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**Appendices**
In October of 1987, Pima County Health Department Division of Public Health Nursing and Maricopa County Community Health Nursing were awarded three-year contracts by Arizona Department of Health Services, Maternal Child Health (later known as the Office of Women’s and Children’s Health and now known as the Bureau of Women’s and Children’s Health) for the purpose of determining the risks children assumed by virtue of being in child care settings and improving the standards of health and safety in group care. Thus began Arizona’s experiences with child care health consultation.

Pima County has maintained a robust child care health consultation program since 1987 integrating the program into the Division of Public Health Nursing. In 2003, Pima County PHN began outreach to others desiring to improve the quality of child care programs by providing training based on the curriculum of the National Training Institute for Child Care Health Consultants (NTICCHC), a cooperative undertaking of the Gillings School of Global Public Health's Department of Maternal and Child Health. As of this date there are more than 80 health and early childhood professionals who have completed the training.

Pima County Public Health Nursing is the statewide administrative entity for child care health consultation taking place under the umbrella of First Things First. Pima will provide statewide coordination, coaching and mentoring, and quality improvement activities. Leading this effort is Kathi Ford, RN, BC, an experienced child care health consultant. Kathi can be reached at (520) 243-7761.

Pima County Health Department has launched a webpage dedicated to the support of Child Care Health Consultants across the state. [http://www.pimahealth.org/pubhealthnursing/cchc.html](http://www.pimahealth.org/pubhealthnursing/cchc.html) Training dates, meetings and other information of interest to CCHCs can be found on this page.
A HANDBOOK FOR CCHCs

This handbook will assist the Child Care Health Consultant who is funded by First Things First. It should be used alongside the Quality First Implementation Guide, the FTF Partner Extranet Users Guide, and the Child Care Health Consultation Minimum Standards developed for First Things First contractors.

Described here are consultation activities with child care programs, communication with others who may be providing services, visit patterns and documentation of activities. Additional resources will also be found throughout this document as links to websites or documents in the appendices. It is anticipated that updates to this document will be needed as the new statewide system of child care health consultation takes shape.

In most areas of Arizona, child care health consultation is new or “under reconstruction. “ Child care programs have not had health professionals available to help with planning for health and safety or with problem-solving issues such as outbreaks of communicable disease, safety or support to serve a child with a special health care need. Interested health professionals have not had opportunities to bring their expertise, based on the health sciences and emerging research, to the child care center or child care home. This handbook can facilitate the development of a co-professional relationship between the consultant and child care provider and others sharing the responsibility for improving the health and safety in a child care setting for the benefit of children, families and child care program staff.

DEFINITIONS AND CONVENTIONS OF LANGUAGE

Definitions and conventions of language used in this document include:

- Child care program (or program): A lawfully operating child care center, nursery, preschool, Mom’s Day Out program, Head Start site or child care home.

- Project: A collaborative endeavor undertaken to create a unique product, service or result. Quality First and other quality improvement group efforts will be referred to as projects in this document to avoid confusion with the use of “program” as described above.

- Child care provider: An individual providing care in a family child care home or caregiving/teaching staff in a child care center. If the text must differentiate the guidance based on where care is provided, the setting will be specified.

- Child Care Health Consultant (CCHC): A health professional who has completed training which utilizes the curriculum of the National Training Institute for Child Care Health Consultants (NTICCHC) developed by the University of North Carolina and is facilitated by an individual who is a graduate of the NTICCHC training of trainers course.
• Child Care Nurse Consultant (CCNC): A CCHC who is a registered nurse licensed to practice in the state of Arizona. Additional information on licensure of Registered Nurses in Arizona can be found at www.azbn.gov

• Pronouns: Although an effort has been made to keep text gender neutral, it was not always possible. The majority of child care providers and Child Care Health Consultants in Arizona are female. This is a call for more men to join in the work of providing quality care to Arizona’s children.
CHILD CARE HEALTH CONSULTATION: A REVIEW

Child Care Health Consultants are prepared to provide consultation and support for a variety of health and safety concerns in out-of-home child care settings including child care centers, group homes, regulated and unregulated family child care homes, Head Start programs, shelters, Sunday Schools, and emergency shelters.

WHAT IS CONSULTATION?

The design of child care health consultation described here is highly influenced by the work of the National Training Institute for Child Care Health Consultants (NTICCHC), a cooperative undertaking of the Gillings School of Global Public Health’s Department of Maternal and Child Health and the Frank Porter Graham Child Development Institute (FPG), both of The University of North Carolina at Chapel Hill. NTI is funded by the Maternal and Child Health Bureau of the Health Resources and Services Administration, U.S. Department of Health and Human Services.

The section below quotes from or draws heavily on “Building consultation skills training module: version 3.” Chapel Hill (NC): The National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill; 2007.

Consultation is a voluntary, helping process which takes place between the CCHC and the child care provider. It is a problem-solving process with the intent of addressing immediate concerns and developing expertise in the child care provider so that when a similar concern arises in the future, the provider will be able to handle it independently. The provider is always free to reject the consultant’s advice.

Although both parties ideally work together as equals, sometimes the CCHC’s expertise drives the decision-making process. This “expert” consultation would most likely be required in an emergency or crisis situation where the child care provider needs immediate assistance, such as during an outbreak of a communicable disease. The consultant provides expert knowledge and skills that the provider needs to achieve his/her goals quickly. The need for this expert mode of consultation is usually short-term, and even in these situations, the provider will have knowledge that will assist in resolving the problem.

When the health or safety needs of the child care program are outside the expertise of the CCHC, the consultant provides referral to other Child Care Health Consultants or health professionals such as nutritionists, oral health practitioners, behavioral health specialists, environmental health staff or other appropriate service providers.

*The American Psychological Association’s Code of Ethics (2003) provides a reminder that professionals should provide services and teaching only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.*

RULES AND REGULATIONS

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CCHCs must provide consultation that is consistent with the regulations that govern the child care program receiving services. A sample of rules and regulations which could apply is listed below. This is not an exhaustive list.

- **R-9-5 Department Of Health Services, Child Care Facilities**
  
  [http://www.azsos.gov/public_services/Title_09/9-05.htm](http://www.azsos.gov/public_services/Title_09/9-05.htm)

- **R-9-3 Department Of Health Services, Child Care Group Homes**
  
  [http://www.azsos.gov/public_services/Title_09/9-03.htm](http://www.azsos.gov/public_services/Title_09/9-03.htm)

- **R-6-5 Article 52, Family Child Care Homes**
  
  [http://nrc.uchsc.edu/STATES/AZ/az_3.htm](http://nrc.uchsc.edu/STATES/AZ/az_3.htm)

- **Food Code 2000**
  

- **R-9-6 Department of Health Services Communicable Diseases and Infestations**
  
  [http://www.azsos.gov/public_services/Title_09/9-06.pdf](http://www.azsos.gov/public_services/Title_09/9-06.pdf)

- **Clinical Laboratory Improvement Amendment (CLIA)**
  
  [http://www.azdhs.gov/lab/license/index.htm](http://www.azdhs.gov/lab/license/index.htm)

- **OSHA regulations**
  
ETHICAL CONSIDERATIONS

Child care health consultation is a new field of practice without a professional home for practitioners. A recognized comprehensive Ethical Code of Conduct for CCHCs does not yet exist although the North Carolina Child Care Health Consultant Association has developed a Professional Practice Statement which describes practice priorities and responsibilities for its members. (North Carolina Child Care Health Consultant Association contact: Jackie Quirk: Jquirk@e-mail.unc.edu)

Other professional organizations for individuals serving children and their families, and organizations for health professionals have developed ethical principles which may be applied to CCHC practice. A few are included below.

THE NATIONAL ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN: CODE OF ETHICAL CONDUCT AND STATEMENT OF COMMITMENT

All CCHCs should be familiar with the National Association for the Education of Young Children’s (NAEYC) Code of Ethics. This code speaks to those who work with children, their families and child care providers. It offers guidelines for responsible behavior and sets forth a common basis for resolving the principal ethical dilemmas encountered in early childhood care and education. The Statement of Commitment is not part of the Code but is a personal acknowledgement of an individual’s willingness to embrace the distinctive values and moral obligations of the field of early childhood care and education. http://208.118.177.216/about/positions/pdf/PSETH05.pdf

THE AMERICAN NURSES ASSOCIATION CODE: CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS

Many CCHCs are nurses. The American Nurses Association (ANA) Code for Nurses has served as a statement of goals and values for nurses and has provided guidance for the conduct of nurses since 1950. In July 2001, an updated Code of Ethics for Nurses with Interpretive Statements was approved by the Association’s Congress of Nursing Practice and Economics. The Code comprises nine provisions which guide nursing practice in these areas:

- Relationships between nurses and their clients and between nurses and their colleagues.
- The nurse’s primary commitment to the patient whether an individual, family, group or community.
- The protection of the health, safety and rights of the patient.
- The accountability of the nurse.
- The competency and morality of the nurse.
- Participation of the nurse in ensuring quality health care environments;
- Participation in advancement of the nursing profession.
- Collaboration with other health professionals to meet health needs
- Articulating nursing values, maintaining the integrity of the profession, and shaping social policy.

http://www.nursingworld.org/ethics/code/protected_nwcoe813.htm

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**AMERICAN PUBLIC HEALTH ASSOCIATION: PRINCIPLES OF THE ETHICAL PRACTICE OF PUBLIC HEALTH**

The practice of Child Care Health Consultation is recognized as a population-based public health practice and is integrated into local and state health departments. Thus, a review of the American Public Health Association’s (APHA) “Principles of the Ethical Practice of Public Health” is in order. Public health is understood within these principles as what we, as a society, do collectively to assure that conditions for people are healthy, affirming the World Health Organization’s understanding of health as a state of *complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.*

These guidelines confirm the value of the individual, respect his beliefs and culture, and protect the confidentiality of health information and all are applicable to the field of Child Care Health Consultation.

http://www.apha.org/NR/rdonlyres/1CED3CEA-287E-4185-9CBD-BD405FC60856/0/ethicsbrochure.pdf
EXPOSURE AND LIABILITY

As child care health consultation is a relatively new field, national standards of care have not been agreed upon, and there has been no guidance developed in the state of Arizona. In 2002, Abby Cohen, JD, contracted by the California Child Care Health Program produced a report with recommendations for minimizing liability exposure in California. Accompanying the recommendations are examples of activities which may be carried out by child care health consultants categorized as Activities with Lesser Exposure, Activities with Moderate to Greater Exposure, and Activities with Greater Exposure. These examples are summarized below.

In general, the more child-specific and less program-general the activity is, the greater the exposure. Activities seen as clinical rather than educational also increase exposure. The websites for the complete documents produced for the California Child Care Health Program are included below; they are worth reading. While these documents provide a frame of reference for considering CCHC practice in Arizona, there has been no legal review specific to Arizona law. To the knowledge of the preparer of this document, no Arizona CCHC has been a party in a legal action related to child care health consultation, although the preparer has been called for depositions, and has been asked to provide expert testimony.

**ACTIVITIES WITH LESSER EXPOSURE**

- Staff/parent meetings (trainings) on health and safety topics.
- Inclusion of information on supporting early brain development.
- Outreach activities for parents such as health-focused newsletters.
- Referring child care programs and families to other programs and community resources.

**ACTIVITIES WITH MODERATE TO GREATER EXPOSURE**

- Staff training including medication administration, recognizing and reporting child abuse, food safety, disease control, emergency readiness in the group setting, blood borne pathogens, arrival health check.
- Child assessments (child development, hearing/vision screening), environmental assessments (food service, diapering areas).
- Staff health promotion (smoking cessation, stress management, healthy eating and physical activity, women’s health issues).
- Telephone consultation.
- Health and safety policy and procedure development and review.
- Assisting with the development of individualized care plans.
ACTIVITIES WITH GREATER EXPOSURE

- Training staff in specific procedures using specific equipment which are complex and could result in significant injury if performed incorrectly, etc.
- Case management.
- Development of individualized care plans.
- Diagnosis and/or treatment of individual children/staff.
- Advice given in a specific situation concerning particular children, especially in an emergency (if not covered by Good Samaritan statutes).
- Immunizations (if not given as a part of a program covered by statutory immunity provisions or not required by law).

Report: Child Care Law Center for the California Child Care Health Linkages Project, 2002
http://ucsfchildcarehealth.org/pdfs/forms/CCHCLiability.pdf
http://ucsfchildcarehealth.org/pdfs/forms/LiabilityContinuum.pdf
CONFIDENTIALITY

The child care program is an example of a community client. In its book, Public Health Nursing: Scope and Standards of Practice, 2007, the American Nurses Association describes community as “a set of persons in interaction, being and experiencing together, who may or may not share a sense of place or belonging, and who act intentionally for a common purpose. A community is different from the group of people who constitute it and can interact with other entities as a unit.” (page 41). Each child care program with its child care providers and staff, children, and their families comprise a distinct community client with the rights of confidentiality.

The ethical principle of confidentiality requires that information gathered by the health professional in the course of treatment is not shared with others. This is important for the helping relationship as it promotes an environment of trust ensuring that information is accessible only to those authorized to have access. The principle of confidentiality is a cornerstone of child care health consultation.

INFORMATION SHARING AGREEMENTS

CCHCs participating in formal quality improvement projects (such as Quality First) may be involved with sharing of information related to assessment, interventions, and evaluation at the child care program level, with other project partners. A confidentiality waiver (or information sharing agreement) which passes the scrutiny of the project’s legal representative and the legal authority of the agency employing the CCHC should be in place. The waiver should be signed by an authorized representative of the program (usually the family child care provider or center owner or director). The waiver should also specify the length of time covered by the waiver and with whom information may be shared. As this waiver covers interactions between a health professional and client, it is separate from other waivers or information sharing agreements used by quality improvement programs. The original signed waiver should be placed in the client chart. A copy of two waivers is included in the appendices of this document.

INFORMATION ABOUT CHILDREN

This waiver or information sharing agreement which applies to the program does NOT cover sharing of health information which can be linked to an individual child. CCHCs employed by the local health department or others to whom the health department’s authority extends may exercise their responsibilities related to public health surveillance, and public health investigation or intervention. These responsibilities may include activities such as assessment of immunization records and disease reporting.
REQUIRED REPORTING
When a CCHC observes that a child’s health, safety or well-being is in danger, or has reason to suspect child abuse or neglect, the concern should be immediately reported to the provider or responsible program staff (director or program designee).

Additionally, CCHCs are mandated reporters by law (as outlined in the A.R.S. § 36-2281). This means that they are required to immediately report or cause a report to be made regarding any suspected incident of child abuse and/or neglect to Child Protective Services (CPS).

Reports of health and safety hazards or risks which present an immediate danger to children (and are not immediately eliminated-fixed when they are called to the attention of the responsible child care center staff or provider or if reports to administrative staff do not demonstrate concern) should be made to the appropriate regulatory or monitoring agency. Also report ongoing deficiencies that have been called to the attention of the responsible child care center staff or provider (for example the center is above the legal ratio of children to the number of supervising adults frequently when a visit is made).

CCHCs may also need to assist child care programs in reporting communicable diseases to the local health authority.

Arizona Communicable Disease Flipchart

SECURING CLIENT CHARTS
Your community client charts are entitled to the same protection that would be afforded an individual’s medical record! Protect confidential information by following your organization’s policies for securing confidential records. Do not leave unattended charts on a desk; do not leave a record on your computer screen visible to unauthorized persons. Remember that information you obtain about a program in the course of your consultation is not to be discussed except in the context of Quality First team planning (these discussions are covered by the Information Sharing Agreement) or as needed with a supervisor. Personal information unrelated to your interventions about staff, children and their families is not included in documentation.

The introduction of electronic medical records is generating new rules and ethical guidelines which should be applied to the community client. Specific for the CCHC providing under the umbrella of First Things First:

- Never include the name of children or their families in the community client record.
- Do not access records of a program not assigned to you. The electronic charting system selected by First Things First (CareFacts) creates a record of who accessed a program record and when.
The Arizona State Board of Nursing considered the impact of electronic medical records and HIPAA compliance in its *Regulatory Journal* in September of 2009, on page 14. It is useful reading whether or not you are a nurse.

Arizona State Board of Nursing Regulatory Journal
FIRST THINGS FIRST: CCHC QUALIFICATIONS

First Things First has established minimum qualifications for Child Care Health Consultants providing services under its umbrella. As the need to include other health professionals is better assessed, specially trained oral health professionals, nutritionists, behavioral health practitioners, health educators and others will continue to join CCHC teams to provide more comprehensive health and safety consultation.

EDUCATION AND CREDENTIALS

- A Registered Nurse (RN) with a current Arizona license or
- An Advanced Practice Nurse with a current Arizona license and certification as an Advanced Practice Nurse (APN) or
- A Physician’s Assistant with a current Arizona license or
- A Physician licensed to practice in the State of Arizona

AND

- A graduate of a training course recognized by the National Training Institute for Child Care Health Consultants.

An application for a waiver can made to First Things First in areas where these criteria cannot be met or more specific consultation is indicated.

EXPERIENCES

There are valuable opportunities for understanding health and safety issues within a child care program as well as gaining insight as to how others who provide monitoring or resources view a child care program. The CCHC should also:

- Keep CPR certification current. The CPR course must include training specific to infants and children and include a demonstration of the individual’s ability to perform CPR.

- CCHCs who are not registered nurses, physicians or physician’s assistants should also have current first aid certification.

- Accompany a health department sanitarian on a visit to a facility with a licensed kitchen to gain understanding of how operation of the kitchen and food service issues contribute to the health of children and staff. You may want to attend a food handler’s class. Some health department sanitarians also have responsibilities related to mosquito control and swimming pools. Child care programs may have water features that need to be maintained or problems related to standing water on playgrounds after summer rains—there is much to learn!
• Accompany health department disease control staff on a visit to a child care center with a communicable disease to gain understanding of how disease control/epidemiology investigates and advises child care programs.

• Attend a new owner/new director orientation workshop sponsored by Arizona Department of Health Services Office of Child Care Licensure.

• Attend an Arizona Department of Economic Security Family Child Care recruitment session or training.

• New CCHCs may accompany experienced CCHCs on consultation visits.

• Attend community early childhood meetings, and early childhood presentations.

• Attend Arizona Early Childhood Development and Health Board meetings and FTF Regional Partnership Council meetings.
  - [http://www.azftf.gov/WhoWeAre/Board/Pages/PublicNotices.aspx](http://www.azftf.gov/WhoWeAre/Board/Pages/PublicNotices.aspx)
  - [http://www.azftf.gov/Pages/default.aspx](http://www.azftf.gov/Pages/default.aspx)

• Visit the nearest Arizona Department of Health Services Office of Child Care Licensing and review the contents of a licensing file.

• Access the Arizona Department of Health Services Office of Child Care Licensing website and become familiar with the forms, resources and inspection reports found there.
  - [http://www.azdhs.gov/als/childcare/index.htm](http://www.azdhs.gov/als/childcare/index.htm)
Child Care Health Consultants: Serving Quality First Programs

All child care centers and family child care providers enrolled in Quality First will have a CCHC available to assist with quality improvement in the areas of health and safety. Details of Quality First, Arizona’s Quality and Improvement Rating System are described in the Quality First Implementation Guide. Each CCHC working with Quality First child care programs should be familiar with the CCHC role as described in the Implementation Guide.

How the Child Care Health Consultant Works with Providers

CCHCs provide advice, information or guidance to staff that provide direct care to children. CCHCs can help staff create a welcoming environment for children with identified health needs. CCHCs act as a one-stop health resource to child care providers by offering:

- Onsite and telephone guidance and consultation
- Staff training on best health and safety practices and requirements
- Referral to community resources
- Health and safety information for families and child care staff

How Does the Child Care Health Consultant Work with the Quality First Coach?

Child care health consultants are members of the Quality First team and following the program assessment, CCHCs will meet with the Coach and provider to identify health and safety issues to be addressed. The CCHC will work collaboratively with the Coach (the case manager) and child care provider to create a plan for raising the level of quality in indentified areas within the health and safety domains. The Coach will alert the CCHC or CCHC agency that a child care program is ready for CCHC services via e-mail, fax, or post and indicate if an initial joint Coach and CCHC visit is desired. The CCHC will use the program assessment, Quality Improvement Plan, the CCHC Minimum Standards and the CareFacts Pathway to guide services provided to child care programs. The Minimum Standards and Pathway are included in the appendices.

The CCHC should be deliberate in building and maintaining trust with the Coach. Trust develops over time when each individual respects the knowledge and experience others bring to the collaboration. Assuming the best of one another and identifying ways to maximize the participation of each collaborator enhances the consultation of both.

Does the Child Care Health Consultant Provide Treatment to Children?

Child care health consultants working under the umbrella of First Things First do not provide hands on care to children but will help providers identify health professionals and/or health resources in the community that can provide needed services for individual children.
Child care health consultant services will be available to child care programs not participating in Quality First in some First Things First regions. The Regional Partnership Councils in these areas selected child care health consultation as a strategy for quality improvement in lawfully-operating child care programs which did not apply or were not selected for Quality First activities. Non-Quality First programs will not be included on the FTF Partner Extranet and when working with these programs, the CCHC is the case manager.

**RECRUITMENT**

CCHCs providing services in non-Quality First programs will need to plan for recruitment of child care programs for both program improvement activities and expert interventions for short term problem solving.

Marketing efforts could include:

- Development of flyers or brochure which describe CCHC services. Such materials can be distributed at libraries, early childhood professional meetings, Regional Partnership Council meetings, and at the offices of agencies which regulate or provide resources to child care programs.
  
  o A brochure which can be personalized by each contractor is available to FTF CCHC contractors. The brochure was designed, and funded through a CATCH grant from the American Academy of Pediatrics. Tom Ball, MD, MPH, the American Academy of Pediatrics, Child Care Contact for Arizona, worked with CCHCs to produce this brochure. More information and an electronic copy of the brochure are available at [http://www.pimahealth.org/pubhealthnursing/cchc.asp](http://www.pimahealth.org/pubhealthnursing/cchc.asp)

  o Submission of proposals to provide health-related presentations or displays at early childhood conferences.

- Utilization of the resources of the CCHC’s home agency for publicity.
  
  o Create a press release to be distributed by the agency’s public information officer.

  o Meet with other home agency divisions who provide services to child care programs including disease control, oral health, immunizations.
o Have information prominently displayed on the home agency website to describe CCHC services and successes and link to a webpage created for CCHC information.

- Joining the listservs sponsored by Arizona affiliates of NAEYC. Post emerging health and safety messages child care programs need to know (vaccine shortages, formula and crib recalls, available training events, new web resources, emerging communicable disease concerns, etc.).

- Enlisting stakeholders to carry the project’s messages. This includes ADHS Office of Child Care Licensing, Department of Economic Security, community colleges, local NAEYC affiliates, United Way projects focusing on child care, and Regional Partnership Councils.

- Developing advertised telephone hours set aside for the CCHC to answer uncomplicated questions related to health and safety in child care. If the caller is from a child care program, offer to send a flyer/brochure about CCHC services.

**ASSESSMENT AND QUALITY IMPROVEMENT PLANS**

Non-Quality First child care programs desiring a health and safety quality improvement relationship with the CCHC will receive an assessment by the CCHC. This will be followed by the collaborative (CCHC and child care program) development of a quality improvement plan before interventions begin. The CCHC will use the program assessment, Quality Improvement Plan, the CCHC Minimum Standards and the CareFacts Pathway to guide services provided to child care programs.
ADMITTING CLIENTS TO THE CCHC CASELOAD

Clients may enter the CCHC caseload in several ways. These include assignment of clients enrolled in Quality First, referral from monitoring or resource agencies, self-referral, or case find. All child care programs will need to complete a waiver (information sharing agreement) as CCHC services provided to all programs under the umbrella of FTF will be evaluated and be part of an aggregate data collection.

ASSIGNMENT OF QUALITY FIRST CLIENTS

Assignments of Quality First child care programs are made to the CCHC by the CCHC supervisor in the CCHC’s home agency. These assignments can be reviewed on the FTF Partner Extranet.

MONITORING OR RESOURCE AGENCIES REFERRALS

Referrals may be received from a variety of agencies which are familiar with the needs of child care programs. The CCHC will first determine if the child care program is enrolled in Quality First. If the program is enrolled connect the referral source with the Coach or CCHC assigned to the program. If not, contact the child care program to determine if there are health and safety issues the program would like to address. As always, child care health consultation is voluntary and a program is free to refuse services.

SELF REFERRAL

When services are requested by a child care program, the CCHC should be sure to understand the goals for the consultation. The program may desire the consultant to provide services that are not within the scope of practice for CCHCs such as providing medical diagnosis or treatments. It may be necessary to clarify the role of the Child Care Health Consultant. The CCHC does not provide hands-on health services, but can assist the child care program to find other appropriate resources for these services.

CASE FIND

Unscheduled visits to child care centers, presentations at early childhood conferences, or attending other child care-related meetings and events may result in discovering programs which would welcome CCHC services. Also programs which applied but were not selected for Quality First participation may still be interested in consultation by a CCHC.
Visit Patterns
VISIT SAFETY TIPS

When preparing for making a visit to a child care program, safety first! Consider the weather, the potential for storms, and traffic you are likely to encounter. “Be prepared” is a motto for all of us, not just the Boy Scouts.

SAFETY TIPS—GETTING READY FOR YOUR VISIT

- Make sure your vehicle is in good running order: Tires, gas, oil, radiator coolant etc.
- Keep doors locked and seat belt on while traveling.
- Call to confirm visit. Verify address and directions; keep the information on the seat next to you.
- Have a map, a flashlight and pair of comfortable walking shoes in the car.
- Ask about dogs or other potential safety hazards.
- Have a plan for what to do if you have any problems (for example a flat tire, getting lost, etc.)
- Know the location of the nearest police and/or fire station.
- Be aware of neighborhood issues and make visits only during daylight in high-risk neighborhoods.
- Beware of areas that are isolated with few people around.
- If you arrive or will leave in darkness, park in a well-lit area away from shrubbery or areas which offer a hiding place to strangers. Use a flashlight or automatic interior lights to assure a stranger has not gained access to your vehicle.
- Leave a schedule with your supervisor or someone in your office; include your anticipated time of return.
- Carry a cell phone and car cell phone charger.
- If you are ill, reschedule the visit.
- Wear comfortable clothes/shoes.
- Do not wear expensive jewelry/clothing/scarves etc.
- Do not take your purse, other valuables or weapons into the program.
• Lock valuables in your trunk and lock your car.
• Park your vehicle so that you cannot be blocked in.

**SAFETY TIPS—DURING THE VISIT**

• Trust your instincts – if something doesn’t look/feel right, don’t go in or else cut the visit short.
• If you hear arguing/fighting as you approach the program, don’t go in. Call 911 if necessary.
• Be aware of emergency exits.
• Wash your hands before/after holding an infant.
• If soap and water are not available, use hand sanitizer containing at least 60% alcohol. Apply about 1/2 teaspoon of the product to the palm of your hand. Rub your hands together, covering all surfaces of your hands, until they’re dry.
• Use discretion when offered something to eat/drink in a program. Beanie Weenies eaten with a table full of four year olds can be a delight, build relationships with staff and allow observation of family-style food service, but if the CCHC is onsite to provide interventions related to an outbreak of diarrhea it is a delight best postponed.

**SAFETY TIPS--AFTER THE VISIT**

• If leaving a child care program after dark, walk to your car with another adult. Wait until you both have your cars started before driving away.
• If you must leave alone, have your keys ready.
• Be sure to wash hands. Carry an alcohol-based hand sanitizer in your bag or car.
• Be aware of surroundings when leaving.
• Report back to the office and tell supervisor of findings/incidents, per agency policies.
• Sanitize all items used during the visit e.g. developmental toys, screening equipment, etc.
BUILDING RELATIONSHIPS

Child care health consultation is characterized by the relationship that exists between the child care providers, the CCHC and other team members. A warm, co-professional relationship based on mutual respect for the contribution each individual makes to the process of creating a quality children’s program can mean the difference between success and failure in reaching consultation goals.

- Wear identification which contains a minimum of your first name and your home agency.
- The CCHC should always announce his/her arrival to the individual in charge.
- If valuables have not been left in the CCHC’s vehicle, ask where they might be secured while on site. (This might include the laptop computer which cannot be left in a hot car).
- Ask which bathroom could be used if needed.
- Sign in on the visitor’s log and wear a visitor’s tag if requested.
- In a family child care home, ask about the provider’s family members who live in the home. Determine how family member’s schedules may impact the timing of your future visits. Additionally determine which rooms in the home the provider considers to be off limits.
- The CCHC should assure that his/her activity will not create a health or safety risk for the children in care. Especially in a family child care home, it may be necessary for an additional provider to be present to supervise children.
- Be on time. CCHC visits may be sandwiched in between helping to clean up after lunch and the first bus run. Child care providers are busy. Avoid Friday afternoons in child care centers when directors are reconciling child care fees and payments.
- When sitting down to begin the consultation services, assure everyone is comfortable. Preferably sit with, side by side, if it won’t invade personal space. Avoid sitting directly across from the director or provider in a confrontational style. Also avoid standing over the provider- this implies a “one-up” position. Make eye contact if this is appropriate within the provider’s culture. In some Native American cultures eye contact is deemed to be disrespectful.
- Give background information about what a CCHC has to offer. This information could include recent reports of injuries to young children, local or seasonal concerns, or some easily understood statistics. Explain how a CCHC could address these issues.
• Determine if other service providers are currently working in the program e.g., oral health program, early interventionists, nutritionists. Avoid conflicts in schedules and consultation.

• Smile and be pleasant when greeting staff, children or families. Identify yourself as a CCHC and your home agency. Say you are there to help the child care program plan for the health and safety of children.

• Thank the provider and children when you leave the room.

• Make notes of program strengths along with needs.

• Always call attention to positive changes you see happening.
INITIAL VISIT

The CCHC’s initial visit in a child care program will have different goals depending on the purpose of the consultation relationship (expert mode or quality improvement activities) and whether or not the program is enrolled in Quality First. The Initial Visit is an appropriate time to ask for an authorized person in the program to sign the information agreement (waiver).

INITIAL VISIT: EXPERT MODE

The purpose of the Expert Mode Initial Visit is to provide expert consultation/advice in an emergency or crisis situation where the child care provider needs immediate expert assistance, such as during an acute outbreak of diarrheal illness. Referral to the CCHC may have come from the child care program, home agency disease control staff, concerned parents, or other agencies/organizations which monitor or provide services in the child care program.

- Ask the director or staff to explain the problem. Determine who is affected by this problem and how long the problem has been going on. Ask about strategies that have already been tried to solve the problem. Find out if reports have been made to other agencies.
- Review documentation that may provide more information (injury and/or illness logs, attendance sheets, diaper logs, etc.)
- Assess the affected classrooms or area.
  - For example, if there is diarrheal disease in the infant room, pay particular attention to the diapering area, diapering supplies and procedures. Review infant food storage and preparation along with feeding procedures. Evaluate the cleaning and sanitation schedule including management of mouthed toys. Ask about exclusion policies particularly as they relate to children and adults with diarrhea, vomiting and fever. Determine if the illness has been posted or if parents have been notified in writing.
  - If there is an increase in playground injuries, conduct a playground safety check and observe playground supervision habits of staff. Determine that the playground equipment is developmentally appropriate for the children who are using it.
- Recommend interventions which fall into one or more of three categories.
  - Do these things now - examples: make the slide off-limits until broken step is repaired; assign a responsible provider to prepare diaper area sanitizing solutions fresh daily.
  - Do these things soon- examples: have energy absorbent ground cover tilled to loosen it, have Formica replaced on diaper changing table.
  - Prevent this situation from occurring again - examples: create a schedule for regular playground inspections and repairs, schedule a staff training related to interrupting the spread of disease in the child care setting.
INITIAL VISIT: QUALITY FIRST
For child care programs enrolled in Quality First, the Coach will alert the CCHC or CCHC agency that a child care program is ready for CCHC services in writing via e-mail, fax, or post and indicate if an Initial Joint Visit is desired. This Initial Joint Visit, fondly called a “meet and greet” may include the Quality First Coach, the CCHC and representatives of the child care program (provider, owner, director, staff, or corporation representatives). As the case manager, the Coach establishes the agenda and goals for this visit. This may be the third or fourth visit the Coach has made to the program.

If available, the CCHC should review the program assessment which can be accessed from the FTF Partner Extranet before the visit.

INITIAL VISIT: HEALTH AND SAFETY PROGRAM IMPROVEMENT (NON-QUALITY FIRST PROGRAMS)
In non-QF programs the Initial Visit is usually an interview. If the CCHC is not familiar with the program, a tour of the premises will be helpful in planning for an assessment visit. The CCHC establishes the goals for the visit. Goals may include:

- To describe the role of the Child Care Health Consultant.
- Sign required agreements and an enrollment data forms, including the Information Sharing Agreement.
- To explore the center’s needs and expectations of consultation.
- To understand the program philosophy e.g., Montessori, Reggio-inspired, therapeutic environment, etc.
- To determine the program’s accreditation status and needs.
- To gather information regarding the size of the program, e.g., number of children served, ages of children served, children with special health care needs, number of classrooms.
- To understand the types of families the program serves e.g., military families, children whose fees are subsidized by DES, many children placed for care by CPS or foster children.
- To determine the program’s structure (e.g., school-based, non-profit, church-related, parent board-managed) to determine who else may be involved in decision-making for the program.
Schedule an assessment visit if needed. Early to mid-morning visits allow the best assessment of health and safety practices. Schedule visits at a time the provider does not have responsibility for direct care of children. You may want to leave a copy of the tool which will be used.

**AT THE END OF THE VISIT**

As you end your visit, summarize what was accomplished at this visit. Schedule the next visit and describe what will happen, who needs to be involved and any records or documents which will be reviewed. Confirm that the provider is in agreement with the plan. Assure the provider has needed contact information should questions arise or if there is a need to reschedule the next appointment.

**DOCUMENTING THE INITIAL VISIT**

Documentation of CCHC activities (charting) must take place in a way that is comprehensive, systematic and accurate. Documentation provides a description of assessments performed, a plan for care, desired outcomes, and evaluation of the effectiveness of interventions implemented with the program. The CareFacts software system is used for documenting all CCHC activities and complies with the legal charting requirements for the health professions. Complete all charting within 5 working days of a visit. Charting for a visit is not considered complete until the visit is confirmed. For more information on confirming visits in CareFacts, consult the documentation information in the CareFacts instruction materials.

In addition to the computerized charting, a hard copy chart which contains the original signature of the CCHC and other pertinent documents must be established and placed in a secure location which complies with the client-record policies of the CCHC’s home agency. A format for hard copy client records is included later in this document.

Dates of visits are also posted on the FTF Partner Extranet as a way of keeping other Quality First team members advised that CCHC activities are taking place.
PREPARING FOR ASSESSMENT VISITS (NON-QUALITY FIRST CHILD CARE PROGRAMS)

Assessment of a child care program occurs early in the quality improvement consultation process. The exception is when a child care program receiving expert mode interventions chooses to participate in quality improvement activities. The assessment is the groundwork for development of a plan of care which (along with the Quality Improvement Pathway found in CareFacts) will guide the activities of the CCHC throughout the consultation process. For child care programs enrolled in Quality First the initial assessment is completed by contracted assessors. This assessment covers a wide range of child care issues. In non-QF programs, assessment will be completed by the CCHC and will focus on health and safety issues.

PREPARING FOR ASSESSMENT

Lay the groundwork for assessment at a visit before scheduling an assessment visit. Assessment can produce anxiety for the provider if the purpose and process of the assessment is not understood. Explain that the assessment is being completed for all programs participating in quality improvement activities.

Explain *in detail* what will happen during the home or center assessment, and about how long it will take to complete. Show any measuring devices which will be used.

When explaining, say, “We will . . . “ Make this an activity the CCHC and the provider are doing together. Ask the provider what health and safety issues are of the most concern before beginning the assessment (“What health and safety issues worry you the most?”).

Anticipate possible questions and concerns the provider may have and bring them up before he or she does. This could be accomplished by using “other client” stories. An “other client” story may be real or made up. To maintain confidentiality, a CCHC never gives the name of another client, however the CCHC could say, “Some providers have asked what will happen to this information. . .” The benefit of using an “other client” story is that it may help the provider feel that he or she is not the only one being asked these questions.

Make sure to answer all the provider’s questions and concerns completely before proceeding. Do not rush through this process. Fears and objections occur anytime people are asked to do something new and different.

Despite your careful presentation, some providers may still be reluctant to participate in the assessment process. Listen for hesitation in the provider’s responses. Watch their facial expressions and body language. If they frown, look away; close their arms tightly around their body, or pull way back in their seat, STOP! Ask what his/her concerns are. Listen carefully and,
before you start talking, make certain the provider has stopped talking before you respond. If you interrupt the provider you may miss valuable information.

If the provider expresses objections, treat this as a need for more information. Ask what additional details might help them be more comfortable with the process. Let the individual look over the checklist if needed. This helps her know you’re not just being nosy and that everyone gets the same treatment.

This part in the introduction of the program assessment can be a turning point. If the CCHC appears to be defensive when the provider voices a concern/objection, the provider may take an offensive stance and the consultation cannot move forward.

Always answer all questions honestly and to the best of your ability. If the CCHC does not have the answer, she should say so. The assessment may need to be delayed until the answer is found. Better a delayed assessment than no assessment at all.

Once all the provider’s questions have been answered, briefly review what will occur during the assessment and check for understanding and agreement to the process one more time.
ASSESSMENT VISIT (NON-QUALITY FIRST CHILD CARE PROGRAMS)

The assessment visit is a snapshot view of the program’s environment and written policies in action. It is generally not a visit which includes a review of children’s health records, care plans, or written policies. A standardized, evidence-based child care assessment tool is used to assist the CCHC in determining the health and safety consultation needs of the program.

HEALTH AND SAFETY CHECKLIST TOOLS

CCHCs providing assessment under the umbrella of First Things First will use the California Childcare Health Program (CCHP) Health and Safety Checklists to provide information needed to develop a quality improvement plan. Links for the checklists (one for the environment and one for written health and safety policies are listed below. First Things First has received written permission to use these tools:

- Checklist:  

- Item Specifications:  

- Orientation Guide:  

- Profile Summary:  
  [http://www.ucsfchildcarehealth.org/pdfs/Checklists/Profile_Summary_CCHP_Checklist0208.pdf](http://www.ucsfchildcarehealth.org/pdfs/Checklists/Profile_Summary_CCHP_Checklist0208.pdf)

- Policy Checklist:  

- Playground Safety Checklist:  

BEFORE THE VISIT

Be prepared!

- Before the visit determine which rooms will be observed. Include
  - All classrooms with infants (not yet one year of age) and
  - In a large program (10 or more classrooms), assess three preschool rooms. In a smaller program select two preschool rooms. Rooms may be selected with input from the provider.
• Make a copy of the assessment tool. The provider may request to have a copy of the tool which will be used, or may wish to accompany the CCHC as the assessment is completed.

• Review the tool to be used and collect any measuring devices needed. This might include a ruler, measuring tape, head and torso probes, thermometer, playground safety inspection kit, etc.

• Pack extra pencils with erasers which do not smear when used.

• Dress comfortably, wear closed-toe shoes. Replace your handbag or purse with a fanny pack to carry items which you might need during the assessment, including a snack and/or bottle of water, keys, extra writing implements, cell phone.

**PROCESS**

• If the tool being used includes criteria that need to be assessed by interview, ask the provider about the best time to work this into the assessment.

• Conduct the observation utilizing all the evidence available. Use schedules and notices posted in the program’s entry and on bulletin boards. Read schedules, menus, emergency information, cleaning/sanitation schedules and notices posted on classroom walls. Check for a monthly parent newsletter and obtain a copy for the program’s chart.

• Make notes of program strengths along with needs.

• Smile and be pleasant. If the staff has not been alerted to the assessment visit or if parents ask, say you are a consultant from (your agency) and you are there to help the program with any health and safety needs they may have.

• Thank the staff and children as you leave the room.

• Do NOT open closed cabinets, drawers, files.

• Do NOT interrupt the classroom activity. If you need to ask a question, wait until the teacher is not occupied with a child’s needs.

• Stay with the group being observed. If outdoor time occurs during the observation, follow the group outdoors.

• The CCHC cannot count in the teacher: child ratio. If ratios are not appropriate, alert the provider.
**AT THE END OF THE VISIT**

Be prepared for immediate questions about the results of your observation. Have ready two or three positive observations (“I really like the way the infant room teachers have marked the cribs of the infants who can roll over by themselves.”)

- Let the director know that an assessment report will be prepared which will summarize the observation and provide information to help with planning next steps.

- If the provider participated in the assessment process and wishes to discuss an assessment item, read the criteria, ask what the provider saw and how that compares to the criteria before you make your response.

- Schedule a visit to return to the center to discuss the assessment results and to create an Improvement Plan.

**DOCUMENTING THE VISIT**

Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Visits are not complete until confirmed. Place a copy of the completed assessment on the left hand side of the chart behind the careplan.
INTERIM VISIT: DEVELOPING A PROGRAM IMPROVEMENT PLAN

The purpose of this visit is to share the results of the CCHC’s assessment, and/or to collaborate with the provider and others who are involved to plan for addressing identified health and safety concerns. It is also an opportunity to begin exploring intervention strategies which utilize the strengths of the program, rely on resources which are available to the program, and can be evaluated. Rules and regulations which apply to the setting and Caring for Our Children should be consulted when developing a Program Improvement Plan. When providing services to an NAEYC-accredited center or a center seeking NAEYC accreditation or reaccreditation, be sure to review NAEYC Accreditation Standards http://www.naeyc.org/community/torch (requires free registration).

PROCESS: NON-QUALITY FIRST PROGRAMS
Provide a copy of the Assessment Report to the director. Have a copy in your hand. Answer any questions regarding the information in the report, referring back to the Program Assessment as needed. Be a good listener and be ready to explain that the assessment is a “snapshot” view of the program and that the CCHC understands things are different from day-to-day. With input from the director, prioritize the problems to be addressed.

PROCESS: ALL PROGRAMS
Ask if the director or others who are present for this visit have any thoughts about how identified health and safety problems might be addressed. Remember this is a collaborative process; the CCHC and provider share the responsibility for finding solutions. Work with the provider to select those issues which present the greatest risk to the health and safety of children and staff for early action. Add additional issues to the planning process overtime. Discuss interventions which seem the most feasible, utilizes the strengths of the program and can be program-driven rather than CCHC-driven. Include a timeline for addressing each problem and evaluation criteria for each problem.

SELECTING INTERVENTIONS
Interventions usually fall into two categories, human or structural.

- Human interventions are focused on changing knowledge, beliefs, feelings, motivation, and/or behavior. Human interventions include staff training and onsite technical assistance.

- Structural interventions are focused on changing policies, procedures, and physical features in the child care environment such as re-arranging the diapering area, or
advising the purchase of additional energy-absorbent ground cover. Referral to other service providers or other CCHCs with needed expertise is also a structural intervention.

Whatever the intervention, a timeline and evaluation plan for solving the problem should be developed.

**AT THE END OF THE VISIT**
Review with the director what each individual has agreed to do. Schedule the next visit and review what is to be accomplished at the next visit. If onsite teaching/training is included in the intervention strategies, determine which room will be used so equipment needs and room arrangement can be considered beforehand.

**DOCUMENTING THE VISIT**
Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Visits are not complete until confirmed.
**INTERIM VISIT: TECHNICAL ASSISTANCE**

The purpose of the technical assistance visit is to provide information based on rules and best-practices, to address an identified problem, or to provide leadership in solving a problem. Technical assistance may also be used for offering specific solutions to a specific issue if needed in expert mode consultations. Technical assistance delivery is short in duration (usually 2 or fewer visits) and is customized to meet the needs of the program. An example might be providing information, demonstration and evaluation of return demonstrations related to carrying out safe and sanitary diapering or provider performance of crib safety inspections.

**PROCESS**

Consider strengths identified for this group in planning the technical assistance. Describe to participants the goal of the technical assistance session, and ask for suggestions for how the goal might be met and what they expect the benefit will be if the goal is met. Providers will resist learning activities they believe are an attack on their competence, so start with what they are doing right. Proceed with activities (demonstrations, policy development, etc.) incorporating recommendations from participants, and acknowledging their opinions and past experience.

**AT THE END OF THE VISIT**

If the CCHC will return for another visit to continue with the technical assistance process or to evaluate the outcome of the technical assistance, provide, in writing, what should take place before the next visit. Make a note to yourself to call 2-3 days before your return visit to provide a reminder of what you will be reviewing and of any assigned tasks that were to be completed. Assure complete follow through with what you said you would do.

**DOCUMENTING THE VISIT**

Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Visits are not complete until confirmed.
INTERIM VISIT: TEACHING/TRAINING

Trainings are useful for helping providers improve their skills and learn how to address health and safety issues effectively. Training may be selected as an intervention to address a current need, or for the purposes of health promotion. Health promotion applies to situations where the program is interested in information about the prevention of a health or safety-related problem in the absence of signs or symptoms of the problem. Good training offers fresh and interesting ideas. It also helps providers grow as professionals.

Standardized statewide CCHC trainings have not been developed for this project. Every training prepared for an individual program need to reflect the program’s unique needs, the rules which govern the setting, local concerns and resources available in the community. CCHCs across the state and across the nation have been very generous in sharing their training curricula for a place to begin. Check with your colleagues and CCHC project websites. Other departments in your agency may have already prepared trainings that are adaptable for the child care setting. You may also be interested in more information about the T3 Training Collaborative.

http://www.ag.arizona.edu/maricopa/t3/about.php

TEACHING/TRAINING FOR HEALTH PROMOTION

Child care programs often ask for health promotion trainings to assist with meeting training requirements included in their licensing or certification requirements. Proof of attendance at the training will be important. Plan to establish a roster of participants and award a certificate which uses language that matches the training requirement in the applicable rules (for example “Sun Safety” not “Skin Cancer Prevention” in child care centers R-9-5-403:14).

TEACHING/TRAINING TO ADDRESS A CURRENT PROBLEM

Training topics and content are often selected by the director in a child care center and do not necessarily reflect the actual or perceived needs of center staff. Within a program improvement consultation visit series, there may be time to determine staff interest. With the director’s permission, ask staff members to complete a simple survey. Include open-ended questions. Ask what they want to know more about. You can also list specific topics related to the outcome of the program assessment, and ask staff how interested they are in those topics.

If you are working with several family child care providers who share a similar problem, you may find it a positive experience to bring them together for training. It may be validating for them to know others share their experience. It may also be a treat to have a break from the social isolation family child care providers often experience due to their long hours with children in the absence of other adults.
**PROCESS**

Group trainings may be used as a way to provide relevant information needed to solve a problem shared by participants. Before the training ask how the how the problem is affecting participants and what they already know about the subject. Ask what else they think they need to know to create a solution for the problem. After the training determine which information needed to create a solution was not included in the training. There are several techniques to make this process more interesting. For an idea, see the KWL table at [http://en.wikipedia.org/wiki/KWL_table](http://en.wikipedia.org/wiki/KWL_table) for assistance in using the KWL teaching strategy.

On-site staff trainings usually take place during evening hours or on a Saturday morning. Nap time trainings may be requested by a program, but before the training is planned determine how children will be supervised during training time. Assure training will take place away from resting children.

On-site trainings with staff of a single center offer the advantage of being able to include the CCHC’s assessment observations in the center. However, trainings can also be scheduled to accommodate a group of programs with similar needs. Libraries and other public spaces can make space available to the CCHC. A disadvantage of trainings with participants from different programs is the need to maintain the confidentiality of what has been observed in a specific program.

Including a 5-10 question pre/post test or other form of evaluation will assist you in determining a knowledge score when you complete your documentation (charting). Testing results can be included in charting the visit either in the Client Specific area or as a note to accompany an interim rating in the knowledge area. There is no system in place to collect pre and post test scores across the state.

**AT THE END OF THE VISIT**

- Assure that all equipment including cords, plugs, remote controls and demonstration supplies are packed. Consider labeling cords and remote devices with your name in case they are left behind.
- Pick up leftover certificates, and handouts, the sign-in roster, evaluation forms, and pre and post tests.
- Make sure all outlet covers which have been removed are replaced.
- Assist with tidying the room as needed.
- Back at the office, clean and sanitize demonstration supplies as needed. Plan to replace supplies which cannot be re-used or are in short supply.
DOCUMENTING THE VISIT

Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Be sure to include the number of individuals trained. Charting for a visit is not considered complete until confirmed.

All T3 trainings delivered by T3 trainers are reported to University of Arizona Cooperative Extension on the T3 Reporting form along with a copy of the participant roster. Certificates for participants are provided by the T3 system. A copy of the T3 reporting form and participant roster is placed in the client chart (usually stapled to the Visit Report) along with other applicable forms.
INTERIM VISIT: REFERRAL

When a service needed to assist the program in moving towards established goals is not within the professional expertise or role of the CCHC it may be necessary to refer the child care program to another CCHC or service provider.

Before referring the child care program or an individual to any resource, make sure the resource agency and the services offered are credible and appropriate. Be aware of eligibility criteria for services, hours of operation and costs of service. If the referral is for an individual or family, know accepted insurance plans, and languages spoken by the agency staff.

EXAMPLES OF REFERRING THE CHILD CARE PROGRAM TO RESOURCES

The CCHC may be aware that health records indicate that few children in this program have had a first visit to oral health care provider. Many records also lack the name of a dentist. While working with child care staff and AHCCCS to increase children’s medical and oral health access, a referral to ADHS Office of Oral Health, local health department oral health programs, or dental education programs may bring services such as oral health screening, fluoride varnish application, staff training on oral health issues, or assistance with establishing a tooth brushing program.

There may be a child without access to oral health care who needs treatment right away. The CCHC may consult with the family and assist the provider with finding care or arrange for a referral to a public health nurse for case management services. The event, but not the child’s name should be included in the charting.

HELPING PROGRAMS TO BECOME INDEPENDENT

Assist the program to create a community resource file which eligibility criteria for services, hours of operation and costs of services, accepted insurance plans, and languages spoken by the agency staff. Establish a link between the child care facility and community and state resources. This will promote independence for the child care program.

DOCUMENTING THE VISIT

Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Charting for a visit is not considered complete until confirmed.
DISCHARGE OR TRANSITION VISIT

All CCHC relationships will change. Some will end as programs reach their goals or withdraw from a program improvement project, and others will experience a transition as frequent, intense consultation is replaced by quarterly or bi-annual maintenance visits. Discharge should never come as a surprise to a child care program. For most it will be a celebration of the program’s accomplishments related to improvements in health and safety. For a few it will be the result of failure to move forward in the consultation relationship. It may also be that the environment presents health or safety risks for the CCHC, or the program determines they do not wish CCHC services. In all cases during this visit the CCHC should provide the program with instructions for reestablishing child care health consultation services if they will be available.

PLANNING FOR DISCHARGE OR TRANSITION

Discharge or transition from a quality improvement project or expert mode consultation relationship may take place when established goals have been met, it has been determined that consultation is ineffective, or when dictated by project timelines. Ideally the CCHC will determine that:

- The child care program has the resources needed to maintain the health and safety improvements attained during the consultation process.
- The child care program is prepared to independently move forward to meet goals not yet attained.
- The Coach has determined that a Quality First enrolled program will not benefit from consultation program at this time or the program does not wish to continue to receive services from the CCHC.
- The CCHC’s home agency policies or guidelines are in agreement that the environment presents health or safety risks for the CCHC.

See the chapter FAILURE TO PROGRESS in this document.

PROCESS

The process will need to be individualized depending on the reason the program is being discharged or moving through transition.

- Review the Program Improvement Plan and what has been accomplished. Identify steps which need to be taken to accomplish goals not yet met if they exist.
- Discuss potential threats to goals which have been met (high staff turnover, opening new classrooms, changes in population served, e.g., adding an infant room or school-age program) and how threats can be minimized.
• The CCHC and child care program agree on a schedule and format for maintenance visits. For example discuss what would be helpful to the program, perhaps scheduling communicable disease training in the fall and sun safety training in the spring or assisting with immunization record review in the fall.

• Provide information related to how the CCHC will or will not be available to the program in the future and how to reestablish consultation services or contact another service provider.

**DOCUMENTING THE VISIT**

Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Charting for a visit is not considered complete until confirmed.
SPECIAL VISITS: SUSPECT MEASLES IN THE CHILD CARE PROGRAM

The consultation activities outlined in this visit are based on guidance from the Centers for Disease Control and Prevention and Arizona Department of Health Services at the time of the 2008 measles outbreak in Pima County. Specific guidance in other counties and at a different point in time may differ. The assumption is made that an accelerated MMR schedule has been ordered and that the visit will be carried out by a registered nurse employed by the local health department acting at the direction of the local health officer. The individual CCHC should determine his or her appropriate role as defined by the employer and applicable regulations. Arizona Department of Health Services has developed a fact sheet which may be helpful for programs.


INVOLVING PARTNERS

If an outbreak is determined, it is advised that local health department staff meet with team leaders from Arizona Department of Health Services, Office of Child Care Licensing and staff from Arizona Department of Economic Security, Child Care Administration, to explain steps that will be taken, by order of the county health officer, if a suspect case of measles is identified in a child care program. The CCHC may be the convener of this meeting. Determine who should be alerted at ADHS or ADES when a child care program is impacted. The agency may want to follow-up with the program to make sure adequate ratios are maintained or provide the program with other guidance. Reassure the agency that if the suspect case is ruled-out they will again be informed.

MONDAY MORNING QUARTERBACK

Much drama could be prevented if child care programs would select a “best practice” approach to staff immunizations and routinely ask for verifiable proof that staff is immune to measles and rubella. At this time (March 2010), child care center rules require only that staff submit a statement that they believe they are immune to measles and rubella. CCHCs should consider this an action item in their consultation. Proactive collection of measles immunity for staff should be encouraged.

Proactively child care programs should be gathering documentation of staff immunity to measles. This can be documentation of vaccination or a positive titer (blood test). All persons born during or after 1957 should have documentation of at least 2 doses of MMR. Those staff born before 1957 must show documentation of at least one dose of MMR or doctor’s documentation of history of disease. A positive titer is also proof of immunity.
VISIT PREPARATION

Identification of susceptible individuals will receive a great deal of attention in a program where there is suspect measles. Call ahead and speak with the director. As needed, explain that it is possible that a child or staff person who attends the program has measles and that others in the program have been exposed. If indicated explain that some individuals may need to be excluded from attendance until vaccine is received or until the measles incubation period has ended.

- Ask for a copy of the current enrollment roster to be available. Assuring that each child who may attend the program has an immunization record will be easier with a copy you can check-off.

- Ask the director to review the immunization records for children ("blue cards") and place them in three groups: those with no history of MMR vaccine, those with 1 dose of MMR and those with more than one dose of MMR vaccine.

- Ask for the immunization records for staff and place them in three groups: those with no history of MMR vaccine, those with 1 dose of MMR and those with 2 doses of MMR vaccine.

- Gather written information for parents which can be shared with their health care provider explaining why their children are being excluded and steps that can be taken to allow reentry into the program.

- Gather written information for child care staff which can be shared with their health care provider explaining why the staff is being excluded and steps that can be taken to allow reentry into the program.

- Determine if the state laboratory will process specimens to determine IgG (immune) status without charge for child care staff. If so, identify an individual who can draw specimens.

REVIEW STAFF IMMUNIZATION RECORDS

There may be few staff immunization records to review, but there will be many questions.

- Known contacts of suspected or confirmed cases of measles should be advised to receive measles-containing vaccine within 72 hours of exposure.

- Child care staff with no record of vaccine should attempt to obtain a copy of their immunization history from their health care provider, their school, family, etc.

- If there is no verifiable vaccine date, staff should receive MMR as soon as possible and be excluded from the program for days 5 to 21 after their last exposure to a suspect
case or until a blood titer indicates a positive IgG (immune to measles). If the state laboratory is not providing this service for child care providers, staff may need to consult their physician and utilize a private laboratory. Titer results will take from 3-5 days and staff will be excluded during this time.

- Staff with at least one dose of MMR vaccine will not need to be excluded.
  - Staff born during or after 1957 should receive a second dose of MMR at least 28 days after the first dose.
  - If the only documented vaccine was given during the 1960’s, a second dose of MMR is recommended (this earlier vaccine was not effective).
  - Pregnant staff may be offered ISG and will be excluded for days 5-21 from the last exposure.
  - Immunocompromised staff may also be offered ISG, even if they have been previously vaccinated against measles. Immunocompromised individuals with disorders associated with an increased severity of viral infections should not be given measles vaccine.

**REVIEW CHILDREN’S RECORDS**

Most infants are protected from infection by passive transplacental maternal antibodies. However, children under the age of 6 months may be offered ISG and will be excluded for days 5-21 from last exposure.

- Immunocompromised children are very susceptible to measles and to complications of measles, even if they have been previously vaccinated against measles. Immunocompromised children with disorders associated with an increased severity of viral infections should not be given measles vaccine.

- Healthy children 6-12 months will be offered MMR if an accelerated schedule is in place. This is a “non-immunizing dose” that will need to be repeated at the age of 12 months followed by a third dose at least 28 days later. They will still need to be excluded for days 5-21 from the last exposure.

- Children 12 months and older with a single dose of vaccine should be offered a second dose at this time if 28 days have elapsed since the first dose. They do not need to be excluded.

- Provide information regarding special immunization clinics or opportunities to have titers drawn that may be available.
CONSULTATION

Assist the program in preparing to notify staff and parents of necessary steps. Have written materials available (if you do not know if the program has a copier, make copies at your office and take them with you). Write the date (22 days from the date of exposure) that individuals without signs or symptoms of measles may return.

- Be sure the director or provider understands that new children cannot be admitted to the center for 21 days from the last date of exposure (the last time the individual with the suspected measles disease was in the program).

- Review basic information related to interruption of disease transmission:
  - Exclusion of individuals with signs and symptoms of communicable disease.
  - Handwashing policies and procedures.
  - Sanitation policies and procedures.
  - Airing out the facility each day.

- Assure the director that CCHC will be available to answer questions and will stay in touch with health department staff to monitor laboratory results so staff and children may return as soon as possible (if appropriate).

AFTER THE VISIT

Call the appropriate monitoring agency to report status of the program. Provide an approximate number of staff and children who may be excluded for the 21 day period. Remind them that some staff may find their immunization records, and that others may receive blood titer results that show them to be immune to measles.

DOCUMENTING THE VISIT

Document the visit in the FTF Partner Extranet (the program’s activity log). Complete all CareFacts documentation (charting) within 5 working days. Be sure to include all communications with internal and external agencies. Charting for a visit is not considered complete until confirmed.
FAILURE TO PROGRESS

Not every program will thrive equally in a program improvement environment particularly where consultation is provided by multiple partners and several issues are being addressed in a short time period. Improvements (changes) may come in bursts of activity followed by periods where it seems nothing is happening. Child care programs which are not responding to consultation despite our best efforts can cause us to throw up our hands and say “I give up!” Not so fast! Giving up is indeed an option but there is often a way to get back on track.

WISE WORDS ON CHANGE

“Change is hard because people overestimate the value of what they have—and underestimate the value of what they may gain by giving that up.” James Belasco and Ralph Stayer in Flight of the Buffalo: Soaring to Excellence, Learning to Let Employees Lead

“People fear the uncertainties of change. The slightest suggestion that things won’t stay the same can cause panic . . . but the real problem isn’t the change . . . it’s people’s reaction to that change.” Dr. Alan Zimmerman, Motivational Speaker

“Change is highly personal while at the same time deeply imbedded in the systemic structure of an organization. Change is primarily about individuals and their beliefs and actions, rather than about . . . materials, technology and equipment.” Dr. Richard A. Villa, Teaching Consultant

WHAT ARE YOU BRINGING TO THE PARTY?

Stop to consider what you understand about your role in bringing about change. You can educate, be encouraging, assist in developing policies and procedures, establish timelines and help create a vision of what might be possible, but the provider is always free to reject your recommendations, or services. You must, however, radiate a confidence that the program can make the needed changes.

INSPIRING CHANGE

While most people understand that change can bring about improvement in their situation or even extend their lives, change is hard! These beliefs must be in place before change can begin:

- The belief that the consequences of current actions and the current situation poses a threat;
- The belief that change will reduce the threat.

The success of bringing about change also depends on individuals’ beliefs about their abilities to do the tasks needed to make the change.
SELF EFFICACY
The belief that we are capable of making the required changes is often referred to as the characteristic of “self-efficacy.” Providers who believe in their abilities to create a healthy and safe program will approach difficult tasks as challenges to be mastered.

- They will show interest in the tasks by gathering information.
- They will put forth great effort to succeed.
- They will set challenging goals and maintain their commitment.
- They will find ways to succeed even when confronted by obstacles and failure.

On the other hand, individuals who demonstrate low-efficacy doubt their capabilities and will shy away from taking on a task because they believe they cannot be successful. They may:

- Shy away from tasks.
- Give up quickly.
- Have low aspirations.
- Dwell on how hard the task is.
- Focus on adverse consequences of failure.
- Undermine efforts to be successful.

Low self-efficacy may be situational, that is people who are very successful in many parts of their life may struggle with specific situations. This is easy to understand if you find you are succeeding in your professional role, but the task of losing ten pounds seems as difficult as climbing Mt. Everest! However, some individuals demonstrate low efficacy in nearly every situation in their lives and this has a profound influence on their willingness to put effort into change.

Understanding the way self-efficacy impacts individuals is important for the issue of quality improvement. If providers do not believe a healthy and safe program is important or they do not believe they have the ability to make the changes needed, they can become frustrated with the CCHC’s recommendations—and the CCHC may become frustrated with their lack of progress.

MANAGING COMPLEX CHANGE
Several elements are needed to support providers and their self efficacy. The absence of any one element can bring about negative consequences that create barriers to change.
The Managing Complex Change Diagram examines the effect of missing elements needed for change. The elements and their definitions are listed below.

Vision: An ideal or a goal toward which one aspires. (Whose vision is this?)
Skill: The capacity to do something well. (Does the skill set of staff match the task at hand?)
Incentive: Something that motivates,rousers, or encourages. (What is the pay-off for achieving change?)
Resource: Something that individuals use to achieve an objective (Do staff have needed resources?)
Action plan: A planned series of actions, tasks or steps designed to achieve an objective or goal (Is the action plan clear, divided into manageable steps, with interim goals and timelines?)

Without each element in place, the diagram below provides a dreary prediction of the response staff may have to quality improvement efforts.

**Managing Complex Change**

\[
\text{Vision + Skill + Incentive + Resources + Action Plan} = \text{Change} \\
\text{Skill + Incentive + Resources + Action Plan} = \text{Confusion} \\
\text{Vision + Incentive + Resources + Action Plan} = \text{Anxiety} \\
\text{Vision + Skill + Resources + Action Plan} = \text{Resistance} \\
\text{Vision + Skill + Incentive + Action Plan} = \text{Frustration} \\
\text{Vision + Skill + Incentive + Resources + Action Plan} = \text{Treadmill} \\
\]

From Knosler 1991, TASH Presentations, Washington D.C.

If you have examined your expectations, revisited and/or revised the goals you established with program staff, reevaluated the timelines and discussed alternate strategies for reaching goals, have been open and honest about what you see (or don’t see) happening, and resistance and barriers still prevent the consultation relationship from moving forward meaningfully it may be time to move forward in a different way. Make sure documentation of consultation activities is complete and results and/or reactions to consultation are included.

**NEXT STEPS**

Programs enrolled in Quality First operate with the Coach as the case manager. Discuss compliance concerns or refusal of services with the Coach. You may discover that your experiences with the program are similar to those of the Coach. The Coach will determine some appropriate next steps. Document all discussions with the Coach in the child care program’s Care Facts communication log.
If the program is not enrolled in Quality First, the CCHC as the case manager will determine if the appropriate next step is to discharge the client, offering to provide services at a time when the program may be more prepared to undertake program improvement.

Child care health consultation is a voluntary process between a help giver and help seeker. If the help seeker has withdrawn from the process despite the CCHC’s best efforts, it is appropriate to postpone or abandon the consultation relationship. Carefully document the unique challenges and the reasons behind this decision.
COMMUNITY CONSULTATION: TELEPHONE HOURS

Telephone hours provide an opportunity for all community child care programs to obtain answers to uncomplicated health and safety questions and keeps your child care health consultation program visible. Telephone hours can also help to identify and recruit clients for quality improvement activities.

ASK A CCHC... THREE EXAMPLES

CCHC Program A established telephone hours Tuesday and Thursday mornings from 9:00 AM to 11:00 AM. These hours fit into their usual routines; there were no departmental meetings or clinics which required their participation scheduled at this time.

CCHC Program B provides telephone consultation by returning voice mails left by child care programs. There is a specific phone number left for this task and the outgoing message begins with “This is the Program B Child Care Health Consultant answer line . . . “ The caller is directed to provide call back information along with a general summary of the question. A return call is promised within 48 hours.

The Child Care Health Consultants funded by the City of Milwaukee at one time supported an “Ask an Expert” e-mail question and answer service which gave child care providers the opportunity to post child health questions. While providing answers to programs, this form of consultation is limited in its ability to build ongoing relationships which lead to quality improvement activities.

Whatever form your CCHC program might choose for community consultation, promote it in printed materials created for the CCHC program, and include examples of appropriate questions.

All community consultation should be logged with the caller’s identity and the program if it can be obtained. The topic of the question and synopsis of any advice provided should be logged. Offer to send your CCHC Program information materials to the caller.

DOCUMENTING YOUR COMMUNITY CONSULTATION

When utilizing Care Facts software, a client with the assigned name “Fictitious County Home Base has been created and the Communication Log can be used to document calls. Pima County currently uses such a system to record CCHC calls from the public or child care programs which do not have an open chart.

Example of a Communication Log entry:
Use the subject field for categorizing the subject of the call by selecting an appropriate problem from the Omaha System Problem List. The date function, used with the call topics will allow various reports to be easily created (e.g., what topics are child care programs most concerned about).

Helpful resources for Telephone Hours or community consultation in any form will include *Caring for Our Children*, the *Arizona Communicable Disease Flipchart*, the *Arizona Safety Information Flipchart*, the *Arizona Health and Safety Policy Manual for Child Care Centers*, and *Managing Infectious Disease in Child Care and Schools* (American Academy of Pediatrics).

If community consultation results in the need for additional follow-up (a report to epidemiology for follow-up, a staff training was scheduled, etc.) admit the client in the CCHC caseload and create a chart for the program.
REFLECTIONS

Your days as a CCHC may be filled with frustrations, triumphs, sadness, and the pleasure that comes with seeing incremental positive changes in programs. The CCHC writing this document has mourned with two programs when infants have been lost to SIDS, experienced frustration when a regulator was heard to say, “I wish the CCHCs would just teach the rules and not this best practice stuff,” cheered when programs have received their confirmation of accreditation, helped with off-site evacuation due to a chemical spill into a sewer which sent noxious fumes into the program, confronted a drunk parent who arrived to pick up his children, and experienced secret joy when a program for the first time reached 95% compliance on the annual Immunization Data Report. One day is rarely like the one before.

The future of CCHC projects supported by grants and special funds is always a concern. Ongoing efforts to demonstrate real changes in health and safety related to CCHC interventions through gathering and reporting related data is an important tool for documenting our work. Our use of the Omaha System of documentation will both inform our practice and help us to tell our story to others.

There must be an ongoing effort to institutionalize the practice of CCHC in local health departments, other government agencies in a position to provide health and safety consultation to child care programs, and other organizations and agencies which believe that children who are healthy will be more successful in their learning years. Supported by reliable and consistent funding streams, CCHCs can with their early childhood partners, make a difference in the quality of child care programs.

This is a moment like none before for the children of Arizona, full of promises for a bright future. Likewise it is our moment as CCHCs to be ambassadors for our role in assuring that future. Everyday tell someone what you do and why it is important. “I am a Child Care Health Consultant . . .”
Documentation Plan
GENERAL GUIDELINES FOR DOCUMENTATION

All onsite visits, trainings and telephone consultations performed by CCHCs providing services under the umbrella of FTF will be documented using the Omaha System of documentation inside the CareFacts® charting software. Other communications, including e-mail which includes elements of assessment or advice-giving will also be documented in the chart’s communication log. Specific instructions for utilizing the CareFacts® software are found in the provided instruction manual. The CareFacts® website has valuable information and tools including video tutorials. You must request a Logon and password from cf-help@carefacts.com to access the tools on this site.

GENERAL INFORMATION

The CareFacts® software allows for documentation and collection of data related to services provided to the client, the outcomes related to those services and how CCHC hours are allocated over time.

Timely charting is required. All charting is to be completed within 5 business days of the consultation event. A computerized charted visit is not complete until the visit is “confirmed.” CCHCs will not have the right to unconfirm their own visits; however, their supervisors may have been provided the right to unconfirm a visit to allow the CCHC to alter the contents. The CCHC administrative entity may also unconfirm a visit. A careful record of the changes must be kept.

Standardized abbreviations and acronyms have been established for CCHC activities and are found at the end of this chapter. They were collected by polling of CCHC projects in January 2010. Recommendations for changes and additions should be made to the CCHC administrative entity. An updated list is planned for January 2011.

Instructions for use of the CareFacts Software built especially for use by CCHCs providing services under the umbrella of First Things First follows.

THE CLIENT CHART

A hard copy of the client chart which includes copies of the visits with the original legal signatures of service providers must be created for each enrolled client.

- A unique id# assigned to the client will be generated by CareFacts.
- The hard copy chart folder will be a letter-size double fastener folder such as Smead product number 14513.
Each admission (if a program is discharged in CareFacts and is readmitted it is a new admission) requires the following set of documents:

- The left side of the chart will contain at a minimum (bottom to top)
  - the intake data base
  - the referral intake form
  - information sharing agreement
  - the client care plan
  - assessment forms
  - other helpful items such as the Google map to the address, etc.

- The right side of the chart will contain
  - visit documentation (oldest to newest)
    - Training visit documentation should include the original participant roster and summarized results of evaluations (pre/post test results, trainer evaluations), and other applicable forms
    - A copy of the T3 reporting form if applicable.
  - the client communication log (printed out at discharge)
  - discharge summary (printed out at discharge)

- Be sure to separate admissions (the client was discharged in CareFacts and is now being re-admitted) with by a colored piece of paper, a tabbed separator, etc. to keep documentation appropriately organized.

- Sign your name in ink to each page of the visit report and intake data base. Use the date the service was provided not the date you charted the visit or the date it was printed out. Remember that the hard copy chart is the legal record because your signature is there, and can it can be subpoenaed. A case can be made for using blue ink. Check the charting guidelines for your organization.

**QUALITY ASSURANCE**
Due to the quick ramp up for use of the Omaha System, activities to evaluate inter-rater reliability will be included in CCHC trainings and other events. Case scenarios will also be posted on the Arizona Child Care Health Consultant Support Center web page at
CCHCs will be asked to submit a response using the Omaha System problem, and intervention lists and the problem rating scale for outcomes.

Quality assurance related to documentation and charting forms is planned. Activities will include ongoing sampling of electronic charting, quarterly peer reviews and hard copy chart audits by supervisors and the CCHC administrative entity. Feedback and recommendations will be provided to project supervisors. These are learning activities and are not meant to be construed as evaluations although aggregate outcomes will be reported.

**THE OMAHA SYSTEM**

This handbook does not provide instruction on the use of the Omaha System. Each CCHC should have a copy of the Omaha System book (2005) for personal use.

Visit the Omaha System web page at [http://www.omahasystem.org/](http://www.omahasystem.org/) for more information about the system, where to purchase the book, trainings, conferences and tools to assist you in using the system.
# Approved Abbreviations for Charting 4/1/2010

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>What it Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>appt.</td>
<td>appointment</td>
</tr>
<tr>
<td>ASAP</td>
<td>as soon as possible</td>
</tr>
<tr>
<td>bid</td>
<td>twice a day</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>c/o</td>
<td>complains of</td>
</tr>
<tr>
<td>cc</td>
<td>cubic centimeter</td>
</tr>
<tr>
<td>cm</td>
<td>centimeter</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>DDST</td>
<td>Denver Developmental Screening Test</td>
</tr>
<tr>
<td>Denver II</td>
<td>Revised Denver Developmental Screening Test</td>
</tr>
<tr>
<td>DNKA</td>
<td>did not keep appointment</td>
</tr>
<tr>
<td>dx</td>
<td>diagnosis</td>
</tr>
<tr>
<td>f/u</td>
<td>follow up</td>
</tr>
<tr>
<td>ft.</td>
<td>foot (unit of measure)</td>
</tr>
<tr>
<td>HCP</td>
<td>health care provider</td>
</tr>
<tr>
<td>hs</td>
<td>bedtime</td>
</tr>
<tr>
<td>hx</td>
<td>history</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
</tr>
<tr>
<td>in.</td>
<td>inch/inches</td>
</tr>
<tr>
<td>iz/izs or imm/imms</td>
<td>immunization(s)</td>
</tr>
<tr>
<td>L</td>
<td>left</td>
</tr>
<tr>
<td>med or meds</td>
<td>medication or medications</td>
</tr>
<tr>
<td>ml</td>
<td>milliliters</td>
</tr>
<tr>
<td>N&amp;V</td>
<td>nausea and vomiting</td>
</tr>
<tr>
<td>N/A</td>
<td>not applicable</td>
</tr>
<tr>
<td>NVD</td>
<td>nausea, vomiting, diarrhea</td>
</tr>
<tr>
<td>OTC</td>
<td>over the counter</td>
</tr>
<tr>
<td>PCP</td>
<td>primary care provider</td>
</tr>
<tr>
<td>PMD</td>
<td>private medical doctor</td>
</tr>
<tr>
<td>p.o.</td>
<td>by mouth</td>
</tr>
<tr>
<td>PPD</td>
<td>skin test used to diagnose tuberculosis</td>
</tr>
<tr>
<td>prn</td>
<td>as needed</td>
</tr>
<tr>
<td>qid</td>
<td>four times a day</td>
</tr>
<tr>
<td>R</td>
<td>right</td>
</tr>
<tr>
<td>r/o</td>
<td>rule out</td>
</tr>
<tr>
<td>re or re:</td>
<td>regarding</td>
</tr>
<tr>
<td>SC</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
</tr>
<tr>
<td>SpSp</td>
<td>Spanish speaking</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>sx</td>
<td>symptom</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TC</td>
<td>telephone call</td>
</tr>
<tr>
<td>tid</td>
<td>three times a day</td>
</tr>
<tr>
<td>tx</td>
<td>treatment or treated</td>
</tr>
<tr>
<td>UTD</td>
<td>up to date</td>
</tr>
<tr>
<td>w/</td>
<td>with</td>
</tr>
<tr>
<td>w/o</td>
<td>without</td>
</tr>
<tr>
<td>wt</td>
<td>weight</td>
</tr>
<tr>
<td># /oz</td>
<td>pound(s) / ounces</td>
</tr>
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### Approved Acronyms for Charting 4/1/2010

<table>
<thead>
<tr>
<th>Acronym</th>
<th>What it Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADHS</td>
<td>Arizona Department of Health Services</td>
</tr>
<tr>
<td>ADHS/OCCL</td>
<td>Arizona Department of Health Services, Office of Child Care Licensure</td>
</tr>
<tr>
<td>AHCCCS</td>
<td>Arizona Health Care Cost Containment System</td>
</tr>
<tr>
<td>ASCC</td>
<td>Association for Supportive Child Care</td>
</tr>
<tr>
<td>AzDES</td>
<td>Arizona Department of Economic Services</td>
</tr>
<tr>
<td>AZEIP</td>
<td>Arizona Early Intervention Program</td>
</tr>
<tr>
<td>CACFP</td>
<td>Child and Adult Care Food Program</td>
</tr>
<tr>
<td>CCHC</td>
<td>Child Care Health Consultant</td>
</tr>
<tr>
<td>CCHP</td>
<td>California Childcare Health Program</td>
</tr>
<tr>
<td>CCNC</td>
<td>Child Care Nurse Consultant</td>
</tr>
<tr>
<td>CCRR</td>
<td>Child Care Resource and Referral agency</td>
</tr>
<tr>
<td>CPS</td>
<td>Child Protective Services</td>
</tr>
<tr>
<td>CPSC</td>
<td>Consumer Product Safety Commission</td>
</tr>
<tr>
<td>ECERS-R</td>
<td>Early Childhood Environmental Rating Scale-Revised</td>
</tr>
<tr>
<td>FCCERS-R</td>
<td>Family Child Care Environmental Rating Scale-Revised</td>
</tr>
<tr>
<td>FTF</td>
<td>First Things First</td>
</tr>
<tr>
<td>IDR</td>
<td>Immunization Data Report</td>
</tr>
<tr>
<td>ITERS-R</td>
<td>Infant Toddler Environmental Rating Scale-Revised</td>
</tr>
<tr>
<td>KIDSCARE</td>
<td>Arizona’s child health insurance program</td>
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<tr>
<td>NAEYC</td>
<td>National Association for the Education of Young Children</td>
</tr>
<tr>
<td>NAFCC</td>
<td>National Association for Family Child Care</td>
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<tr>
<td>NPPS</td>
<td>National Program for Playground Safety</td>
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<tr>
<td>NSACA</td>
<td>National School-Age Care Association</td>
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<td>OSHA</td>
<td>Occupational Health and Safety Act</td>
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<td>QF</td>
<td>Quality First</td>
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<tr>
<td>QIP</td>
<td>Quality Improvement Plan</td>
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<tr>
<td>RD</td>
<td>Registered Dietician</td>
</tr>
<tr>
<td>SNAP</td>
<td>Supplemental Nutrition Assistance Program</td>
</tr>
<tr>
<td>WIC</td>
<td>Special Supplemental Nutrition Program for Women, Infants, and Children</td>
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</tbody>
</table>