a lot of credibility, and it has best practice information.”

Creating Incentives

States had differing success marketing training sessions. Even within a state, attracting attendants in urban areas was often easier than doing so in rural and suburban regions. Several chapters offered incentives to boost attendance or to ensure that participants brought their new knowledge back to their facilities.

In Utah, getting suburban child care providers to trainings proved difficult at first. The chapter gave incentives to increase participation.

Dr Hashikawa has used part of his chapter’s grant to give out *Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs* to participants. “I use the book with the training so they actually have something to go home and use,” he says. “Providers say, ‘We use this book all the time. We have completely changed our policies.’”

Professional development hours and credit toward state certification are also valuable incentives, Chapter Child Care Contacts say.

“*I’m not just any nurse giving a response to a question. I’m using a training approved by AAP.*”
First Adapter
Andrew Hashikawa, MD, FAAP
Technology enables Michigan’s Dr Hashikawa to tailor the Healthy Futures medication administration curriculum to every audience he stands before, in real time.

Audience members have clickers hooked up to a TurningPoint wireless student response system. They respond to knowledge-check questions that appear on screen. Dr Hashikawa can track their answers anonymously.

“It gives me real-time feedback during the lecture,” he says. “If everyone’s comfortable with pinkeye, we spend less time on that topic—if everyone’s getting that question right.”

Outside his Healthy Futures training schedule, Dr Hashikawa sees other ways technology can promote the health and safety of children in child care settings. He’s working with a Michigan company to design a Web-based program that will track sick children in the state’s child care facilities. “The hope is, you do a training, and you can see how [the child care providers] manage kids [or] kids with allergies,” he says.

Dr Hashikawa and developers are adapting an electronic health records system that is already used by summer camps and potentially might be used by child care providers to track illness, injuries, and allergic reactions.

Child Care Champion
Renee Olesen, MD, FAAP
Dr Olesen is the face of child care in Utah.

As video spokesperson for the 2-year-old Care About Childcare Utah Web site, Dr Olesen presents herself as a knowledgeable resource about child care quality for 2 reasons: she’s a pediatrician and a parent with a young child in child care. She wore both hats when she prepared child care health consultants to present the Healthy Futures medication administration curriculum across Utah.

“When my child is on amoxicillin for an ear infection, what are the steps taken to make sure that that medication is given appropriately?” she says. Being both a parent and a pediatrician, she could describe this sort of situation to trainers so that they could train child care providers with confidence, she says.

Dr Olesen takes on her spokesperson role during every office visit in her practice at the Intermountain Kearns Clinic in Kearns, UT, offering parents information about licensed child care. “I ask every family, ‘Where is your child every day?’” she says.

Pediatrician-Provider
Laura Jana, MD, FAAP
When she moved from Denver, CO, to Omaha, NE, 11 years ago, Dr Jana couldn’t find the high-quality day care she wanted for her young children. Never one to settle, she responded by opening a child care franchise, which she owned and operated for 9 years.

Owning the center dovetailed nicely with Dr Jana’s interest in supporting children’s health and development beyond traditional pediatric practice. “I didn’t get into child care because of the 4 walls of child care,” she says. “It’s a new way of looking at pediatrics in that you go to where the kids are.”

Because she has “been there and done that,” Dr Jana says she can easily walk in the shoes of child care providers who attend Healthy Futures training. “Owning a child care center really gives you a healthy dose of reality,” she says. “Something may sound great, but I can’t see how it will ever work. Something else may be great, but it’s simply too expensive to be realistic. I haven’t seen anything better written than the AAP’s medication administration curriculum. You don’t have to wonder whether it’s accurate advice.”
Two birds, one stone.

That’s Dr Lopez’s approach to implementing the Healthy Futures curricula as the Arkansas Chapter Child Care Contact: train child care providers and new pediatricians at the same time.

Child care providers have received training from 10 residents at Arkansas Children’s Hospital, where Dr Lopez is an associate professor. Meanwhile, residents have the opportunity to provide training and one-on-one consultations, speak at child care and early childhood conferences, and learn about the importance of collaboration among medical, early education, and child care professionals.

Dr Lopez arranged for residents’ participation in Healthy Futures to count as their scholarly project, a requirement for graduation. “Pediatricians provide credibility to the curriculum,” Dr Lopez says. “I think it’s good for child care providers and early childhood professionals to see that pediatricians are their partners. Pediatricians care and want to help them.”

Regional Approach

The Arkansas Chapter has received 3 grants to implement both Healthy Futures curricula, including a 2013–2014 grant to expand the medication administration training. In addition, Healthy Child Care Arkansas, which is managed by Dr Lopez and other University of Arkansas for Medical Sciences faculty and staff who work to support child care providers, received state funding in 2012 to provide infectious disease and medication administration trainings for 1 year.

Using a train-the-trainer approach, the chapter has trained resource and referral agency coordinators, licensing specialists, child care health consultants, and Head Start personnel, who in turn train early education and child care professionals in their regions of the state.

“At the end of the training we grouped people in the same region to sit down together and discuss how to hold trainings in their area,” Dr Lopez says. “With the grant money, we asked each regional Child Care Aware agency to coordinate with other folks, such as community health nurses, to conduct a training in their area.”

Pediatricians provide credibility to the curriculum.

Child care health consultant Wanda Walker, of Healthy Child Care Arkansas, coordinates with the 7 regional resource and referral agencies to set up and market the regional trainings. Ms Walker conducts the trainings, and the Arkansas Chapter provides materials.
Obstacles to Attendance

Ms Walker and Dr Lopez struggle with boosting attendance at trainings for child care providers. “However hard we try to train,” Dr Lopez says, “I don’t think we’re reaching enough child care providers. It has to be done on a larger scale, but we don’t have funding to do all that.”

“Many providers will register for the course but then do not attend,” Ms Walker says. “They have full-time jobs and families, so it is difficult for them even though we try to be flexible, offering the trainings at various times and on Saturdays. We do offer continuing education credit. That’s always some incentive.”

Offering online training or e-books won’t solve the problem in a state where many child care providers don’t have easy access to the Internet or computers, Dr Lopez says. “We really need to provide them with hard copies.”

The effort to reach child care professionals is worth it, though, Ms Walker says. “If I was going to pick something that I felt was a huge impact on health and safety in child care programs, it would be this [medication administration] course,” she says. “I don’t think this course should ever go away, regardless of funding. Every child care director should take this course to teach … staff and use these forms. So much medication is given now, and it’s probably going to be more. There are sicker kids in child care, [and] there are more kids with chronic health needs.”
In August 2012, whooping cough swept through Washington’s King County. To be proactive in fending off the disease, Ami Satterfield, principal of Evergreen Academy Montessori Preschool in Issaquah, WA, doubled up with a sister school to get infectious disease training for staff members.

“I think it was a huge eye-opening event for staff to learn if they don’t immunize themselves, they could carry it to students,” she says.

That fall, she encouraged staff members to get flu shots. Independent child care health consultant Peggy King, a trainer for the Washington Chapter’s Healthy Futures projects, helped Ms Satterfield and her child care providers find free flu clinics.

Ms Satterfield’s staff has also taken the medication administration training. Now, staff members know to read medication packaging.

“We went through all of the medication in the cupboard and returned 3 meds that weren’t appropriate for the child’s age,” she says.

“The Cost Benefit of Training

A common theme in interviews for this report was the difficulty of scheduling times and finding locations that were convenient for training child care providers, who often take care of children from 7 am to 6 pm. Even when chapters offer free sessions after working hours, providers must pay for transportation and in some cases hire others to care for their own children.

Some child care managers described going to great lengths to ensure their staff receive adequate training on health and safety. Ms Foged closes her center twice a year to train her staff. She also provides Sunday trainings for her 140 part-time employees, many of whom are students at the University of Nebraska. Sunday trainings cost the center $9,000, she says.

Getting free training for herself and her assistant director on medication administration was a big help, she says. As a result, she redeveloped her center’s policies. “We only give medication once a day unless it’s required to give it every 4 hours. We hardly do any [as-needed] medicine. If the parent says, ‘Just give them some Tylenol,’ maybe they shouldn’t be here.”
Ms Foged also began using forms from the training, including a checklist staff members complete before locking up medications. “I think the training empowers the child care providers to say to the parents, ‘We need this’ or ‘I can’t do that.’ It gives the providers the tools and information that they need in order to keep the children safe,” says Ms King.

“Administering medication is something some child care providers have a lot of angst over,” says Carolyn Christensen, professional development specialist in the Utah Department of Workforce Services’ Office of Child Care. “Having this class helped them to realize that they were able to do it and that it was important.”

> Now they’ll have a connection to an actual person who can help them if they have any questions about health and safety in the future.

**Following Up**

Many people interviewed for this report, whether pediatricians, child care health consultants, or providers, say 1 training event is not enough to ensure safe medication administration and infectious disease prevention.

After attending Healthy Futures training, several facility directors asked Gina Engenberger, child care health consultant for Nebraska’s Lincoln Lancaster County Health Department, to help them tighten up their policies for documentation and revise their medication administration forms.

The Washington Chapter is experimenting with formalizing follow-up, offering child care health consultant visits to several centers and to individuals who take the online class. Participants get certification credit for the visits, which include a nurse checking policies and procedures and answering providers’ questions about medication administration.

The visits ensure that training lessons have been put into practice and help establish relationships. Ms Paul says, “Now they’ll have a connection to an actual person who can help them if they have any questions about health and safety in the future,” she says.

For her part, Ms Foged plans to stay up to date on medication administration. “We have someone set up to come give the course to us again at the health department,” she says. “It’s something directors need to take every 2 years. Medicine is always changing. You become complacent. Maybe you’ll hear something you missed before.”
Even in a state with robust policies to protect the health and safety of children, things don’t always work out as planned.

Take New York. The state has strong regulations on medication administration in early childhood settings and a certification process providers must complete to be approved to give medication to children in their care. But because providers can choose whether to give medication at all, and because myths abound about the cost and difficulty of certification, many family child care homes in the state have opted out.

“We found out through the Office of Children and Family Services that 75% of day care centers are medication approved,” says Emily Leone, a child care health consultant with resource and referral agency Child Care Council Inc. and a collaborator with New York’s Chapter 2 on Healthy Futures implementation. “They’ve taken the training and contracted with a nurse or physician to oversee policies. But of the large family home-based child care [settings], 15% are medication approved, and 5% of small family day cares are approved.”

Also large disparities exist in the number of child care centers approved in certain regions. For example, in New York City, far fewer than half of the centers were approved. Parents may not realize that their child care providers cannot give children medication when they need it, Ms Leone says.

Stepping Back

Chapter Child Care Contact Dr Lieser, who co-directs the advocacy group Docs for Tots and directs community pediatrics at Nassau University Medical Center, had planned to begin implementing Healthy Futures training last year. Instead, she took a step back.

She surveyed 50 child care health consultants and held focus groups with providers to learn about providers’ perceptions of medication administration and the process of becoming an approved site, as well as the ways consultants might be able to promote training.

Dr Lieser learned that child care providers:

► Feared giving medications might lead to legal liability
► Felt getting medical paperwork filled out could be challenging
► Mistakenly thought training was expensive and would take too much time
► Did not feel an obligation or a pressure to embrace medication administration as part and parcel of holistic, high-quality child care
Even at approved facilities, Dr Lieser found that providers were not always confident about medication administration. Many expressed a desire for ongoing training that reinforces specific components of the curriculum. Programs did not want the added cost of hiring a nurse to monitor compliance with state medication administration policies.

In addition to gathering information from providers and consultants, Dr Lieser enlisted Ms Leone to “crosswalk” the Healthy Futures medication administration curriculum with the state’s training. “Each was stronger in different ways,” Dr Lieser says. She hopes the Healthy Futures curriculum can become a state-approved training for medication administration certification.

**Reaching Out**

With this year’s expansion grant, New York’s Chapter 2 is embarking on a public outreach and awareness campaign. Dr Lieser and her colleagues are creating materials to raise parents’ awareness of the need for medication administration training at child care facilities and to educate them about what a center with appropriate training looks like.

In addition, an online training module, currently in development, will prepare pediatric residents to visit early learning settings and serve as “child care champions.”

“They are going to work with the setting to convert them to want to take the medication administration training and process necessary in New York,” Dr Lieser says.

The chapter will also reach providers by presenting at the 2014 New York Association for the Education of Young Children Conference. In the long term, the chapter aims to educate doctors about their role in helping families communicate with child care providers about medication administration and other issues.

Dr Lieser says an opportunity is possible for exploring the state approval process and advocating for incorporating the Healthy Futures curricula into the New York state medication administration training landscape.

Meanwhile, the chapter will use a grant from the federal Health Resources and Services Administration to strengthen New York’s child care health consultant network and bolster professional development for early education and child care providers.

“I credit the medication administration grant with helping us get that [funding],” Dr Lieser says.
The Healthy Futures grants for implementation and expansion of training on medication administration and infectious disease prevention in early childhood settings have led to positive changes in all 10 states included in this report.

The grants have enabled AAP chapters to enhance the knowledge of thousands of child care providers. They also have led to concrete policy changes in many child care facilities, helped increase child care providers’ comfort with pediatricians, and bolstered the important role that child care health consultants, who are key allies for pediatricians, play in some states.

Some Chapter Child Care Contacts say the Healthy Futures projects gave them a foot in the door with state agencies and advocacy networks concerned with early childhood education and development. In all 10 states, the projects have complemented other work the chapters are doing to promote the health and safety of young children.

Danette Glassy, MD, FAAP, Washington Chapter Child Care Contact, says, “These grants continue to provide credible health trainings and have been extremely important in keeping child care health consultation organized across the state.”

Pediatricians and child care health consultants interviewed for this report mentioned several ways they would like to see the curricula expanded or improved:

► Add modules or create a new curriculum on anaphylaxis and allergies, topics of urgent concern to health care providers

► Create more robust, interactive online learning experiences for child care providers who have access to the Internet and would like to take the trainings whenever they choose, as well as ways to deliver the curricula using mobile devices and Web video services such as Skype and Google Hangouts

► Increase child care providers’ access to print copies of Caring for Our Children

Chapter Child Care Contacts emphasized the need for ongoing training. Some conveyed a need for increased funding, but most said small grants can be effective because they can be supplemented with in-kind support from state agencies and child care resource and referral networks. For example, several chapters’ partners provided space, marketing, logistical support, and other assistance for the Healthy Futures projects.

Sustaining training programs from year to year is a concern that might be offset by longer grant periods.

Several states have involved residents in their Healthy Futures implementation. Funding aimed specifically at integrating Healthy Futures into medical education might be beneficial.

Several chapters offer the Healthy Futures curricula in languages other than English, such as Hmong, Somali, and Spanish. And several Chapter Child Care Contacts expressed the need to target “friend and family” care providers and child care settings that fall outside state licensing requirements.

As Dr Wills sees it, ensuring health and safety in child care settings is as important as filling classrooms with developmentally appropriate toys. “As pediatricians, we have had the experience of seeing what can happen when things do not go well under the umbrella of health and safety,” she says. “So if an unsafe situation happens—a child doesn’t get [her] prescribed medicine—we would be on the clinical end of having to take care of that child.”

Conclusion

The Healthy Futures grants for implementation and expansion of training on medication administration and infectious disease prevention in early childhood settings have led to positive changes in all 10 states included in this report.

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Without question, the Chapter Child Care Contacts will continue to promote professional development on health and safety for child care providers, with support from the AAP and the early childhood systems in their states. The Healthy Futures implementation projects have exemplified the ways pediatricians and child care providers can work together to nurture and protect young children’s health and well-being in child care settings. By making it possible for more pediatricians, state systems, child care professionals, and early childhood education advocates to join in this effort, the AAP and its funders ensure healthy futures for thousands of children in child care across the nation.

**Resources**

*Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition* (National Resource Center for Health and Safety in Child Care and Early Education)

[Healthy Child Care America Web site](#)

[Healthy Futures Curricula Web site](#)