WASHINGTON STATE
Department of
Children, Youth, and Families

Report to the Washington State Legislature

CHILD CARE HEALTH CONSULTANT REPORT

April 2019

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CONTENTS

EXECUTIVE SUMMARY

On March 27, 2018, Governor Jay Inslee signed into law Engrossed Substitute Senate Bill 6032 (ESSB 6032). Section 223 of ESSB 6032 requires the Department of Children, Youth, and Families (DCYF, or the Department) to:

- Provide background on which nurse consultation services are currently available to licensed child care providers; and
- Provide options and recommendations, including fiscal estimates, for a plan to provide nurse consultation services to child care providers who request assistance in addressing the health and behavioral needs of children in their care.

DCYF proposes to systemically support the provision of child care health consultation (CCHC) to early learning settings in order to create healthier environments and stronger relationships with children and families. Addressing physical and behavioral health needs in the early learning system will help to reduce expulsions and "best fit" concerns and will help more children stay in appropriate settings to prepare them for preschool and K-12.

As demonstrated in the 2018 Department of Early Learning Child Care Market Rate Study, approximately 5-10 percent of children in licensed child care have special health care needs, including behavior supports for challenging behaviors, medication management and communication supports. The same population in the K-12 system is approximately 34 percent, as reported by the Office of the Superintendent of Instruction School Nurse Corps Administrators. Similar percentages are reported in Head Start and Early Childhood Education and Assistance Program (ECEAP) programs. These needs range from anaphylaxis risks from allergies, asthma, restrictive diets such as Celiac or casein/gluten free, to support attention-deficit/hyperactivity disorder (ADHD)/Autism diagnoses, diabetes, developmental delays and extreme behaviors, etc. Helping families address health and behavior issues early will allow them to access needed services sooner.

Helping child care providers create an appropriate environment for children of all abilities and needs will allow more children to be safe and healthy in licensed child care and help to close the gap between the number of children seen with special needs in Head Start, ECEAP or public school versus those seen in child care.

This report specifically addresses nurse consultation, as requested. Ideally, child care health consultants will be nurses who are part of regional, shared and interdisciplinary health services teams. The long-range goal of DCYF is that CCHC will consistently occur in nursing and mental health in all regions across the state. Additionally, other services that a child care provider or community may need, desire or be referred to by Early Achievers coaches, licensors, etc. will also be offered by these health service teams. These may include environmental, nutritional, health education or inclusion consultation.

This will ensure that infants and ultimately every child in licensed child care will be as healthy and safe as possible in child care settings because their child care provider is receiving ongoing support of their practices, policies and environments from a child care health consultant.

- 772: number of child care centers that are licensed to serve infants.
- 20-50: number of child care centers that a full-time nurse consultant can carry on their caseload, depending on the size of the programs.
- 16-40: number of full-time nurse consultants needed to meet the minimum Washington Administrative Code (WAC) requirement for child care centers.
- 3,049: number of family home child care facilities that are licensed to serve infants.

- 50-195: number of additional full-time child care health consultants needed to implement an expansion of nursing services to all facilities licensed to care for infants.

The following are the suggested systems-level improvements needed to effectively implement a system of CCHC for infants, along with three options to increase access to this consultation and expand it to children of all ages who are served by licensed child care.

Systemic Improvements Needed for All Proposed Options:

- Nine regionally-based nurse consultation managers, one for each of DCYF's six regions and one extra in the three most populous regions.
    - These consultation managers are necessary for enlisting community support, conducting outreach, coordinating with other consultants in the local community and recruiting and training private nurses to serve as child care health consultants.
    - *The cost for nine regional nurse consultant managers and one DCYF program manager to oversee the program: $1,676,125 annually.*
- Creation of a new, or adaptation of a current, online platform for data collection.
    - This system will allow nurses to register as child care health consultants, track and receive required training and access forms and contracts. This online platform will also be a place where child care providers can look for a nurse to contract with. There are several current online systems that may work or it may be most efficient to create a new system.
    - *The one-time cost to adapt the current system or create new platform: $100,000.*
    - *The cost of ongoing support: $10,000 annually.*

Option A: DCYF Pays for A Comprehensive Child Care Health Consultation System.

- DCYF would hire nurses in local communities to be full-time child care health consultants to complete all of the WAC required visits to infant-licensed centers in each Option of the six DCYF regions. This would entail hiring 25 full-time child care health consultants across the state. Further, if DCYF were to also provide nurse consultants to all family homes which are licensed to serve infants, an additional 15 nurses would need to be hired. Finally, if DCYF were to offer on-request CCHC for all 5,360 licensed centers and family child care homes, while still meeting WAC requirements, an additional 25 nurses would be needed. Therefore, to staff a statewide comprehensive model, DCYF would need to invest in the statewide systemic improvements listed above and hire 50 consultative nurses. This option would address the health and safety needs of all children in licensed care, greatly reduce the financial burden on child care centers and family homes that are serving infants as well as build upon consultation that is currently offered through the Early Achievers quality rating program.
- *The total cost to meet WAC requirements for the 2019-21 biennium: $11,092,366.*
- *The total cost to meet WAC requirements and offer statewide on-request consultation for the 2019-21 biennium: $18,760,154.*

Option B: DCYF Creates an Infrastructure to Support Child Care Health Consultation and Contracts Directly with Independent Nurse Consultants.

- Instead of directly hiring nurses, DCYF would contract with independent child care health consultants to meet all of the required visits to centers across each of the six DCYF regions. This would instill greater consistency of quality and coverage for nurses and would encourage nurses to be dedicated full-time to this work. Additionally, nurse contractors could invoice DCYF for professional development and other administrative

burdens. The challenge with this option is that while it costs less than Option A, it is very difficult to keep an on-demand independent workforce engaged and consistently participating in the system. The investment in the statewide systemic improvements would support this system and also help to address some of the inherent challenges.
- *The total cost for the 2019-21 biennium: $6,169,450.*

Option C: DCYF Hires a Small Number of Nurses to Supplement Consultation Needs Where an Independent Nurse Workforce Is Lacking.
- DCYF would identify service area gaps and hire full-time child care health consultants to meet the needs of centers in these geographic locations. Assuming that each region would need approximately 15 percent of its child care health consultant workforce to be supplemented by state-employed nurses, DCYF would need to hire 2-4 nurses per geographic region in addition to the statewide systemic supports.
- *Total cost for the 2019-21 biennium: $8,926,212.*

INTRODUCTION

Child Care Health Consultation (CCHC), formerly called infant nurse consulting, is required for licensed child care centers that serve four or more infants. The current Washington Administrative Code (WAC) does not apply to licensed family homes or non-licensed care settings, nor does it apply to child care settings serving children after their first birthday. The WAC was revised so that as of August 1, 2019, it will apply to licensed centers that serve any infants, rather than specifying a minimum number. Family home providers, Family, Friend, and Neighbor providers and providers serving children older than age one expressed interest in being eligible for child care health consultation services.

CCHC is considered the best practice to support the health and safety of children in group care. The American Academy of Pediatrics supports and encourages growing a CCHC system. Caring for Our Children, Third Edition under Chapter 1.6, spells out the expected duties of a person in the role of a child care health consultant. As of the last summary report completed in 2012, The National Resource Center for Health and Safety in Child Care and Early Education reports that 24 states, including Washington, have some requirement for child care health consultation.

Caring for Our Children states that the role of a child care health consultant is to support child care providers to promote the health and development of the children, families and staff in their center. A child care health consultant helps the child care provider to create and maintain a healthy and safe environment for the children in care. A child care health consultant does not typically offer direct nursing services to families but rather shares health and developmental expertise, conducts assessments of child, staff and family health needs and makes referrals to community resources as necessary or requested by the staff and families. The child care health consultant can assist families in care coordination with their medical home and other health and developmental specialists or assist the child care provider in addressing developmental concerns with families. In addition, the child care health consultant should collaborate with an interdisciplinary team of early childhood consultants, such as early childhood education, mental health and nutrition consultants and Early Achievers coaches. The specific health and safety consultation needs for an individual facility will depend on the characteristics of the facility, the experience of the staff and the group of children in attendance.

Child care health consultants provide services to centers in Washington State through monthly onsite nurse visits in infant rooms, as well as by phone or email consultation, as needed. Other

states utilize a variety of health consultants in areas such as nutrition, kinesiology (physical activity), mental health, oral health and environmental health. They then operate through a team approach to consultation. Connecticut is an example of one state that developed interdisciplinary training for early care and education consultants (health, education, mental health, social service, nutrition and special education) in order to develop a multidisciplinary approach to consultation.

Some states offer CCHC training with continuing education units, college credit and/or a certificate upon successful completion. Typical qualifications include graduation from an accredited or approved program and acceptable performance on a qualifying examination. There is not currently an official or state-sanctioned training for nurses in Washington. There are several states and universities that have training programs that can readily be adapted for use in Washington.

CCHC services may be provided in different ways, as they have throughout the history of infant nurse consulting in Washington. At various times over the past 20 years, services were funded through the public health system, resource and referral agencies, community action programs and by universities. Consultants who are not employees of health, education, family service or child care agencies may be self-employed. Compensating them for their services via fee-for-service, an hourly rate or a retainer fosters access and accountability. The model currently in use in Washington is fee-for-service with independent contractors paid by the child care providers.

DCYF operates the Infant/Toddler Consultation program for a small number of participants in the Early Achievers quality improvement rating system. There are about 18 part-time consultants across the state offering different types of consultation, as well as two full-time consultants in King County. Of these, between 5-10 are providing either mental health or physical health consultation on a part-time basis; additionally, FIND (Filming Interactions to Nurture Development) and developmental screening supports are offered.

The regions report that it is difficult to hire staff to be part-time health or mental health consultants for this program. Most of the consultants offer some mix of mental health, physical health and/or FIND services. Additionally, many of the regions chose to reassign their health consultation dollars into a developmental screening strategy.

CURRENT REQUIREMENTS

Current Requirements Regarding Child Care Health Consultation in Washington State.

Existing Requirements in The Washington Administrative Code (WAC)

WAC 110-300A-4130 (valid until July 2019) requires that child care centers who serve four or more infants obtain the services of an infant nurse consultant to visit monthly. They are required to maintain written onsite reports of the visits, along with a written agreement between the consultant and the provider. There is not a consistent or productive universal system or any supports in place to connect child care providers and child care health consultants.

Changes Coming to WAC Requirements

As part of the Standards Alignment process, the WAC was revised and will take effect on August 1, 2019 (110-300-0275). This revision is intended to move the practice and the services that child care providers will receive toward best practice and evidence-based outcomes.

Change: All centers licensed to serve infants will need to contract for nursing child care health consultants. The new WAC will require consulting in licensed child care centers that serve infants, but the number restriction was removed. The general consensus among both internal and external partners is that there should not be a distinction between the health and safety of children in a center that serves one to three infants and one that serves more than four. The nurses' services are utilized in the same way for three infants as it would be for four, hence the removal of the number restriction.

Change: Improved definitions and clarification of roles. Additionally, there were some specific changes that were incorporated to meet the needs of the field. The terminology changed from "infant nurse consultant" to "child care health consultant" to match the American Academy of Pediatrics recommendations. The role of the consultant was clarified to explain that it is not the prime responsibility of the health consultant to evaluate individual children, but their expertise can be utilized to assist in the health status and outcomes of individual children as needed. The ability to advise about an individual child should remain an option. To further align with *Caring for Our Children*, concerns from internal staff, and also nurse consultants' descriptions of what is currently happening on their visits, a general description of the types of services expected of a child care health consultant was added to the WAC. There was not a baseline in the original WAC for services for either the nurses to offer or the child care centers to expect.

Additionally, the time limit after a nurse completes his or her pediatric nursing practice requirement and is still eligible to begin providing CCHC services was extended from one year to five years to enable a larger pool of providers to access this service.

New: DCYF will provide a consistent, written contract template. The provision of a Department-approved written contract will allow child care providers to enter into consistent agreements with different child care health consultants and will also allow for consistent monitoring across regions for DCYF staff. Part of the impetus for this template was the need to align the requirements for child care health consultants to the best practices found in the *Caring for Our Children* standards. These standards will be spelled out clearly in the contract template that DCYF will provide to child care centers for use. The template represents both an increase in the expectations on the nurses and a clarification of what is required of them.

Change: Child care health consultants will begin reporting their child care center visits to DCYF. One of the major challenges with collecting information about child care health consulting is that the current WAC only requires hard copy documentation of visits to be maintained by the child care provider on site. The licensor then checks on the history of visits when they do their annual monitoring. There is no roll-up or state-level reporting. Beyond visiting the hard copy onsite files of each of the more than 700 child care centers licensed to serve infants, there is no way to collect and analyze the data. The new WAC requires that the child care health consultants report their visits to DCYF.

This will allow DCYF to collect data on the number of child care health consultants practicing, where they are, what topics they are addressing at visits and what needs they or the child care providers have that could potentially be addressed through training or other consultation opportunities. There will be no reporting, collection or sharing of private or personally identifiable information. Rather, this process is a way to collect data about what the system looks like across the state, as well as what needs consultants and child care providers might have to improve the quality of child care services.

Change: Child care providers are now required to keep enhanced records of child care health consultant visits. In addition to consultants reporting their visits to DCYF, the child care provider must keep records of what follow-up was recommended and what actions were taken to address the stated concerns. This is intended to increase accountability between the consultant and the child care provider. Additionally, licensors and coaches will be able to monitor what improvements the child care provider is implementing in response to the child care health consultant.

CURRENT SNAPSHOT

Current Snapshot of Child Care Health Consultation Programs and Workforce in Washington State.

The Nursing Commission at the Washington State Department of Health (DOH) reports there are approximately 125,000 licensed nurses (ARNP, RN, LPN and Nursing Technicians) in the state. There is not a common specialization within nursing to prepare nurses for the field of CCHC. DOH does not currently have a team that specifically works with this population.

A sample survey of nurses in Washington State was conducted by DCYF in response to ESSB 6032. By surveying nurses associated with the statewide Coalition for Safety in Health in Early Learning and the two geographically-based and active child care consultation nurse groups, the Snohomish County Nurse Consultant Consortium and the King County Child Care Health Consortium, more than 40 nurses were interviewed either individually or in focus groups. The DOH Nursing Commission assisted DCYF in obtaining access to a list of currently licensed nurses to enable a comprehensive statewide survey of who is doing this work and where. Upon the completion of an additional exhaustive scan of child care licensors, child care providers and the health care consultation workforce, an even more defined picture will continue to emerge.

Diminishing Financial Support for Nurse Consultation by Counties

There are several regions where the local health jurisdiction was supporting child care health consultation out of their general fund budgets after state dollars were repurposed more than a decade ago. As the nurses in these positions retired, those counties eliminated or repurposed the positions. These counties include Skagit, Yakima, Grays Harbor, Mason and the Tri-Cities metropolitan region. The majority of the licensed infant child care across the state is served by independent nurse consultants who are working part-time in addition to another job. There are some who do this work full-time, but currently only a handful; it is estimated there are fewer than five on the east side of the state and approximately 10 on the west side. One of the most common strategies for child care centers who cannot find a nurse is to employ a parent to do this work. *Caring for Our Children* states, however, that this creates a conflict of interest, just as having a current staff member doing this work would.

Snohomish County

Snohomish County Health District currently funds a child care health outreach team with 2.5 full--time employees (FTEs) through their general fund. The team consists of 1.0 FTE public health nurse, 0.5 FTE behavioral health specialist, 0.5 FTE environmental health specialist and 0.5 FTE nutritionist. There are approximately 25 nurses on their referral list for approximately 550 child care providers. The District does not offer direct services; however, it offers technical assistance, training and policy reviews. Only in emergency situations does the District offer direct services; otherwise, it connects the child care providers with the nurses that are on their referral list.

Seattle/King County

The Seattle-King County Public Health Department has a Child Care Health Program with:

- Six public health nurses,
- Three mental health specialists,
- One nutrition consultant, and
- One community health worker that offers direct consultation services to child care providers in Seattle.

Funding for the above team is supported by local tax dollars including the sugar-sweetened beverage tax. They are only able to serve a small proportion of the licensed child care centers in Seattle and none outside city limits. Funding from the Best Starts for Kids Initiative (BSK) contributes an additional child care health consultation program FTE.

In July 2018, BSK funded three traditional public health-style consultation models and four community-informed models addressing specific needs in individual communities within the county:

- One will support center-based care in East King County
- One will support licensed child care providers in south King County
- One will support licensed providers and Family, Friend, and Neighbor caregivers in Renton and Skyway
- One will serve Family, Friend, and Neighbor child caregivers in the Chinese immigrant community
- One will work with Somali-owned child care facilities serving primarily immigrant populations in Seattle and South King County
- One will serve Somali-speaking family home child care facilities in Kent
- One will serve Family, Friend, and Neighbor child caregivers within the African American and East African communities in South King County and Seattle

There is great potential that these models will be able to inform consultation services in other specific populations across the state in the future. At least one of the models has a goal of creating a replicable model to be used in other immigrant populations.

Additionally, BSK funded a systems development project. By the end of the three-year funding period, this project will create a roadmap to CCHC in King County, with a strong racial equity focus that may help inform and adjust the state system as appropriate.

IMPLEMENTATION

Implementation of a State System for Child Care Health Consultation.

DCYF proposes to systemically support the provision of child care health consultation to early learning settings in order to create healthier environments and stronger relationships with children and families. Addressing physical and behavioral health needs in the early learning system will help to reduce expulsions and “best fit” concerns and help more children stay in appropriate settings to prepare them for preschool and K-12.

Approximately 5-10 percent of children in licensed child care settings have special health care needs while the same population in the K-12 system is approximately 34 percent. The children that are later identified in the K-12 system and the Head Start/ECEAP systems are not currently being seen in licensed child care settings. These needs range from anaphylaxis risks from

allergies, asthma, restrictive diets such as Celiac and casein/gluten free for ADHD/Autism diagnoses, diabetes, developmental delays, extreme behaviors, etc. Helping families address health and behavior issues early will allow them to access needed services sooner. Enhancing this type of service to child care providers will help them create an appropriate environment for children of all abilities and needs, will allow more children to be safe and healthy in licensed child care and help to close the gap between the number of children seen with special needs in Head Start, ECEAP or public school versus those seen in child care.

This report specifically addresses nurse consultation, as requested. Ideally, child care health consultants will be nurses who are a part of regional, shared and interdisciplinary health services teams. The long-range goal of DCYF is that CCHC will consistently occur in nursing and mental health in all regions across the state. Additionally, other services that a child care provider or community may need, desire or be referred to by Early Achievers coaches, licensors, etc. will also be offered by these health service teams. These may include environmental, nutritional, health education or inclusion consultation.

This will ensure that infants and ultimately every child in licensed child care will be as healthy and safe as possible in child care settings because their child care provider is receiving ongoing support of their practices, policies and environments from a child care health consultant.

- 772: number of child care centers that are licensed to serve infants.
- 20-50: number of child care centers that a full-time nurse consultant can carry on their caseload, depending on the size of the programs.
- 16-40: number of full-time nurse consultants needed to meet the minimum WAC requirement for child care centers.
- 3,049: number of family home child care facilities that are licensed to serve infants.
- 50-195: number of additional full-time child care health consultants needed to implement an expansion of nursing services to all facilities licensed to care for infants.

The following are the suggested systems-level improvements needed to effectively implement a system of CCHC for infants, along with three options to increase access to this consultation and expand it to children of all ages who are served by licensed child care.

Systemic Improvements Needed for All Proposed Options:

- Nine regionally-based nurse consultation managers, one for each of DCYF's six regions and one extra in the three most populous regions.
    - These consultation managers are necessary for enlisting community support, conducting outreach, coordinating with other consultants in the local community and recruiting and training private nurses to serve as child care health consultants.
    - *The cost for nine regional nurse consultant managers and one DCYF program manager to oversee the program: $1,676,125 annually.*
- Creation of a new, or adaptation of a current, online platform for data collection.
    - This system will allow nurses to register as child care health consultants, track and receive required training and access forms and contracts. This online platform will also be a place where child care providers can look for a nurse to contract with. There are several current online systems that may work or it may be most efficient to create a new system.
    - *The one-time cost to adapt the current system or create new platform: $100,000.*
    - *The cost of ongoing support: $10,000 annually.*

A successful state system will allow child care providers some leeway while they are trying to find a consultant. This concept was suggested in House Bill 2779 and with the creation of a system to build capacity in the connections between child care providers and nurses, a baseline training to ensure that nurses understand what is expected of them, and a clearer understanding of what a child care provider can expect from a child care health consultant, it can be accomplished. The system will be able to connect child care providers with a child care health consultant and also with any needed forms, policies and expectations to make the process as seamless as possible for them.

Table 1: Budget for State Systemic Supports for Successful Child Care Health Consultation

Expenditure by Object	FY 2020	FY 2021	FY 2022	FY 2023
Nine Regional Nurse Managers	$1,520,446	$1,455,646	$1,455,646	$1,455,646
One DCYF Program Manager	$155,679	$148,479	$148,479	$148,479
Database Adaptation	$100,000	-	-	-
Annual Database Support	-	$10,000	$10,000	$10,000
Total	$1,776,125	$1,614,125	$1,614,125	$1,614,125

Every option listed below will require the creation of a statewide infrastructure and systemic improvements to support the services being offered. Regional support, database creation and program management will allow all options to operate successfully.

Option A: DCYF Creates an Infrastructure to Support Child Care Health Consultation and Pays for A Comprehensive Child Care Health Consultation System.

DCYF would hire nurses in local communities to be full-time child care health consultants to complete all of the WAC required visits to infant-licensed centers in each of the six DCYF regions. This would entail hiring 25 new full-time child care health consultants across the state. Further, if DCYF were to also provide child care health consultants to all family homes licensed to serve infants, an additional 15 nurses would need to be hired. Finally, if DCYF were to offer on-request child care health consultation for all 5,360 licensed centers and family child care homes, while still meeting WAC requirements, an additional 25 nurses would be needed. Therefore, to staff a statewide comprehensive model, DCYF would need to invest in the statewide systemic improvements listed above and hire 65 consultative nurses. This option would address the health and safety needs of all children in licensed care, greatly reduce the financial burden on child care centers and family homes that are serving infants[1] as well as build upon consultation currently offered through the Early Achievers quality rating program.

The DCYF-employed child care health consultants would be regionally housed and supervised by a nurse consultation manager. These nurses would have the ability to offer more comprehensive services beyond the WAC-required consultation for infants, as needed or requested by the child care provider, as they would not be tied to a fee-for-service payment structure.

[1]Today, child care providers hold contracts with independent nurse consultants for an average of $100 per month, though costs vary across the state from $85 to $160 per month.

Full-time independent nurse consultants report that they can serve between 30 and 40 sites at one time. Local public health nurse consultants consider approximately 20 sites a full-time caseload. The difference in caseload depends on the size of the centers, the geographic distances between centers and what services are required of the nurses onsite. Each child care center requires one visit per month, approximately three telephone or email consultations, travel and follow-up paperwork. This option assumes that 25 full-time child care health consultants can each visit 30 sites per month to visit all 772 sites per month.

If DCYF were to provide services for all of the child care centers as well as family homes that are currently licensed to serve infants, the number of child care health consultants would need to expand, although the requirements of what the relationship would look like would be different. WAC requires monthly visits for centers serving infants currently; however, the visits could be less frequent and on an on-request basis for family homes.

There are 3,049 family homes licensed to serve infants. With an assumption that 10-15 percent of family homes would request child care health consultation services at any one time, approximately 300-450 sites would require visits monthly. This would require an increase in approximately 15 additional nurses to the plan above, for a total of 40 nurses. However, if the same monthly consultation service mandated for centers was offered to all family homes licensed for infants, the number would increase by approximately 101 nurses. To be able to offer monthly visits to all 2,006 child care centers and 3,354 family homes who serve children of all ages, the number of nurses needed would increase by 152 nurses to approximately 175.

Table 2: Option A – Budget for State Systemic Supports and a Comprehensive System to Meet WAC Consultation Requirements and On-Request Consultation for All Licensed Child Care

Expenditure by Object	FY 2020	FY 2021	FY 2022	FY 2023
State Systemic Support	$1,776,125	$1,614,125	$1,614,125	$1,614,125
Comprehensive WAC Consultation Support (25 Nurses)	$3,932,476	$3,752,476	$3,752,476	$3,752,476
Subtotal	$5,717,183	$5,375,183	$5,375,183	$5,375,183
On-Request Consultation for Remainder of Licensed Child Care (Additional 25 Nurses)	$3,932,476	$3,752,476	$3,752,476	$3,752,476
Total	$9,641,077	$9,119,077	$9,119,077	$9,119,077

Option B: DCYF Creates an Infrastructure to Support Child Care Health Consultation and Contracts Directly with Independent Nurse Consultants.

Instead of hiring nurses, DCYF would contract with independent child care health consultants to meet all of the required visits to centers across each of the six DCYF regions. This would instill greater consistency of quality and coverage for nurses and would encourage nurses to be dedicated full-time to this work. Additionally, nurse contractors could invoice DCYF for professional development and other administrative burdens.

Currently, each child care provider contracts with and pays for their own child care health consultant. There is consequently a large amount of variety and inconsistency for consultants, child care providers and child care licensing staff. The price of a monthly contract varies by the consultant, depending on the area and need for travel, among other considerations. The average cost is $100 per month.

The existing structure allows for any nurse who meets the requirements of the WAC and independently gets connected with a child care provider to offer services. The vast majority of the nurse consultants in the field work part-time, carrying a caseload of between one and 20 child care centers. The difference in caseload is related to whether the nurse is doing this work solely or in addition to another job. Many nurse consultants are retired from previous local public health positions.

One of the main supports missing from a system supporting an independent workforce is the ability to bill for networking, professional development, travel and the time consumed by email and phone consultation that occurs outside the monthly onsite visit. Option B would address this by having the child care health consultants contract for a suite of services with the child care provider and then submitting an invoice to DCYF for payment. This would allow nurses to attend community meetings, regional child care licensing meetings and professional development opportunities. Without the state's support, this would not be possible, as it would create a further negative fiscal impact on the child care providers or the independent nurse consultant. Nurses that are able to complete more professional development and be more connected to the local community will be better able to offer comprehensive services to child care providers. Providing this type of support for child care health consultants will create a stronger workforce to serve the child care centers.

Table 3: Option B – Budget for State Systemic Supports and Independent Contractor Workforce of Child Care Health Consultants

Expenditure by Object	FY 2020	FY 2021	FY 2022	FY 2023
State Systemic Support	$1,776,125	$1,614,125	$1,614,125	$1,614,125
Independent Nurse Consultants to Meet WAC	$1,389,600	$1,389,600	$1,389,600	$1,389,600
Total	$3,165,725	$3,003,725	$3,003,725	$3,003,725

The challenge with this option is that while it costs less than Option A, it is very difficult to keep an on-demand independent workforce engaged and consistently participating in the system. There would most likely be enough work to keep the child care health consultants employed; however, it would be a concern that would require the constant attention and engagement of nurse consultation managers to monitor. Additionally, it is not realistic that the state could hire enough independent contractor child care health consultants to meet all of the need for consultation across the whole state for all 5,360 licensed child care sites with this model, and thus it is really only an option for supporting WAC-required visits in centers serving infants.

Option C: DCYF Creates an Infrastructure to Support Child Care Health Consultation and Hires a Small Number of Nurses to Supplement Consultation Needs Where an Independent Child Care Health Consultation Workforce Is Lacking.

DCYF would identify service area gaps and hire full-time child care health consultants to meet the needs of centers in these geographic locations. Assuming that each region would need approximately 15 percent of its CCHC workforce to be supplemented by state-employed consultants, DCYF would need to hire 2-4 nurses per geographic region. DCYF would need to consider the most equitable way to allocate these state-funded consultants by looking at the percentage of children served using subsidy at each center for example, or by the overall capacity of each region to hire child care health consultants. As with the other options, the creation of a state backbone system of supports would be critical to making this option effective.

Table 4: Option C – Budget for State Systemic Supports and Limited State-Employed Consultants to Meet WAC Requirements

Expenditure by Object	FY 2020	FY 2021	FY 2022	FY 2023
State Systemic Support	$1,776,125	$1,614,125	$1,614,125	$1,614,125
Supplemental WAC Consultation	$2,832,781	$2,703,181	$2,703,181	$2,703,181
Total	$4,608,906	$4,317,306	$4,317,306	$4,317,306

CONCLUSION

Child care health consultation is an important part of keeping children in licensed child care healthy and safe. A portion of nursing-specific health consultation is required by WAC but currently has no systemic supports. The creation of a regionally-based team of nurse consultation managers, a state level program administrator and a database to both connect child care providers to consultants and report data to DCYF is the minimum investment that Washington State needs to provide successful child care health consultation in licensed child care. In addition, one of the three above options will create a seamless system that child care health consultants, licensing and child care providers will be able to utilize to create a safe, healthy environment for the approximately 80,000 children being served in licensed child care in Washington.

For reference, this report should be read in conjunction with the appendix “Infant/Early Childhood Mental Health Consultation – Proposed Services for Washington” and the report entitled “Expansion of Trauma-Informed Child Care in Washington State: Recommendations from the Trauma-Informed Care Advisory Group,” as DCYF views these three documents as components of one larger, cohesive system.