STATE POLICIES IMPACTING THE PARTICIPATION OF YOUNG CHILDREN WITH MEDICAL NEEDS IN CHILD CARE

A Policy Analysis Conducted In Connection With A Developmental Disabilities Project Of National Significance

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INTRODUCTION

In 2002, the University of Connecticut's A.J. Pappanikou Center for Excellence in Developmental Disabilities Education, Research, and Service received funding to work with families of infants and toddlers with complex medical needs in Connecticut and help identify the supports they need in order to participate in child care. Our aim was to assure that the targeted families and child care providers would have the information, training, and equipment or material supports that might be needed to enable these children to successfully join in the daily routines and activities of community-based child care. As we began to engage ourselves in front-line activities with families and providers, we anticipated learning about supports and barriers at the level of state policy in Connecticut.

This report is a companion piece to the efforts we have undertaken in our home state. We wanted to learn what policies other states have adopted to ensure that the

benefits of child care would be available to children with medical challenges and their families.

A few quotations will illustrate some of the key issues we encountered and demonstrate why policy development in this arena is a matter of urgency both for families hoping to receive services and for individuals and organizations trying to provide services.

We learned that the time, training, and documentation required by caregivers to enroll and safeguard children with special health care needs can be substantial.

> Our children, because of their age, would for the most part be experiencing their illness for the first time and would be 'unstable' (meaning their medication and dosage would change frequently). This would require new documents, and new training with the staff for each change.
>
> (Administrator of a multi-site child care program operated by a public school system in the Northeast.)

We learned that there may be no one place in many states to look for explanations of policies and responsibilities and many "gray areas" not explicitly addressed by regulations and policies. Practitioners and consumers must combine knowledge of state regulations with an understanding of the Americans with Disabilities Act's provisions for "reasonable accommodations."

> I am not certain child care providers would give shots for allergic reactions (or if they can legally). Our regulations do not prevent them from doing these things but we do not mandate that they must. I think the Americans with Disabilities Act mandates more than we do in these types of situations. It is kind of a gray area.
>
> (Director of the state agency that licenses child care in a southeastern state.)

We learned that in some states, it is not just the licensing regulations and the ADA that come into play; Boards of Nursing and Nurse Practice Acts may have a

powerful impact on what medically-related activities are legally permitted to child care teachers and providers.

> Child care providers in our state were told that if they were dispensing medication and receiving money from their clients or customers—even if dispensing medication was not one of their primary activities—then they were practicing nursing without a license and could be in big trouble.
>
> (A Healthy Child Care Coordinator in a Midwestern state)

We learned that the needs of some children exceed the capabilities even of highly-motivated, well-trained child care professionals and that quality care may require round-the-clock coverage by registered nurses.

> Our center looks like any other quality child care center, but we have two shifts of nurses on staff and a ratio of one caregiver to three children for all children under age three.
>
> (The executive director of a center specializing in care for children with complex medical needs in a mid-Atlantic state.)

The scope of our investigation

The questions we posed at the outset of this study were about policies explicitly designed to enable the participation of children with complex medical needs in child care--or to delimit their participation in some fashion. Within a short period of time, it became clear that any report detailing state-level child care policies intentionally aimed at this group of children would make for very light reading indeed, as the great majority of states had none.

Just as quickly, we learned that a large number of states were grappling with broader policy questions related to matters of health care and medical procedures within child care settings. The policy revisions they were making and the resources

they were bringing to bear were not in the main designed with children with complex medical needs in mind. Some could be expected to affect every child (e.g., availability of child care health consultants, updated regulations covering the dispensing of medications). Others would affect children whose medical issues were of a serious nature but would not be described as "complex" (e.g., children who need daily blood glucose testing, children who carry injectable Epi Pen cartridges in the event of an allergic reaction). Others would be applicable to a much smaller group whose medical needs were more intensive or were combined with physical or mental disabilities (e.g., Medicaid waiver policies).

As we learned about these policy developments in telephone interviews and e-mail correspondence with program operators and state agency representatives, we also began to "unpack" (i.e., take apart and examine its contents) the term "children with complex medical needs." What became clear is that while a few children will consistently have medical needs that are of a complex or intensive nature, many other children will move back and forth along a spectrum. A child with cerebral palsy may present as a healthy child having intensive needs in the area of communication or mobility--but after a hospitalization for surgery, may emerge with her medical needs taking precedence. A child with a recently diagnosed seizure disorder may require intensive monitoring and frequent adjustment of medications, and then enter a period of stability in which the seizure disorder is in the background. Another child may enter child care without any special health conditions, but acquire one or more following a trauma, an illness, or for unexplained reasons.

Policies at the state level as well as the practices of providers, rather than equating "medical complexity" with any fixed group of children, will ideally help to create a state of readiness for responding to any child during a period when he or she enters the zone we call "medical complexity." As we came to appreciate this, our inquiry evolved into one that looked at the full spectrum of policies and resources that affect the implementation of medical monitoring, medical interventions, and medical procedures impacting any child enrolled in a child care setting.

Program profiles

As we pursued this inquiry, we learned about numerous programs that specialized in serving children with complex medical needs, and others that did not specialize but were able nonetheless to respond to individual children with medically significant needs. We decided that brief descriptions of a few of these centers, noting the kinds of resources and supports that make their services possible, would add to the understanding of readers and enrich the policy findings with illustrations of day-to-day practice. The centers profiled do not necessarily represent the full range of organizational approaches to serving the population targeted in this study, nor should the presence or absence of a program profile for any particular state be taken to connote the quality or level of policy development in that state. Nor are we trying to suggest that specialized centers with higher concentrations of children with more complex medical needs is the best policy route. (We profiled for illustrative purposes one community-based, "non-specialized" center that has served children with intensive

medical needs. We look forward to adding more examples in this category as readers respond to this report.)

How we obtained information

The persons who provided information to us are listed in Appendix A. They worked primarily in state agencies involved in child care licensing, subsidized child care, and children's medical services, as well as in state affiliates of the American Academy of Pediatrics' Healthy Child Care America project, and as researchers at some of our sister University Centers for Excellence in Developmental Disabilities. Some of our best-informed contacts came from list-serves operated by the Division of Children with Special Needs at the American Academy of Pediatrics, and by the National Resource Center for Health and Safety in Child Care at the University of Colorado Health Sciences Center.

We wish to thank each of our informants for their generosity in sharing their knowledge and time with us. Any inaccuracies or gaps in the findings are solely the responsibility of the author.

A "work in progress"

The fact that policies in several different arenas of state government can impact the provision of medical supports to children in child care (child care licensing, nursing regulations, child care reimbursement policies, Medicaid waivers, and so forth) meant that it often required conversations with representatives of multiple agencies to paint a complete portrait of any given state's policies and practices. Our timetable and

resources did not permit us to spend unlimited time trying to identify and connect with every possible player in each of the 51 states (counting the District of Columbia). Therefore we do not claim that the findings we report below are complete or comprehensive.

We expect that as this report begins to circulate and draw comment, we will learn more about relevant policies and practices in many of the states we have profiled. We also hope to receive information about the two states (Mississippi and West Virginia) that are currently missing from the matrix. As we do so, we look forward to updating and expanding the report.

AN OVERVIEW OF THE FINDINGS

We have placed information about each state's policies into a matrix, the six headings of which represent aspects of state policy that emerged as themes of our findings. The six headings (and themes) are as follows:

1. Restrictions on Dispensing of Medications
2. Policies on other Medical Treatments
3. Higher Subsidies and Other Financial Supports
4. Child Care Health Consultants and Other Informational Resources
5. Policies Regarding Specialized Centers
6. Issues Related to Boards of Nursing or Nurse Practice Acts

Restrictions on Dispensing of Medications

Every state's child care regulations address the dispensing of medications to children in care. Nearly all of them give providers the option to decide if they are going to administer medications. Since the passage of the ADA, however, the option not to dispense medication is nullified in the case of a child for whom the giving of medication is a "reasonable accommodation" for a disability. The ADA defines disability as an impairment in "one or more life functions." If a physician has found a young child to be in need of medicine on a daily basis, then a life function such as blood circulation, breathing, or digestion is typically jeopardized without it.

Regrettably, regulatory language seldom states this point straightforwardly. The revised District of Columbia regulations (in Final Draft form when this report was written) make explicit what other states leave unstated: "each facility has the option of deciding whether to administer medications 'with the exception' of medications 'covered under the Americans with Disabilities Act.'" New Jersey's regulations are also exemplary in making this point explicit. Centers may choose not to administer medication as a general policy but must make "reasonable accommodations for the administration of medication or health procedures to a child with special needs, if failure to administer the medication or health care procedure would jeopardize the health of the child or prevent the child from attending the center."

For those providers who do choose to administer medications as a general policy, licensing rules spell out several standard rules in all states. Typically the medication

must be in the original container; prescription medication must have a label stating the name of the physician, child's name, name of the medication, and medication directions; all prescription and non-prescription medication must be dispensed according to written directions on the prescription label or printed manufacturer's label; and written parental authorization must be on file. Requirements for logging the time and date of each dose given and the safeguarding of such records for a specific period of time are a little less commonplace. For states where requirements are limited to the standard litany, we have left this column of the matrix blank. When we encountered state policies that went beyond this, we filled in descriptive information for that state. What we found is that a small but growing list of states is imposing further restrictions on the dispensing of medications. Such policies have the potential to ensure higher quality health care for all children but they also may complicate the picture when it comes to serving children whose need for medications is chronic.

The following states are requiring child care staff and providers to receive some kind of documented training or certification prior to dispensing any medications: Colorado, Connecticut, Delaware, District of Columbia, Louisiana, and Wyoming. Typically (but not universally) the providers subject to these new requirements are directed to get their training from registered nurses.

The development of medication administration requirements is clearly a cutting edge issue across the country. In Kansas, such a requirement is expected within a few years. In Virginia, a similar provision was deleted by the head of a task force after the membership recommended it, but could be reconsidered. In New Jersey, a task force

has already implemented voluntary medication administration training and is hoping to have it incorporated into licensing requirements for centers.

Just as there is no lawful option not to dispense medications to children in need of them due to disabilities, the lack of properly trained or certified staff (in states that impose these new requirements) will not be a legally defensible justification for a provider or center to decline to enroll a child with a chronic condition who needs medication. Many of the licensing officials with whom we spoke made it clear that they understand that the Americans with Disabilities Act supersedes the regulatory restrictions. For example, in the event a new child with a chronic health condition was being enrolled in a center, the center would presumably have to expedite the process of getting someone trained to dispense medications if they didn't already have someone properly certified on staff. However, we did not find any regulatory language that incorporates this kind of specific guidance.

Policies on other Medical Treatments

Child care regulations as a rule omit any specific reference to medical procedures other than the dispensing of medications. Yet families and providers need guidance on whether such medically-related procedures as blood glucose testing, use of gastronomy tubes, and nebulizers are appropriate responsibilities for staff and providers in the child care field.

In numerous states, regulations which used to impose extra requirements on centers that served children with disabilities (including those with medical needs) were

revised to eliminate these references in order not to condone any discrimination on the basis of disability. Maryland, for instance, eliminated a section of their child care regulations addressing “children with special needs” in order to be in compliance with the ADA and instead incorporated language throughout the regulations that called for meeting individual needs. Michigan, New York, and Wisconsin are among the states that made similar revisions in their regulations. Each of these states now leaves it to the licensees to determine what might constitute a "reasonable modification" in the area of special health care needs.

Because many states do not spell out their policies on medically-related procedures other than medication, much of the information that appears in this column of the matrix summarizes current "policy in practice" as explained to us in correspondence and telephone interviews by our sources. Only where there is specific reference to regulations or legislation have these policies been put into print and made explicit.

As noted, California and Connecticut have recently addressed certain specific procedures through legislation: the former passing separate bills relating to blood glucose testing and the use of nebulizers; the latter passing a bill targeted to support the enrollment of children carrying pre-filled injectable cartridges (Epi Pens) to treat allergic reactions.

Arizona is one of the few states whose regulations have attempted to account pro-actively for the whole range of possible special health care conditions that have to be addressed within the child care context. Their regulations stipulate that when a child

has a special health care need that is covered in an IEP or IFSP, the child care setting is required to "review and adopt" these plans. For a child who has a special health care need but no such prior plan, the center or home must convene a meeting with the child's health care provider and family and develop a plan.

Higher Subsidies and Other Financial Supports

The third and fourth columns in the matrix examine two essential forms of support that states can make available to providers of child care: financial and informational. The third column describes financial supports we were able to identify. Higher reimbursements have been designed in many states to address the challenge that providers face in serving children with disabilities. Children with special health care needs may or may not have disabilities, but serving these children can have a similar impact on providers: need for training, improved staffing ratios, access to specialized equipment, and so forth.

The approaches that states have taken to providing higher rates under their subsidized child care programs are numerous. In some states (e.g., New Hampshire, South Carolina, Wyoming), there is a uniform amount that can be added on for an eligible child. In other states, there are two or more levels: Oklahoma offers a "moderate" and a "severe" rate increase, while Alaska has four different levels of increase, topping out at 100% above the standard rate, based on an "accommodations scale." In Montana and Oregon, the rate is individually negotiated based on documented needs, and can normally go as high. Respectively, as 200% and 300% of the

standard rate. In Arizona, the state contracts with a small number of inclusive centers around the state to enroll children whose support needs are greater--and allocates substantial funding to help them cover the extra costs, but doesn't break it down to a "special needs" rate. Massachusetts and Vermont have policies that allow for the hiring of extra staff or other supports in child care and do not restrict the beneficiaries of this support to families eligible for subsidy--but these programs are restricted to children under three who are participating in early intervention. Oregon has a separate subsidy program run by its Developmental Disabilities Council, which can serve children all the way through school age and whose families exceed the income guidelines for the state subsidy program.

Many of the subsidy programs were created with children who had disabilities in mind--defined either as participating in Part C programs, having an Individualized Educational Program (IEP), receiving SSI, or being a child with a disability under the ADA. Some (Alaska, Montana, Oregon) were broader, with the extra funding triggered by the need for individual accommodations, regardless of any particular label (or lack of label).

There are numerous states where nothing is noted in the matrix that we know have their own subsidy programs for children with disabilities. It was not possible within our time frame and resources to untangle the eligibility criteria and clarify which of these would apply to children whose needs were strictly or primarily in the chronic health care category. The information in this column of the matrix should be

considered a beginning. We anticipate updating as we learn more about additional state policies.

Child Care Health Consultants and Other Informational Resources

Providers are in need not only of financial supports but just as critically, informational supports. Healthy Child Care America, which has been providing grants and technical assistance to state-level projects through the American Academy of Pediatrics, has been a prime mover in promoting the concept of child care health consultants (CCHCs), who are generally nurses who are trained to carry out a variety of health- and safety-promoting activities with child care centers and providers. Providing information and support to a center or provider that enrolls a child with special health care needs is one of numerous functions that CCHCs carry out.

This column of the matrix indicates whether a state has developed a program of CCHCs and also identifies other forms of informational support to providers that we were able to identify.

So far, Colorado, Connecticut, and Minnesota appear to be the only states that has written into their licensing requirements the obligations for centers to have CCHCs. In Colorado, all centers serving children five or under must have a monthly consultation with a nurse consultant trained in pediatric care. In Connecticut, centers that serve infants and toddlers full time are required to have weekly visits by a health consultant, with specific tasks defined in state regulations. Part day programs for infants or toddlers must have monthly visits. Minnesota regulations require that every

center-based child care facility utilize the services of a "health consultant professional" (registered nurse, public health nurse, nurse practitioner, physician or physician's assistant) to annually review center health and safety policies. Centers enrolling infants must receive monthly on-site visits from their health consultants. (In none of these states does the requirement apply to family child care homes.)

Policies Regarding Specialized Centers

We found only a handful of states with any kind of infrastructure supporting the development of specialized centers in which skilled nursing care was available in child care settings. We entered that information in this column of the matrix.

Noteworthy is the fact that a handful of states have developed regulations for an entity variously called a PPEC or a PPECC (Prescribed Pediatric Extended Care Center). In some states (e.g., Florida), it is not viewed or regulated as a child care center, but rather as an alternative rehabilitative site for a child who would otherwise be receiving medical supports in the home. In other states (e.g., Delaware, Pennsylvania), the PPECCs are licensed as child care centers in addition to being licensed and regulated as PPECCs by (respectively) the Office of Health Facilities Licensing of the Delaware Division of Health and Social Services and the Pennsylvania Department of Health. One of Delaware's two centers serves their target group alongside typically developing peers. (See description below of Children's Secret Garden.)

Maryland has two centers that are comparable to PPECCs but they do not use that terminology. The centers are subject to draft "medical child care" regulations

which were promulgated in the mid 1990s under the Department of Health and Mental Hygiene. No matter how such programs are regulated, they do serve a child care need for the families, and they do offer the full-scale nursing and other services needed by these children.

North Carolina does not have a regulatory infrastructure to create either a PPECC or a "medical child care center" but appears to be unique in having made available state funding recently to initiate the development of a center that will specialize in serving a small number of children with medical and technological dependency. It will be licensed as a child care center but also subject to a series of more stringent requirements developed by the task force that brought it into being. The operator of the center will be a private company which also operates PPECCs in Florida and Georgia. (For a description of one of these PPECCs in Georgia, see Tender Health Care, under Program Profiles below.)

Also worth noting is that a few states (Nebraska, Iowa, Vermont) allow families to receive the support of Medicaid waivers when their children with medical needs are attending child care.

Issues Related to Boards of Nursing or N*u*rse Practice Acts

As illustrated by one of the quotations highlighted in the Introduction, child care providers have sometimes run afoul of rules designed to restrict certain activities to trained medical professionals. In the last column of the matrix, we report what our informants told us about any issues that had arisen in this arena. It appears that there

are two major implications for the child care field of Board of Nursing (BON) policies and of the closely related Nurse Practice Acts (NPA) that each state has on the books. The first implication is that certain procedures may be disallowed to non-(medically) certified staff.[1] This means that even with parental authorization, the willing child care provider or teacher may not lawfully conduct the procedure. The BON and NPA regulations in Kansas disallowed providers there from giving medications, and could have done so in New York, but for a recent legislative act that temporarily waived the NPA provisions pending the crafting of a longer term solution. It was also NPA restrictions that led to the passage in California of two recent pieces of legislation, as discussed above, making it lawful for child care providers to conduct the finger-prick test for blood glucose and to administer nebulizers, provided they arranged for proper training, put into place emergency procedures, and complied with other specific provisions. NPA restrictions have left different states with a wide variety of rules. For instance, providers who receive the new medication training in Wyoming may administer nebulizers and the finger-prick test for blood glucose but under no circumstances may they give injections, such as insulin or an Epi Pen. The latter can only be given by nurses.

The second implication of BON and NPA rules are that even when nurses are working with child care providers or teachers, they must beware of how they conduct themselves. The various state rules define when a nurse may or may not "delegate"

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[1] BON and NPA rules do not restrict the activities of parents or guardians in tending to the equipment and medical procedures of their own children.

(teach and authorize someone to conduct) a procedure, and in general these rules require nurses to be very conservative about the circumstances in which they delegate to a medically non-certified person. In many states, nurses must avoid giving direct instruction on how to work with any specific child on any specific procedure, because that would be inappropriate delegating and could jeopardize her or his nursing license. However, if a parent has trained a child care provider to work with their child, the nurse may observe and offer feedback. The nurse may also provide presentations, demonstrations, and literature relating to a procedure as it is generally conducted, so long as she or he does not directly train someone to work with a particular child.

In Louisiana, for instance, CCHCs are trained not to solicit instructions directly from physicians, which would place greater professional liability on them, but to provide general information and training and to empower the providers to speak with parents and physicians to develop child-specific plans. In Montana, Child Care Plus and Healthy Child Care Montana are working with the State BON to clarify regulatory issues in advance of setting up a statewide network of CCHCs. In New Hampshire, the state BON revised its rules regarding delegation of procedures in 2001 to remove barriers to the training of non-medically certified persons in early childhood programs and other settings and facilitate the participation in these settings of children with special health care needs. However, for certain procedures such as Epi Pens, the Board advised nurses to make sure it was the parents that conduct the training, with nurses offering resources and support.

Some state BON rules offer greater flexibility than others. Oregon's rules exemplify this: Procedures that are considered "special tasks of nursing" may be taught and delegated to staff without medical credentials if several conditions are met, including but not limited to the following: the child's condition is stable and predictable; the RN determines how frequently the child's condition must be reassessed; the RN evaluates the ability of the unlicensed person to perform the task and documents the rationale for delegating the task to this person.

How do licensed centers and providers become familiar with the nursing regulations within their own states? Many are not even aware of them, and in places like California, Kansas and New York, some of them have been caught by surprise, conducting procedures that were in fact reserved to nurses. Many state child care regulatory frameworks are completely silent on any rules relating to the nursing profession, leaving it to providers to navigate the potential discrepancies and gaps between child care regulations and BON/NPA rules. Arizona is one of the few which addresses it more directly. The child care regulations explicitly refer providers to the Board of Nursing to learn which procedures (e.g., insertion of gastronomy tubes) may only be carried out by qualified health care personnel. They then leave it to providers to be guided by the ADA as to what obligation they have to provide a service that is restricted to a nurse. Contracting for such services is obligatory when doing so is a "reasonable accommodation" but not when the cost would create an "undue burden."

STATE BY STATE: A MATRIX OF POLICIES IMPACTING THE PARTICIPATION OF YOUNG CHILDREN WITH MEDICAL NEEDS IN CHILD CARE

STATE	RESTRICTIONS ON DISPENSING OF MEDICATIONS[2]	POLICIES ON OTHER MEDICAL TREATMENTS	HIGHER SUBSIDIES AND OTHER FINANCIAL SUPPORTS	CHILD CARE HEALTH CONSULTANTS AND OTHER INFORMA-TIONAL RESOURCES	POLICIES REGARDING SPECIALIZED CENTERS	ISSUES RELATED TO BOARDS OF NURSING OR NURSE PRACTICE ACTS
Alabama	Parental authorization must be renewed every 7 days.			There are 8 CCHCs responding to the needs of providers in 45 of the state's 67 counties.		
Alaska			For a child eligible for a subsidy, the state will increase the subsidy 25%, 50%, 75%, or 100% based on an "accommodations scale."	The state will pay for 9 hours of training specific to a subsidized child who has an individual need.		
Arizona		For any child whose special health care need is covered in an IEP or IFSP, the child care setting is required to "review	The state contracts with child care centers through a competitive bidding process to pay nearly double	Healthy Child Care AZ has developed a publication geared to help parents (in both Spanish and English) to approach child		Child care regulations refer providers to the Board of Nursing to learn which procedures (e.g.,

[2] Wording describing state regulations in all columns of the matrix is condensed and paraphrased from actual regulatory or statutory language.

[3] Arizona Early Childhood Diabetes Coalition. (1999). Diabetes and Child Care: A Guide to Serving Children with Diabetes in the Child Care Setting.

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		and adopt" these plans. For a child who has a special health care need but no such prior plan, the center or home must convene a meeting with the child's health care provider and family and develop a plan. Nebulizers and Epi Pens are subject to the standard permissions required for any medication.	the typical child care rate for children with disabilities or special health care needs. In 2002, 334 children at 17 inclusive child care centers were receiving support through this mechanism. Contracted programs may (for instance) hire additional staff, consult with specialists, employ part time nurses, and provide transportation.	care providers and explain the individual needs and strengths of their children with medical and other issues. The Arizona Early Childhood Diabetes Coalition produced a manual.[3]		gastronomy tubes) may only be carried out by qualified health care personnel. The ADA then governs the next steps: Contracting for such services is obligatory when doing so is a "reasonable accommodation" but not when the cost would create an "undue burden."
Arkansas				A curriculum is in development through Healthy Child Care Arkansas to train nurses to become CCHCs. Pilot training was		

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				initiated August 2002.		
Califor-nia		Two recent bills were passed to ease restrictions imposed by the state's Nurse Practice Act, One permits child care employees and providers to administer nebulizers and the other permits them to conduct finger prick tests for blood glucose. Each law sets out requirements for training, emergencies,, and access to medical providers. To conduct other procedures, providers may seek waivers of NPA resurrections on a case-by-case basis.			Medi-Cal (the state version of Medicaid) will pay under certain circumstances for nursing services in center-based programs for children defined as having medical fragility. (See description of Together We Grow.)	(See second column at left.)

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Colorado	In order to administer medications, centers have been required since 1999 to have one or more staff members complete a 4-hour training. The regulations clearly establish the terms under which any specific procedure may be delegated by a nurse to a member of a child care staff.	In 2002, the required medication training added the administration of Epi Pens and nebulizers.	In Colorado, County Departments of Social Services make all rate-related decisions. State policy allows them to pay up to twice the rate for subsidized children with special needs, including those with strictly medical issues. But it is a county option, and not all counties pay a higher rate. For those that do, a professional has to certify the special needs condition, and then the rate is based on an individualized written plan completed by County Child Care staff and the provider.	A 2001 updating of regulations required all full-day licensed child care centers serving birth through five to have a monthly consultation with a nurse consultant trained in pediatric care. Healthy Child Care Colorado offers a two day training to nurses to teach them the role of nurse-consultant and address issues and concerns related to delegation of procedures to child care staff.		The nurse-consultant to a given center may delegate the administration of medications to a person who has completed the required training (see first column at left). Parental consent and the development of a care plan precede the process of delegation.

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Connecti-cut	Policies were revised in 2001to require documentation that any center-based staff member giving medications shall have been trained by a registered nurse, physician's assistant, or doctor, Approval by the medical professional must be renewed every year.	New legislation prohibits as of Jan. 2003 that licensed centers and group family child care homes refuse enrollment to children who have allergies and/or carry Epi Pens (see Glossary). Procedures adopted for other medications (see left) are now applicable to administration of pre-filled, injectable cartridges.		Centers that serve infants and toddlers full time are required to have weekly visits by a health consultant, with specific tasks defined in state regulations. Part day programs for infants or toddlers must have monthly visits. Centers serving preschool or older children have no such mandate. Healthy Child Care CT has piloted training to help those who serve this function better understand their role and increase their competency.		
Delaware	Child care providers may administer medications (but not injections) if		The "special needs" supplement allowed for state-subsidized child		Regulations have been in place since the 1980s for PPECCs (see	The Nurse Practice Act was revised by the legislature to permit child care

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	they receive certification based on a test following a self-study training, and then follow protocols as mandated by the training.		care is $2.00 per week.		Glossary), which are group care facilities that serve as an alternative to nursing care in private homes. These regulations are under the same division that deals with facilities such as nursing homes. Only recently has one organization combined the services of a PPECC with those of regular child care. (See description below of Children's Secret Garden.)	teachers and providers to administer medications after passing a test (see first column at left).
District of Columbia	Regulations adopted in 2002 require any facility that administers medications to keep records showing that each individual	The updated D.C. regulations make explicit what is left unstated (but true) in many state licensing standards: each facility has the				

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	staff member providing medications to children has been trained on proper administration techniques, recognition of adverse reactions, and documentation. However, it does not specify the source or credentials of the party providing the training.	option of deciding whether to administer medications "with the exception" of medications "covered under the Americans with Disabilities Act."				
Florida	Florida licensors have recently proposed a new rule addressing children with allergies to medication or special restrictions to medication. The rule would require documentation from a physician in the child's file,	It is the opinion of the licensing bureau that the ADA imposes a mandate for providers to conduct needed medical interventions for a child with a disability, but the issue is not addressed in	Under the Florida Partnership for School Readiness, the School Readiness statute allows a child care provider to establish rates that may differentiate for various levels of special needs or risk.	Public Health Nurses in the County Health Departments in the 67 counties are available as resources to the child care facilities in their respective counties but there is no statewide model of CCHCs currently being implemented.	Florida has 15-20 PPECCs (see Glossary) that provide "medical day care" to children that meet eligibility criteria. Florida's Department of Health Children's Medical Services Division has 15	

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	informing appropriate staff, and posting the information in the classroom.	regulations.			Children's Multidisciplinary Assessment Teams (CMAT) which can authorize certain high cost services for medically complex children in accordance with guidelines.	
Georgia		Child care teachers and providers are permitted to carry out a variety of procedures, such as blood glucose testing, insulin injections, G-tubes, and nebulizers, so long as the parents have demonstrated the procedures and given them written instructions and written, signed, dated authorization (which must be annually updated).			Medicaid in Georgia will support medical day treatment for children with technology dependence (see description of Tender Care).	

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Hawaii		The state child care regulations stipulate that when a child has a health condition, plans shall be made for the facility's medical consultant and the child's regular source of health care to communicate.		Healthy Child Care Hawaii, through the University of Hawaii, has begun recruiting and training pediatric interns to act as CCHCs. However, they are asked to do this on a voluntary basis and most of the activity in 2002 was in the Honolulu area.		
Idaho				In April 2002, the subsidized child care program, ICCP (Idaho Child Care Program) began requiring relatives (i.e., kith and kin care) being paid with subsidized child care funds to have CPR, First Aid, one health and safety inspection, and attend a two hour orientation. At the		

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				same time, the state dispensed with all previously existing requirements it imposed on other entities receiving the funds, Through Healthy Child Care Idaho, they are in the process of training nurses to become CCHCs. However, there was no immediate prospect in 2002 of funding or policy activity to promote the availability of this service.		
Illinois				There are 24 nurse-consultants housed in the Child Care Resource and Referral agencies across the state and jointly supervised by the Department of		

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				Health and the CCRR system. They conduct training and on-site consultation.		
Indiana		State policies permit child care staff and providers to perform medical procedures such as blood glucose testing so long as they have written instructions from a M.D. (i.e., the same restrictions that would apply to any medication).				
Iowa			Iowa has a "special needs child care rate" available when parents of eligible children qualify for the child care subsidy. Children with special health care needs attending a licensed child care	A statewide system of CCHCs has been available to child care providers since 1999,		

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			center or registered home are potentially eligible for Medicaid waivers for (a) Interim Medical Monitoring and Treatment (IMMT); or (b) Respite. When a waiver is granted for IMMT, the child care staff or provider can be reimbursed at a higher hourly rate for those periods of time in which they are engaged in specialized treatments such as catheterization or G-tube feedings. Local Area Education Agencies sometimes contract with child care			

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			centers to be the Service Coordinator for infants and toddlers participating in Iowa's Early Access (early intervention) program. The centers receive a much higher rate for those hours billed as service coordination. This helps defray the costs of meeting individual needs.			
Kansas	Over the next three to five years, the licensing agency expects to incorporate a requirement for centers and home providers to have taken a course on administering			Healthy Child Care Kansas has designed a 10-hour course and resource manual covering many health-related topics, including medication administration. They have been training providers		

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	medication and to have passed a test based on the course prior to administering any medications. This policy change was on the verge of enactment in 1999-2000 but was derailed by a legislative committee.			using this course since 1998		
Kentucky				The state has introduced a statewide network of 88 Healthy Start nurse-consultants available to work with child care settings.		
Louisiana	As of January 2003, center-based child care employees will administer medications only after taking a 4-hour course on	Other procedures that go beyond the material covered in the new certification standards such as use of G-tubes or		Through Healthy Child Care Louisiana,, they have put together a network of 162 nurses who act as CCHCs. This is a		CCHCs are trained not to solicit instructions directly from physicians, which would place greater professional liability on them,

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	medication administration, implemented by CCHCs. Teachers passing a test based on the course will be certified for two years. The certification will allow them to dispense a wide variety of medications, including those requiring nebulizers.	injections, can be carried out after arrangements are made between parents, providers, and physicians.		public-private partnership and the members of the network vary in the amount of time they are available as child care consultants.		but to provide general information and training and to empower the providers to speak with parents and physicians to develop child-specific plans.
Maine				CCHC training was in the planning phase in 2002 through Child Care Plus Maine. A video prepared in response to a 2001 law requiring training for non-licensed school personnel to		

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				administer medications will be utilized to train child care providers as well.		
Maryland		Maryland eliminated a section of their child care regulations addressing "children with special needs" in order to be in compliance with the ADA and instead incorporated language throughout the regulations that called for meeting individual needs.			Draft "medical child care" regulations were promulgated in the mid 1990s under the Department of Health and Mental Hygiene, Title 10.09. Although they have never been formally moved from draft to final, the two centers that specialize in serving children in need of skilled nursing care (see description of PACT, below) have been abiding by these regulations.	
Massachu-setts			Families whose infants and	The Child Care Resource and		

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			toddlers are eligible for the regional consultation program (see column to right) receive vouchers, and centers that enroll these children can access funding for equipment, extra staffing, and other supports as needed.	Referral system has staff at each regional site to provide "customized" support to families seeking child care for a child with special needs including medical needs. Starting in 2001, the state created a system of consultation to permit integration of medically dependent children qualifying for Part C services into child care and other "natural environments." The consultants are accessed through the Child Care Resource and Referral system.		
Michigan		Child care regulations as revised in 2000 do				

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		not address specific policies relating to special health care needs but require providers to make reasonable accommodations for any individual needs, pursuant to the ADA.				
Minne-sota				State regulations require that every center-based child care facility utilize the services of a "health consultant professional" (registered nurse, public health nurse, nurse practitioner, physician or physician's assistant) to annually review center health and safety policies. Centers enrolling infants must receive monthly on-site	Some insurance companies in MN have explicitly declared that they would revoke coverage related to the liability of centers that enroll children with complex medical needs.	Nurses are currently barred from training non-medical staff to do procedures. Advocates are reviewing the Nurse Practice Act to determine if there need to be revisions to ease these barriers.

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				visits from their health consultants. In 2002 the Minnesota Department of Health was finalizing a job description for CCHCs and moving towards a more formalized system of professional development for them. Healthy Child Care Minnesota has disseminated a two-credit hour Internet course based on a resource manual called, “Special Children with Special Health Needs.”		
Missouri				As of fiscal 2003, there were 108 out of 114 counties in the state where a		

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				CCHC was available. They are accessed through local public health agencies. Missouri has established a statewide program of Inclusion Coordinators as well as CCHCs. The professionals in these two roles work cooperatively with one another in many parts of the state.		
Montana			Montana in 2001 adopted a mechanism to offer one-time or ongoing supplemental support to children in subsidized child care slots, based on need for special accommodations, not necessarily in			Child Care Plus and Healthy Child Care Montana are working with the State Board of Nursing to clarify regulatory issues in advance of setting up a statewide network of CCHCs.

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			conjunction with a diagnosed disability. The parameters allow the rate to go as high as double the usual rate; however, requests for rates higher than double are considered and decided by the Early Childhood Services Bureau. One-time payments for training, equipment, physical modifications and other matters that exceed what would be considered "reasonable accommodations" are normally capped at $1000. However, the regulations allow			

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			discretion to exceed that amount with appropriate documentation.			
Nebraska			Medicaid in Nebraska will pay for nursing services for children receiving Part C services through the Early Intervention waiver. Medicaid will pay for nursing services for children three and over for specific numbers of hours or days based on family needs under the Aged and Disabled Waiver; however, there are a limited number of families allowed use of these "slots" and the Medicaid		Medicaid waivers (see left) enable one center in the state to specialize in providing care to children with complex medical needs in a somewhat inclusive environment. (See description of Children's Respite Care Center.)	

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			rules are cumbersome.			
Nevada				Nevada is in the process of setting up a network of CCHCs. The first services to licensed homes and centers were expected to begin in early 2003. The CCHCs do not work for any one central agency, but for various agencies which have agreed to partner with Healthy Child Care Nevada and make part of their staff members' time available for this purpose.		
New Hamp-shire			Providers for children in subsidized care who have documentation of a disability by a	Healthy Child Care New Hampshire has worked to provide training for nurses to become CCHCs and through the		The state Board of Nursing revised its rules regarding delegation of procedures effective July 2001 to

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			physician receive $4.00 per day above the rate for that age group.	contributions of some local agencies, there were CCHCs available in some areas in 2002.		remove barriers to the training of non-medically certified persons in early childhood programs and other settings and facilitate the participation in these settings of children with special health care needs. However, for certain procedures such as Epi Pens, the Board of Nursing advised nurses to make sure it was the parents that conduct the training, with nurses offering resources and support.
New Jersey	New Jersey's MAP to Inclusive Child Care Team, Healthy Child Care New Jersey and the state	Child care center staff may not insert gastronomy tubes, even with parental permission. They		Providers access CCHCs through their local CCR&Rs. Each of 21 county	The Department of Health and Senior Services licenses and funds "medical day care centers"	The Act prohibits anyone but a nurse to administer g-tubes in center-based programs.

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	affiliate of the AAP have worked together to create a Medication Administration Training for child care providers. Fifty nurses had been trained by 2004 to provide the training statewide. The plans included a Universal Health Record and a standardized Special Care Plan. Those who developed the training were advocating for the Office of Licensing to make the training mandatory for center-based staff. However, in 2004, the training remained voluntary.	are allowed to carry out many other procedures.		CCR&Rs has a CCHC Coordinator, supported through CCDF funding. The coordinators are nurses, and they recruit and train other nurses to become CCHCs as part of their responsibilities in their current jobs. The CCHCs offer training, on-site consultation, and referrals to other sources for a variety of health issues related to child care. By 2004, 200 nurses had gone through the training.	that have nurses on staff and specialize in serving children with complex medical needs. In 2004,, they were reviewing the policies and the way the funds were being expended.	The regulations of the Nurse Practice Act are followed through the Department of Health and Senior Services
New				Healthy Child Care		

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Mexico				New Mexico is in the planning stages in addressing the needs of children with special health care issues in child care.		
New York	(See column at far right.)	Regulatory requirements specific to providers serving children with special needs were removed to comply with the ADA.		New York has a network of public health nurses who serve as nurse-consultants to child care settings. Funding decisions are made at the county level, so the commitment varies widely across the state.		It was recently recognized that the Nurse Practice Act (which forbade certain procedures to be carried out by non-medical personnel) and the legal view of child care providers as acting "in loco parentis" (giving medications or treatments with the authorization of parents) were in contradiction. A bill was passed in 2002 entitling providers to continue to give

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						medications according to parental wishes up through June 30, 2003. By then, "appropriate legislation" should be adopted.
North Carolina		An Inclusion Work Group is reviewing data and current practices to determine future directions in facilitating participation by children with medical needs in typical child care centers. It is hoped that only very few children will require the kinds of separate, specialized program represented by a new demonstration	Medicaid support is available under certain circumstances (see description of model center, at right) to support children with intensive needs in group care settings.	North Carolina has established a network of approximately 140 CCHCs across the state. Among their responsibilities is to work with child care providers to develop individualized care plans for children who require medical monitoring and procedures, including G-tubes, nebulizers, and apnea monitors.	The state appropriated $100,000 and targeted another $300,000 in federal funds to spur the development of a child care center that will enroll six children, birth through five, with intensive medical needs. It was delayed by state budget cuts but was anticipated to begin services by January 2003. The operator selected through	

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		project (see column to right).			competitive bidding was PSA (see description of Tender Health Care). The model center will be licensed under normal child care regulations; however. a statewide advisory board has spelled out ratios and other requirements that go above and beyond those for typical child care.	
North Dakota		Providers are not required by regulations to administer medications or other specialized health care measures. However, with training and authorization from		The Healthy Child Care North Dakota grant has provided each of the four regional Child Care Resource and Referral offices with a nurse to work as a CCHC. A Healthy Child Care manual has		Nurses are prohibited under the state's Nurse Practice Act from providing child-specific training to staff. (This would be regarded as delegating.) However, they can do general

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		parents, they are permitted to engage in a wide range of activities, including use of nebulizers, G-tubes, blood glucose testing, Epi Pens, and insulin injections. The CCHCs (see right) are promoting the practice of developing an Individual Health Plan for every enrolled child who needs routine medical monitoring or treatment. But there is no regulation to this effect.		been distributed to every licensed family child care provider and center. A curriculum addressing chronic conditions such as allergies, asthma, and seizures will be completed and disseminated in 2003.		education, answer questions from providers who are carrying out medical procedures, after receiving training and authorization from parents, and help with trouble-shooting.
Ohio		Special health care issues are one area being explored by a work group established in 2002 by the Ohio	A work group established in 2002 by the Bureau of Child Care and Development, is recommending that			

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		Department of Job and Family Services, Bureau of Child Care and Development.	providers be allowed to bill for up to 50% more for children in subsidized care that require specialized attention.			
Okla-homa			Oklahoma has instituted a supplement of $8.00 per day for children with "moderate" disabilities and $14.00 per day for children with "severe" disabilities applicable to children of families receiving subsidized child care. To apply, the child must already be receiving SSI, Part C (early			

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			intervention), or Part B (special education).			
Oregon			The subsidized child care program has a “high needs” rate which can be applied to any child whose care requires additional expense. The rate is individually negotiated and can go up to 300% of the regular rate (about $7.50 per hour or $1250 per month in 2002). A smaller Inclusive Child Care Project operated by he Developmental Disabilities Council offers similar supports and serves some families not income-eligible for	A Child Care Health Links Project initiated by Healthy Child Care Oregon, will be piloted in a few counties with state funding in 2003.		Procedures that are considered "special tasks of nursing" may only be taught and delegated to staff without medical credentials if several conditions are met, including the following: the child's condition is stable and predictable; the RN determines how frequently the child's condition must be reassessed; the RN evaluates the ability of the unlicensed person to perform the task and documents the rationale for delegating the task to this person.

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			the other program.			
Pennsyl-vania				A model of child care health consultation has been adopted as state policy under the leadership of Healthy Child Care Pennsylvania, and the Early Childhood Education Linkage System. They are providing training to CCHCs. However, the system relies in most regions on the volunteer efforts of nurses. Training for child care is subdivided into six regions, and there is training on inclusion of children with medical needs available in each region.	There are two centers (one in Pittsburgh and one in Philadelphia) that are staffed with full-time nurses and supported through Medicaid. These are licensed both by the Department of Public Welfare as child care centers and by the Department of Health as PPECCs (see Glossary).	In settings where nurses are involved, they must adhere strictly to the Nurse Practice Act. In settings where there are no nurses, providers have more flexibility to conduct procedures and to train staff to conduct procedures without reference to the provisions of the Act.
Rhode		In October 2002, Rhode Island				

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Island		Department of Human Services issued new regulations and certification standards applying to therapeutic services for children who have medical concerns, chronic illness, or mental health needs in state licensed child and youth care facilities. A center in which a child needs any kind of specialized supports will be required to have on staff a “therapeutic integration specialist” to coordinate the special supports and staff with the regular program activities and staff. Centers which are				

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		certified in this manner will have lower ratios of caregivers to children than other centers.				
South Carolina		With the written authorization of families, South Carolina providers are free to administer any medical procedures which may be requested of them, provided they follow their own written policies.	For children in subsidized care, a rate can be negotiated up to $20.00 per week above the going rate for the age group and geographical area. One-time "access grants" are made available for purchase of equipment or supplies adapted to individual needs.			
South Dakota	Providers are obligated to dispense medications, so long as they have the proper	Regulations do not address specific policies relating to special health care needs or disabilities but require		South Dakota was in the beginning phase in 2002 of establishing a network of CCHCs.		At one time there was discussion as to whether the administration of prescription medications should

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	documentation.	providers to make reasonable accommodations for any individual needs. Providers are obligated to engage in medical procedures requested by parents, provided training is made available and the procedure is not legally restricted to nurses.				be restricted to nurses but that policy change was not adopted.
Tennes-see		State child care regulations permit but do not require licensed providers to dispense medications and carry out other health care procedures. In addition to written permission from parents, they must		Three Tennessee state agencies have developed a network of 11 Resource Centers designed to promote developmentally appropriate practices, health and safety, and the participation of children with special	There are hospital-based child care programs in Tennessee that include children with more complex medical needs. These are licensed as child care centers and also subject to other standards imposed by the	Nurses in Tennessee may not train child care staff for specific procedures to be conducted on specific children. However, when parents train and authorize providers to conduct procedures, nurses

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		have on file a written explanation of the procedure from a physician. The physician must explicitly indicate that a child care provider without medical training may provide the specific service. The state's Respiratory Therapy Act prohibits anyone but a respiratory therapist from giving nebulizer treatments or suctioning a tracheotomy. This prohibition extends even to nurses. However, some child care providers provide these services with parent approval.		needs in licensed child care throughout the state. Each of the Resource Centers has a CCHC on staff. Part of their responsibility is to make on-site visits to support children who have special needs, including special health care needs.	entities that regulate their host institutions.	may offer education and support. Within the public school instructional day, only a registered nurse or a child deemed competent to self-administer may give medications. In a quirk of policy, however, staff in child care programs--even those programs operated by and located within public schools--do give medications in accordance with child care regulations.

STATE	RESTRICTIONS ON DISPENSING OF MEDICATIONS[2]	POLICIES ON OTHER MEDICAL TREATMENTS	HIGHER SUBSIDIES AND OTHER FINANCIAL SUPPORTS	CHILD CARE HEALTH CONSULTANTS AND OTHER INFORMA-TIONAL RESOURCES	POLICIES REGARDING SPECIALIZED CENTERS	ISSUES RELATED TO BOARDS OF NURSING OR NURSE PRACTICE ACTS
Texas		Texas regulations allow the dispensation of medications with proper parental authorization and documentation, as well as other procedures such as blood glucose testing, nebulizers, and G-tubes.				
Utah				Utah was in the early phase of training CCHCs in 2002.		
Ver-mont		Vermont regulations are silent on medical procedures (other than medications) but providers are encouraged to work with families to carry out any necessary treatments.	When the IFSP team finds that a child in early intervention requires the support of a paraprofessional to attend child care, the cost for this is equally shared between the Department of	Since the summer of 2000, Healthy Child Care Vermont has implemented a network of 12 public health nurses (one in each region) who are available to work as CCHCs with licensed homes and centers.		Nurses may not conduct child-specific training but may offer information and education on serving children with special health care needs.

STATE	RESTRICTIONS ON DISPENSING OF MEDICATIONS[2]	POLICIES ON OTHER MEDICAL TREATMENTS	HIGHER SUBSIDIES AND OTHER FINANCIAL SUPPORTS	CHILD CARE HEALTH CONSULTANTS AND OTHER INFORMA-TIONAL RESOURCES	POLICIES REGARDING SPECIALIZED CENTERS	ISSUES RELATED TO BOARDS OF NURSING OR NURSE PRACTICE ACTS
			Health (lead agency for Part C) and the Child Care Services Division. Medicaid waivers sometimes allow for payment of costs of individual adaptations and supports within child care settings.			
Virginia	A task force reviewing the state child care regulations recently proposed a revision that would have required that child care providers receive training before being allowed to dispense medication. However, that proposal was removed by the chair of the task force. A	Regulations do not address any specific medical procedures besides medications, but they permit providers to carry out any and all procedures at the request of parents. It is left to providers and parents to arrange for any needed training.		Virginia in 2002 was in the second year of implementing a program of CCHCs. About 100 nurses from the public health sector have received training but and their availability to child care facilities relies on employers that release them for some of their time for this purpose or on their volunteering their time.		Nurses acting as CCHCs may provide general information about special health care issues but are instructed not to conduct child-specific training.

STATE	RESTRICTIONS ON DISPENSING OF MEDICATIONS[2]	POLICIES ON OTHER MEDICAL TREATMENTS	HIGHER SUBSIDIES AND OTHER FINANCIAL SUPPORTS	CHILD CARE HEALTH CONSULTANTS AND OTHER INFORMA-TIONAL RESOURCES	POLICIES REGARDING SPECIALIZED CENTERS	ISSUES RELATED TO BOARDS OF NURSING OR NURSE PRACTICE ACTS
	subsequent change in governors and political appointees may give the proposal new life.					
Wash-ington		An ad hoc committee on children with special medical needs in child care was formed in 2000 between the Inclusive Child Care Subcommittee (formerly the Map to Inclusive Child Care team) and the Health and Safety Subcommittee of the state Child Care Coordinating Committee. An action plan was drawn up and circulated in 2002.		18 out of 34 local health jurisdictions (LHJ)began offering child care health consultation in the late 1990s in response to a campaign by Healthy Child Care Washington. 24 of 34 LHJ participated in a program in 2000-2001 called Building Child Care Capacity for Children with Special Needs through Public Health Partnerships. Local public health nurses and Child Care Resource and Referral staff		Nurses in Washington may not delegate to child care teachers or providers; however, they may observe and play a supportive role when parents have authorized and trained providers on specific procedures.

STATE	RESTRICTIONS ON DISPENSING OF MEDICATIONS[2]	POLICIES ON OTHER MEDICAL TREATMENTS	HIGHER SUBSIDIES AND OTHER FINANCIAL SUPPORTS	CHILD CARE HEALTH CONSULTANTS AND OTHER INFORMA-TIONAL RESOURCES	POLICIES REGARDING SPECIALIZED CENTERS	ISSUES RELATED TO BOARDS OF NURSING OR NURSE PRACTICE ACTS
				collaborated in helping to support the increased enrollment of children with a variety of special needs. One quarter had medical needs.		
Wiscon-sin		Wisconsin removed regulatory language relating to special needs in order to hold all licensed programs accountable to meet their obligations under the ADA and to make accommodations as needed to meet medical as well as other special needs.				Wisconsin's Nurse Practice Act allows parents to train the providers on how to do medical procedures and nurse consultants to act in an education role.
Wyo-ming	The child care regulations were revised in 2001 to require that any child care staff or provider must take	The class covering medication administration (see left) also covers such procedures as nebulizers and	Providers serving children in subsidized care can be authorized for a supplement of up to $350 per month	Healthy Child Care Wyoming is involved with the training of CCHCs through a distance-learning program at		See second column at left.

STATE	RESTRICTIONS ON DISPENSING OF MEDICATIONS[2]	POLICIES ON OTHER MEDICAL TREATMENTS	HIGHER SUBSIDIES AND OTHER FINANCIAL SUPPORTS	CHILD CARE HEALTH CONSULTANTS AND OTHER INFORMA-TIONAL RESOURCES	POLICIES REGARDING SPECIALIZED CENTERS	ISSUES RELATED TO BOARDS OF NURSING OR NURSE PRACTICE ACTS
	a two hour class, usually conducted by a pharmacist and a nurse, and pass a test on the material before being allowed to give any child over-the-counter or prescription medications. Once individuals pass the test, they retain the authority for the remainder of their careers in the field.	blood glucose testing. It does not cover any type of injections, which are restricted to nurses under the state's Nurse Practice Act.	to address individual needs, including special health care needs, when documented by a physician.	the University of Wyoming (combined with one day of on-site training). As a pool of CCHCs becomes available, it is left to individual counties to operate the program, often through public health departments.		

BRIEF PROFILES OF SELECTED CHILD CARE PROGRAMS SERVING CHILDREN WITH COMPLEX MEDICAL NEEDS

California: Together We Grow

- Together We Grow operates two centers near San Diego; one at Camp Pendleton and the other in Oceanside. They call themselves a comprehensive preschool, respite, and day care for "ALL" children. Approximately half of their enrollees have medical needs and the other half are viewed as typically developing.
- The centers are licensed like other CA child care centers by the Child Development Division, state Department of Education. In addition, they are licensed by the Department of health Services as pediatric day health care centers. These are defined in CA law as a way to provide "a community-based non-institutional resource for families."
- The center offers two weekends of coverage per month as respite in addition to 11.5 hours per day, Monday through Friday.
- Staffing is a mix of therapists, registered nurses, credentialed teachers, and others. Families submit a Treatment Plan submitted by a physician as part of the enrollment process and sign a statement indicating that their child is not in need of emergency resuscitation equipment on-site.
- Medi-Cal (the state version of Medicaid) pays for nursing and day care services for children defined as having medical fragility. To qualify, a child must be in need of "two aspects" of nursing care. Medi-Cal reimburses the center for up to a maximum of 170 hours of nursing care per month. (The rate in 2002 was a little under $30.00 per hour.)

Delaware: Children's Secret Garden

- This program opened in 2000 as a child care center (licensed by the Department of Services for Children, Youth, and Their Families) and a PPECC or Prescribed Pediatric Extended Care Center (licensed by the Office of Health Facilities Licensing of the Division of Health and Social Services). The owner/director is a R.N. It is licensed as a child care center for up to 80 children and as a PPECC for up to 30. The enrollment in the fall of 2002 was approximately 30 child care and 20 PPECC.

- They maintain separate classrooms for PPECC enrollees, staffed by registered nurses with a 1:3 ratio as mandated by PPECC regulations. The "regular" child care staffing ranges from 1:4 (infants) to 1:7 (toddlers) to 1:10 (preschoolers). However, there is an effort to include PPECC children in the activities of the typically developing peer groups whenever individual needs permit.
- Admission to the PPECC is by physician's orders and eligibility requires a need for daily skilled nursing care. Medicaid nurses monitor and determine continued eligibility. Many of the children receive occupational, physical, or other therapies in addition to nursing care. The center contracts for therapies as needed from an Easter Seal program. Medicaid pays a flat per diem rate for each enrolled child (for each day of actual attendance) regardless of the intensity of the supports required.
- A significant proportion of the children attending as "typical" child care enrollees are "graduates" of the PPECC who no longer require daily skilled nursing care but still require ongoing monitoring and/or treatments such as nebulizers. Parents wishing to enroll their children can do so at state expense if they are eligible for subsidized child care (these are referred to in Delaware as purchase-of-service slots). If they are not eligible, they can enroll as private-paying families.

Georgia: Tender Health Care

- Tender Health Care is owned and operated by a national pediatric home health care company called PSA (Pediatric Services of America). The company provides home health care services in 23 states and is now providing child care to children with significant medical needs in Florida, Georgia, and North Carolina. The original branch (there are now two) of Tender Health Care in Atlanta began in 1992 as a joint venture with another health care system and has only been operated exclusively by PSA since 2001. The Florida model (where the company first offered this service) is referred to as a PPECC; however, in Georgia they are considered "medical day treatment."
- They are licensed under the Georgia child care regulations; there are no additional state-imposed licensing requirements. However, as a recipient of Medicaid funds they must follow Medicaid guidelines for staffing levels.
- Medicaid in Georgia supports pediatric services only for children who are technology-dependent. There are two hourly rates, one for those with high technology needs and a lower rate for children with lower technology needs. The center may bill only for hours that children are in attendance.

- The center specializes in serving children who are born very premature and have birth complications. The director, Kathy Vargulic, is a R.N. with experiences as a NICU and PICU nurse. The classroom for young infants usually includes several children who are in care prior to their original "due date." This classroom is staffed exclusively by NICU nurses.
- All other classrooms are staffed by at least one nurse at all times and an overall ratio of three children to one caregiver (a Medicaid requirement). One room that has many children who are technology-dependent has two nurses at all times.
- They encourage many of their families to transition into public school supported programs at age three, as they are nearly all eligible for special education. However, they do serve children up to age six, including some before and after their public school programs.
- The center is not inclusive; however, a small number of siblings and children of staff offer a smattering of typically developing models. In addition, there are some children attending who have special needs (such as Down Syndrome) but no needs for skilled nursing care or technological support.

Maine: Bath Area Family YMCA Child Care

- This center, which operates full-day child care and part-day nursery school for preschoolers ages three and up in its own facility, plus programs for school-agers in three school sites, does not "specialize" in support for children with significant or complex medical challenges in the same way as other programs featured on this list. Rather, this program was identified by Healthy Child Care Maine as a typical community-based program which is exemplary in striving to obtain information and other resources as individual children with disabilities and special health care needs have come along.
- They have included a child with an ostomy on his liver and another who was newly diagnosed (and therefore not yet stable) with diabetes. The former required attending to the receptacle over his ostomy that collected bile. The latter required blood glucose testing several times per day, frequent daily communication with a parent, and (eventually) giving daily insulin injections. Each required comprehensive documentation of all activities related to the health condition.
- They have sought and received training from a local Volunteer Fire Department in dealing with blood-borne pathogens, disposal of needles, emergency procedures, and other issues that have arisen.

- The Center for Community Inclusion (University of Maine Center for Excellence) has helped them with information and training, by identifying another provider serving a child with diabetes they could visit, by funding an extra staff member due to the time required with the monitoring of the child with diabetes, paying for a locked cabinet with modifications suitable for properly storing "sharps" (i.e., injection needles), and purchasing walkie-talkies to enable communication between staff in different areas of the YMCA (including the swimming pool) who were involved in supervising the child with diabetes.
- A Diabetes Center provided educational materials for the staff, as well as a book suitable for preschoolers and a stuffed bear with a medical bracelet to help them empathize with their classmate.
- The center has designed a "special care packet" which is offered to every parent applying for care, offering them an opportunity to describe the individual needs of children and to sign permission for the center to contact physicians and other specialists who may be involved with the child and family.

Maryland: PACT's World of Care

- Since 1998, PACT: Helping Children with Special Needs, has been as an affiliate of the Kennedy Krieger Institute in Baltimore, but it began as an independent, nonprofit, early intervention program for infants and toddlers in 1981. In 1996 they opened a child care center for infants and toddlers with medical fragility and in 1998 another program serving three and four year olds. This is one of two centers in the state that specifically target children who require daily skilled nursing care. .
- Eligibility for the center is in accordance with medical acuity levels as defined by the state's Department of Health and Mental Hygiene. The center has two shifts of nurses on staff in addition to social workers and early childhood educators.
- The center is partially funded through Title V and the state Medicaid programs. The actual cost of operating the center is approximately $140 per child per day. Their state reimbursements total much less than that and therefore it is only through special grants, United Way, and other funding sources that they are able to continue operations.
- The center is committed to developmentally appropriate practice and is accredited by the National Association for the Education of Young Children. They maintain a staffing ratio of one caregiver for three children.

Nebraska: Children's Respite Centers

- The first of three centers opened in Omaha in 1990, with the goal of addressing cognitive, therapeutic, and social needs of children who have issues of medical dependency as well as developmental delays. Typically developing peers (one-third of the enrollment) are included as well as those with special needs (medical-only, developmental-only, and those with both developmental and medical needs).
- CRCC provides skilled nursing services, including medications, respiratory treatments, and tube feedings. Each child is assigned a primary nurse to provide continuity of care and coordinate services in the community.
- They are licensed and regulated as a child care center.
- The educational program is based on a blend of the High Scope and Creative Curriculum models, emphasizing an active approach to learning and supporting the development of skills in making choices and solving problems. The educational curriculum is implemented by teachers and paraprofessionals, with a ratio of 1:2 for infants and 1:3 for others.
- Funding for the services is a combination of Medicaid, private paying, insurance, and state child care subsidy funds.

Virginia: Rainbow Station

- Rainbow Station™ is a privately owned program which includes acute and chronic day health care supervised by pediatric R.N.'s as well as early childhood education and child care. Nurses oversee the health and safety of all children in the program. The program began at a single site in 1989 in Richmond. It now includes three campuses in the Richmond area, and has begun to franchise itself, with programs in development in 2002 in Texas and Georgia. The population served in the three Richmond programs in 2002 was approximately 800. According to their web site, children with medical needs represent approximately ten percent [10%] of the enrolled population.
- Each campus features a separate wing called the Get Well Place™ geared primarily for mildly ill children who are temporarily excluded from the settings that they normally attend (including regular Rainbow Station classrooms). This consists of several separate rooms, with children segregated by types of illness to avoid cross-contamination.

- The "well room" within the Get Well Place™ is called "R & R" (Rest and Recuperation). Children attend the R & R program when they are judged not contagious but too fragile to thrive within the regular inclusive classrooms. Typically this includes children who are awaiting surgery or who have recently been discharged from having surgery. Depending on their medical condition and the level of nursing supervision required, children who have chronic medical needs may be admitted directly to a regular early childhood classroom or to the R & R room.
- In some cases a child will stay in the R &R program for an extended period of time, as much as a year or longer. To the extent the staff deems it feasible and appropriate, they offer children in the R & R setting opportunities to engage in social and educational activities with children from other classrooms.
- The programs are licensed as child care centers by the Virginia Department of Child Care Services.
- Their early childhood programs are accredited through the National Academy of Early Learning Programs of the National Association for the Education of Young Children. They follow the Virginia licensing ratios for infants up to age two (1:4 for those under 16 months and 1:5 for those 16 to 24 months). At age two, they impose a 1:6 limit although the state regulations allow 1:10. They similarly impose more stringent ratios than required by law on their classrooms for four year olds and for school-agers before and after school.
- Parent fees are the sole source of the program's revenue for the regularly enrolled clientele. The organization receives no Medicaid funding or other public or private revenues to cover the costs of the nursing staff and specialized services. In keeping with the requirements of the ADA, they charge the same rate for (well) children in need of nursing care as for others. Children who are sick are charged at a different rate and the company does have contracts with private corporations to cover the participation of employees' children in the Get Well Place™.

GLOSSARY[4]

ADA	Americans with Disabilities Act (1990). The act prohibits discrimination on the basis of disability and requires "reasonable accommodations" in several arenas, notably in public accommodations (which covers most child care venues) and in the activities of state and municipal government.
CCDF	Child Care and Development Fund (the block grants received by states from the federal government for child care subsidy and quality improvement)
CCHC	Child Care Health Consultant
CCRR	Child Care Resource and Referral
Delegation	A term used in nursing; state Nurse Practice Acts and State Boards of Nursing defining to whom and under what circumstances a registered nurse may "delegate," (i.e., train and authorize someone else to conduct a procedure).
Epi Pen	Automatic pre-filled cartridge injection commonly used for allergy treatment
NICU	Neonatal intensive care unit
PICU	Pediatric intensive care unit
PPECC	Prescribed Pediatric Extended Care Center, an out-patient health care service prescribed by a physician for children who are medically and/or technologically dependent. A PPECC includes an array of services focused on meeting physiological as well as developmental, physical, nutritional and social needs. A PPECC provides a less-restrictive alternative to institutionalization and reduces the isolation which the home-bound, medically dependent child may experience. [Language adapted from Delaware PPECC regulations]
TANF	Transitional Assistance for Needy Families (The program

[4] The glossary needs to be further expanded. Any reader viewing the current draft is encouraged to write to dfink@uchc.edu with suggestions for additional glossary entries that would benefit future readers of this publication.

created for temporary public assistance when “welfare” or Aid to Families with Dependent Children was abolished in the 1990s.

APPENDIX A

INDIVIDUALS WHO RESPONDED TO OUR REQUESTS FOR INFORMATION[5]

Alabama

- Sharis LeMay, Coordinator, Healthy Child Care Alabama, Alabama Department of Public Health

Alaska

- Annie Rayburn-Wolfe, Alaska Department of Education & Early Development, Child Care Program Office, Coordinator of the Alaska Inclusive Child Care Initiative

Arizona

- Theresa Greiner, Early Childhood Education Specialist, Arizona Department of Economic Security Child Care Administration
- Lourdes Ochoa, Child Care Licensure, Department of Health Services
- Dr. Anu Partap, Director, Healthy Child Care Arizona (American Academy of Pediatrics of Arizona) and Pediatrics Department, Maricopa Medical Center, Phoenix
- Brad Willis, Department of Economic Security

Arkansas

- Jo Ann Bolick, Central Public Health Region, Little Rock
- Pat Ford, Healthy Child Care Arkansas, Child and Adolescent Health, Arkansas Department of Health
- Nancy Yarbrough, Division of Developmental Disabilities Services, Department of Human Services (Lead agency for early intervention)

California

- Abby Cohen, National Child Care Information Center (formerly with the Child Care Law Center)
- Marsha Sherman, CA Children's Health Program
- Nancy Strohl, Child Care Law Center, San Francisco

[5] We did not receive any replies from Mississippi or West Virginia. We hope to add those states to this report in a later update.

Colorado

- Jane Cotler, Director, Healthy Child Care Colorado, Colorado Department of Public Health and Environment
- Oxana Golden, National Child Care Information Center (formerly with Colorado Department of Human Services)
- Linda Satkowiak, Healthy Child Care Colorado, and Nurse-Consultant for Colorado Resource and Referral Association (CORRA)

Connecticut

- Claudette Hinds, Project Coordinator, Healthy Child Care Connecticut

Delaware

- Pam Harper, Owner/Director, Children's Secret Garden
- Lynn E. Jezyk, Office of Child Care Licensing
- Leslie Kosek, Coordinator, Healthy Child Care Delaware, Delaware Division of Public Health
- Lorraine Loera, Children with Special Health Care Needs, Maternal Child Health Division

District of Columbia

- Beverly Jackson, Director, Head Start Collaboration Office

Florida

- Vikki Griffin, Child Care Licensing, Department of Children and Families
- Mary Heintz, Maternal and Child Health Nursing Consultant
- Lou Ann Long, Central Directory of Early Childhood Services, Florida Children's Forum
- Susan J.Redmon, RN, Consultant, Children's Medical Services, Florida Dept. of Health
- Deborah Russo, Director, Department of Children and Families, Child Care Program

Georgia

- Meghan McNail, Georgia Child Care Council, Atlanta
- JanMarie Popovich, Inclusion Manager/Trainer, Child Care Resource and Referral Metro Atlanta, Quality Care for Children
- Kathy Vargulic, Director, Tender Health Care, Atlanta

Hawaii

- Garry Kemp, Benefit, Employment, and Support Services Division, Department of Human Services
- Julie Morita, Benefit, Employment, and Support Services Division, Department of Human Services
- Ruth Ota, Chief of Public Health Nursing Branch, Department of Health

Idaho

- Heidi Opheim, Child Care Link Coordinator, Twin Falls; and secretary for statewide Child Care Resource and Referral network.

Illinois

- Beverly English, Healthy Child Care Illinois, Bureau of Community Health Nursing
- Tess Rhodes, Program Support Unit, Division of Specialized Care for Children, U. Of Illinois at Chicago.

Indiana

- Betsy Traub, Indiana Institute on Disability and Community/Early Childhood Center

Iowa

- Ann Riley, Childcare Inclusion Coordinator (consultant to Healthy Child Care Iowa)

Kansas

- Kim Salaway, Healthy Child Care Kansas, independent consultant to Kansas Department of Health and Environment, Child Care Licensing Bureau

Kentucky

- Kim Townley, Governor's Office of Early Childhood Development

Louisiana

- Angelique M. White, Director, Child Care Health Consultant Program, Maternal and Child Health, Department of Health and Hospitals, Office of Public Health

Maine

- Judy Matthews, Health consultant, Child Care Plus Maine,

Maryland

- Phil Koshkin, Child Care Administration, Office of Licensing, Department of Human Resources
- Audrey Leviton, Executive Director, PACT, Kennedy Krieger Institute, Baltimore

- Cheryl Mercer, Project Manager, Healthy Child Care Maryland

Massachusetts

- Suzanne Gottlieb, Director, Family Initiatives, Massachusetts Department of Public Health

Michigan

- Joan Deschamps, Michigan Dept of Community Health, Children's Special Health Care Services
- Patricia Hogg, Bureau of Family Services, Department of Consumer and Industry Services

Minnesota

- Michelle Hahn, coordinator, Healthy Child Care Minnesota

Missouri

- Val Lane, Children's Therapy Center, Sedalia
- Kathleen Penfold, Bureau of Child Care, MO Department of Health and Senior Services

Montana

- Sandra L. Morris, Child Care Plus+, The Center on Inclusion in Early Childhood, The University of Montana Rural Institute
- Patti Russ, Early Childhood Services Bureau, Montana Department of Public Health and Human Services

Nebraska

- Theresa Fitzgerald, Children's Respite Care Center, Inc., Omaha

Nevada

- Crystal Swank, Healthy Child Care Nevada

New Hampshire

- Maria Butler, Nurse Coordinator, Special Medical Services/NH Title V
- Dawn Rouse, Child Development Bureau, Division for Children, Youth and Families, Department of Health and Human Services
- Brooke Stebbins, Child Care Nurse Consultant, Healthy Child Care New Hampshire, NH Bureau of Maternal and Child Health
- Ann Vondle, Early Childhood Center, Rivier College, Nashua, N.H.
- Lee Zoellick, Institute on Disabilities/UCE, University of New Hampshire

New Jersey

- Jane Voorhees, Special Project Manager, Office of Early Care and Education, NJ Department of Human Services

New Mexico

- Cindy Davies, Community and Social Services Specialist, Children Youth and Families, Prevention and Intervention Division, Family Nutrition Bureau

New York

- Mary Huber, Director, Healthy Child Care New York, New York State Department of Health

North Carolina

- Anna Carter, Division of Child Development, North Carolina Department of Health and Human Services
- Cathy Kluttz, Nurse-consultant, Specialized Services Unit, Division of Public Health, North Carolina Department of Health and Human Services
- Jeannie Reardon, Early Childhood Specialist, North Carolina Child Care Health and Safety Resource Center, Raleigh

North Dakota

- Ellen Anderson, Education Coordinator, Child Care Resource and Referral
- Kim Senn, Nurse-consultant, Child and Adolescent Health, N. Dakota Department of Health

Ohio

- Michelle Albast, County Technical Support Section, Bureau of Child Care and Development
- Kimberly Travers, Early Intervention Manager, Cuyahoga County (Cleveland)

Oklahoma

- Lynne C. McElroy, nutrition consultant, Early Intervention Program
- Nancy von Bargen, Oklahoma Department of Human Services, Division of Child Care

Oregon

- Terry Butler, Inclusive Child Care Project, Oregon Council on Developmental Disabilities
- Helene Tolliver, Family Support Manager, United Cerebral Palsy of Oregon and Washington

Pennsylvania

- Maureen Barber-Carey, Dr. Gertrude A. Barber Center, Erie
- Mauri Druash-Gladys, EPIC Medical Home Initiative, PA Chapter, American Academy of Pediatrics
- Theresa McKelvey, Philadelphia Public Schools
- Anita Somplansky, EPIC Medical Home Initiative, Pennsylvania chapter, American Academy of Pediatrics

Rhode Island

- Sheldon Levy, M.D., consultant to Center for Child and Family Health, Rhode Island Department of Human Services

South Carolina

- Kitty Casoli, Child Care and Development Services, South Carolina Dept. of Health & Human Services
- Helen Lebby, Director, Division of Child Care Licensing and Regulatory Services, S.C. Department of Social Services

South Dakota

- Lisa Jordre, Child Care Licensing, Office of Child Care Services, South Dakota Department of Social Services

Tennessee

- Marilyn Ontiveros, Maternal and Child Health, Tennessee Department of Health
- Anne Turner, Director of Licensing, Tennessee Department of Human Services

Texas

- Michele Adams, Day Care Licensing Standards Specialist, Texas Department of Protective and Regulatory Services, Child Care Licensing Division

Utah

- Konnie Parke, RN, Healthy Child Care America Project Coordinator, Utah Department of Health

Vermont

- Helen Keith, Part C Services, Vermont Department of Health
- Suzanne Leavit, Co-coordinator of Healthy Child Care Vermont, Vermont Department of Health
- Christina Manna, Co-coordinator of Healthy Child Care Vermont, Child Care Services Division, Social and Rehabilitation Services

Virginia

- Bethany Geldmaker, Project Director, Early Childhood Health, Virginia Department of Health

Washington

- Debbie Lee, Public Health Nursing Consultant, Washington State Department of Health
- Tory Clarke Henderson, Developmental Disabilities Council

Wisconsin

- Anne Carmody, Bureau of Regulation and Licensing, Wisconsin Department of Health and Family Services
- Jill Haglund, Department of Public Instruction

Wyoming

- Sue Bacon, Child Care Program Consultant, Wyoming Department of Family Services
- Glennda Lacey, Child Care Licensing Program Manager, Department of Family Services