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# State Policy as an Influence on the Participation of Young Children with Medical Needs in Childcare

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The authors collected data from 48 states and the District of Columbia regarding state policies that affect the participation of children with medical needs in licensed childcare. They began with a more narrowly focused agenda of identifying policies affecting children with medically complex needs, but because few regulations are directed to this population, broadened their inquiry. The authors propose a conceptual change in the way professionals think about children with medical complexity. They argue that individual children may enter (and leave) a “zone of medical complexity” rather than being part of a fixed population they term *children with medical complexity*. Additional findings are clustered into six thematic areas: restrictions on dispensing of medications, policies on other medical treatments, higher subsidies and other financial supports, childcare health consultants and other informational resources, policies regarding specialized centers, and issues related to boards of nursing or nurse practice acts. Within each thematic area, the authors identify specific states that have recently enacted important policy changes.

A shortage of available, affordable, and quality childcare continues to grow in this country in proportion to an increasing number of mothers who are working outside the home. Consequently, the quest for quality childcare continues for many parents, especially those who have children with disabilities. Although legislation concerning these children that is part of the Americans with Disabilities Act prohibits exclusion from childcare settings on the basis of disability, many families are unable to find or retain quality childcare for their child with disabilities (Bruder, 1998; Conn-Powers, Hutter-Pishgahi, & Cross, 1999; Fink, 1991; Markos-Capps & Godfrey, 1999).

Recently, a number of articles, chapters, and books on inclusive childcare for children with disabilities have been published (Booth-LaForce & Kelly, 2004; Bruder, 1998; Buysse, Wesley, Bryant, & Gardner, 1999; Dinnebeil, McInerney, & Juchartz-Pendry, 1998; Kelly & Booth, 1999; O'Brien, 1997, 2001; Warfield & Hauser-Cram, 1996). Most of these documents focus on the needs of young children, although the needs of this particular population in regards to childcare remain constant through school age (Fink, 1992). Barriers to inclusive childcare for children with disabilities have been well documented

by the authors previously cited. These barriers include the attitudes of childcare providers, the lack of systemic training and technical assistance on children with disabilities that is available to childcare providers, the lack of consultants to help ensure that children with disabilities succeed in the childcare setting, and a lack of resources within childcare programs to accommodate a child's individual needs. As a result, families of children with disabilities who want or need to work out of the home find it very difficult to obtain accessible, affordable, and appropriate care for their children (Fink, 1992).

In this article, we describe a study that examined access to childcare for families of infants and toddlers with complex medical needs. Informants in every state were contacted to identify policies and supports in place for this unique population of children. This article represents a portion of a larger national study on this issue.

## METHOD

Our method was tailored to the heterogeneity of states and the multiplicity of state agencies and departments

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that may potentially influence the services provided to children with medical needs in childcare settings. It was not feasible to preselect a single uniformly positioned informant in each state (e.g., state administrators of childcare and development funds) as the participants in this inquiry. Instead, we developed a method that we hoped would allow us to identify at least one informant in each state who had both knowledge about our topic and a willingness to share that knowledge.

### **Participants**

Respondents in this study eventually consisted of 85 individuals from 48 states and the District of Columbia who answered our questions either by telephone or through e-mail correspondence. Respondents had the following affiliations:

- state Healthy Child Care initiatives (state grantees of a national project of the American Academy of Pediatrics);
- developmental disabilities councils, state Title V (children's special health-care) programs;
- state child care licensing, state managers or consultants for childcare programs and services;
- state Head Start Collaboration;
- state and local early intervention;
- state departments of education;
- state departments of health or public health;
- state departments of human services or health and human services;
- state departments of children, youth, and families;
- statewide childcare resource and referral;
- governors' offices of early childhood development;
- National Child Care Information Center;
- Child Care Law Center;
- United Cerebral Palsy;
- local education agency;
- specialized childcare, therapy, or respite centers;
- Child Care Plus; and
- University Centers for Excellence in Developmental Disabilities.

### **Instrument**

The second author, who has been involved in research studies on childcare since 1986, initiated all contacts and conducted all interviews. Our interviews and correspondence consisted of five questions, with follow-up questions asked as needed for clarification.

1. How do the state's childcare regulations address the dispensing of medications and the conducting of medical procedures, such as blood glucose testing, insulin injections, administration of nebulizers, G-tubes [gastrostomy tubes], and so forth?
2. Does your state have a Nurse Practice Act, and if so, do the provisions of this act restrict the kinds of procedures that may be carried out by childcare teachers and providers?
3. Has your state adopted a policy of making nurse-consultants or childcare health consultants widely available to childcare centers and homes? If so, please describe the program and indicate what role these health consultants play in supporting the participation of children with chronic health issues.
4. Does your state have one or more childcare centers that specialize in serving children with complex medical needs? If yes, please tell us how these centers are licensed or regulated, what the sources of funding are, how eligibility is determined, and whether any typically developing peers are in attendance.
5. Please tell us about any state policies, resources, and activities supporting the enrollment in childcare of children with medical needs that are not addressed by the preceding questions.

We asked our informants questions only in the areas in which they professed to have knowledge. This meant that we did not pose all five questions in each interview but restricted ourselves to the questions an informant was prepared to answer. We also asked them to help us identify other informants who might address the questions they were unable to answer.

### **Step 1**

We placed brief descriptions of the purpose of our project on two list-serves with national constituencies. One is operated by the Division of Children with Special Needs at the American Academy of Pediatrics; the other is maintained by the National Resource Center for Health and Safety in Child Care at the University of Colorado Health Sciences Center. We asked any readers with knowledge of the topics of our inquiry to contact us by telephone or e-mail. Some participants in these list-serves provided us with information, whereas others passed along contact information for colleagues in their states. Still other participants did both.

## Step 2

After we completed interviews and correspondence with respondents who contacted us (and with the colleagues to whom they had referred us), we drew up a list of states for which we did not yet have meaningful data. We contacted the state childcare administrator for the Child Care and Development Fund in each of these states. If these individuals were not able to answer our questions, we asked them to refer us elsewhere. If they did not respond to our queries, we contacted other state agencies. The diverse affiliations for our respondents that were listed previously reflect the efforts that were required to find knowledgeable (and willing) informants.

## Step 3

We sent a fax to the offices of the state Child Care and Development Funds in states from which we still had not received information. We asked the representatives for their cooperation, informing them that we were about to publish findings of a national study on state policies affecting the participation of children with special health-care needs in childcare and noting that the current draft had “little or no information about your state.” We then submitted the five questions and encouraged them to circulate the questions to anyone who might be able to respond.

## RESULTS

A monograph displaying state-by-state information is posted on our research center’s Web site (<http://www.uconned.org/state%20policies%20fink.htm>; Fink, 2002). Very few state-level childcare policies *intentionally* focused on our target group, although a large number of states were grappling with broader questions related to health care and medical procedures within childcare settings. Some questions affected every child in care (e.g., availability of childcare health consultants, regulations covering the dispensing of medications). Other questions affected children with important, but not complex, medical issues (e.g., children who need daily blood glucose testing, children who carry prefilled injectable cartridges [Epi-pens] in the event of an allergic reaction). Yet other questions were targeted to children with disabilities but could be applied to children with medical issues, depending on the defined eligibility. A handful of states had policies or resources specifically targeted to serving young children with intensive medical needs in group settings.

To accommodate the scope of the terrain that these policies embraced, the policy analysis evolved to examine the full spectrum of policies and resources that affect the implementation of preventive health care, as well as medical monitoring, medical interventions, and medical

procedures affecting any child enrolled in a childcare setting. The information was more qualitative in nature and was analyzed as such. The actual data from the interviews (via e-mail or phone) were coded, categorized, and assigned to a theme by project staff. One major finding must be presented prior to delving into the identified themes, however.

### **Medical Complexity—A Zone, Not an Identity**

The data on current policy developments and program practices indicated confusion concerning the term *children with complex medical needs*. What became clear was that a few children consistently have medical needs that are of a complex or intensive nature, but many other children move back and forth along a spectrum. A child with cerebral palsy may present as a healthy child with the most intensive needs in the area of communication rather than health care, but after a hospitalization for surgery, his or her medical needs take precedence. A child with a recently diagnosed seizure disorder at first may require intensive monitoring and frequent adjustment of medications, but then enter a period of stability in which the health issue recedes to the background. A child may enter childcare without any special health conditions but acquire one or more problems following an injury or illness, or because of unexplained reasons. One outcome of our study was acknowledging fluidity in the definition of the phrase *children with complex medical needs*. Children entered (and left) a “zone of medical complexity” rather than being part of a fixed population labeled as children with medical complexity.

### **Themes Associated with Providing Inclusive Childcare**

Assessment of the information gathered in the interviews resulted in the identification of the following six major themes:

1. Restrictions on dispensing of medications
2. Policies on other medical treatments
3. Higher subsidies and other financial supports
4. Childcare health consultants and other informational resources
5. Policies regarding specialized centers
6. Issues related to boards of nursing or Nurse Practice Acts.

We describe briefly each theme next.

**Restrictions on Dispensing of Medications.** For decades, childcare regulations have addressed the dispensing of medications to children in care. Nearly all of these

regulations offer providers the option of deciding if they are going to administer medications. Providers who choose to do so must follow licensing rules. Typically, these include the following: medication must be in the original container; prescription medication must have a label stating the name of the physician, the child's name, the name of the medication, and dispensing directions; and written parental authorization must be on file. Some states add requirements for logging the time and date of each dose given and safeguarding such records for a specific period of time.

Recently developed state policies, however, have gone above and beyond this fairly standard list in ways that may be protective of the needs of children with medical issues but also sometimes act as roadblocks to including these children. Most noteworthy is a group of states that require childcare staff and providers to receive some kind of documented training or certification prior to dispensing any medications. This group consists of Colorado, Connecticut, Delaware, Louisiana, Wyoming, and the District of Columbia. Typically (but not universally), the providers subject to these new requirements are directed to obtain their training from registered nurses.

When states impose these requirements, the lack of properly trained or certified staff should not be justification for declining to enroll a child with a chronic condition who needs medication. The licensing officials with whom we spoke made it clear that the Americans with Disabilities Act (ADA) of 1990 supersedes their restrictions.

**Policies on Other Medical Treatments.** As a rule, childcare regulations omit any specific reference to medical procedures other than the dispensing of medications. Families and providers need guidance, however, on whether medically related procedures, such as blood glucose testing, use of gastrostomy tubes, and nebulizers, are appropriate responsibilities for staff members and providers in the child care field.

In numerous states, regulations that used to impose extra requirements on centers that served children with disabilities (including children with medical needs) were revised to eliminate these references to avoid condoning any discrimination on the basis of disability. For example, Maryland eliminated a section of its childcare regulations addressing "children with special needs" so as to be in compliance with the ADA and instead incorporated throughout the regulations language that called for meeting individual needs. Michigan, New York, and Wisconsin are among the states that have made similar revisions in their regulations. Each of these states now leaves it to the licensees to determine what might constitute a "reasonable modification" in the area of special health-care needs.

We found only a few examples of specific procedures being addressed explicitly through policy channels. Two

states have recently passed legislation to clarify the rights of families and the responsibilities of providers. California passed two separate bills authorizing blood glucose testing and the use of nebulizers in licensed centers and homes so long as certain conditions are met. Connecticut passed a bill prohibiting centers from discriminating against children carrying Epi-pens to treat allergic reactions.

The only state we found in which regulations have attempted to account proactively for the whole range of possible special health-care conditions that have to be addressed within the childcare context is Arizona. Its regulations stipulate that when a child has a special health-care need that is covered in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), the childcare setting is required to "review and adopt" these plans. For a child who has a special health-care need but no such prior plan, the center or home must convene a meeting with the child's health-care provider and family members for the purpose of developing a plan.

In the vast majority of states, policies on medically related procedures other than the dispensing of medications are not spelled out. In many instances, home and center-based childcare providers are left to consult peers within their networks to help determine their obligations.

**Higher Subsidies and Other Financial Supports.** Many states have adopted higher reimbursements for children in state-subsidized care to address the challenge that providers face in serving children whose care requires a higher level of resources. Training, planning, improved staffing ratios, and access to specialized equipment are some of the common needs that arise. Many of the subsidy programs define eligibility as participating in Part C programs, having an IEP, receiving Supplemental Security Income (SSI), or being defined as a child with a disability under the ADA. Some programs (e.g., those in Alaska, Montana, and Oregon) were broader, with the extra funding triggered by the need for individual accommodations regardless of any particular label (or lack thereof).

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

of inclusive centers to enroll children whose support needs are greater than the typical child—and although it allocates substantial funding to help these centers cover the extra costs, it does not break this funding down to a “special needs” rate for each enrolled child.

Massachusetts and Vermont have policies that allow for the hiring of extra staff or other supports in childcare and do not restrict the beneficiaries of this support to families eligible for a subsidy—but these programs are restricted to children under the age of 3 years who are participating in early intervention programs. Oregon, a Developmental Disabilities Council runs a separate subsidy program that can serve children all the way through school age and also families that exceed the income guidelines for the state subsidy program. Rates are in accordance with the identified support needs rather than not with any specific label or level of severity.

**Childcare Health Consultants and Other Informational Resources.** Providers need not only financial supports. They also require informational supports. Healthy Child Care America, which has been providing grants and technical assistance to state-level projects through the American Academy of Pediatrics, has been a prime mover in promoting the concept of childcare health consultants (CCHCs), who generally are nurses who are trained to carry out a variety of health- and safety-promoting activities with childcare centers and providers. Much of the role of the CCHCs is geared to encouraging the use of universal practices that promote health and prevent the spread of infection, such as proper hand-washing by children and childcare staff members. The CCHCs can also play an important role in providing information and support to a center or provider that enrolls a child with special health-care needs. When they are not able to provide support themselves, they may help connect providers to other resources.

Colorado, Connecticut, and Minnesota appear to be the only states that have written into their licensing requirements the obligation for centers to have CCHCs. In Colorado, all centers serving children age 5 years or under must consult monthly with a nurse consultant trained in pediatric care. In Connecticut, centers that serve infants and toddlers full-time are required to have weekly visits with a health consultant, with specific tasks defined in state regulations. Part-day programs for infants or toddlers must conduct monthly visits. Minnesota’s regulations require every center-based childcare facility to employ the services of a “health consultant professional” (registered nurse, public health nurse, nurse practitioner, physician, or physician’s assistant) to annually review center health and safety policies. Centers enrolling infants must receive monthly on-site visits from their health consultants. (In none of these states does the requirement apply to family childcare homes.)

**Policies Regarding Specialized Centers.** We found a handful of states with a policy infrastructure supporting the development of specialized centers in which skilled nursing care is available in childcare settings. Several states have developed regulations for an entity variously called a PPEC or a PPECC (prescribed pediatric extended care center). In some states (e.g., Florida), it is not viewed or regulated as a childcare center but rather as an alternative rehabilitative site for a child who would otherwise be receiving medical supports in the home. In other states (e.g., Delaware, Pennsylvania), these facilities are licensed as childcare centers in addition to being licensed and regulated as PPECCs by the Office of Health Facilities Licensing of the Delaware Division of Health and Social Services and the Pennsylvania Department of Health, respectively. No matter how such programs are regulated, they serve a childcare need of the families, and they offer the full-scale nursing and other services these children require. Most of these centers separate children within the zone of medical complexity from their peers who have no need for nursing services; however, one of Delaware’s two PPECC centers serves its target group in an inclusive setting in which they are interacting with typically developing peers.

Maryland has two centers that are comparable to PPECCs, but they do not use that terminology. The following example illustrates the regulatory netherworld in which we found ourselves as we pursued this study. As of 2002, the two Maryland centers were subject to draft “medical child care” regulations that had been promulgated but never finalized in the mid 1990s under the state’s Department of Health and Mental Hygiene.

North Carolina does not have a regulatory infrastructure to create either a PPECC or a medical childcare center, but it appears to be unique in that it has recently made available state funding for developing a center that will specialize in serving a small number of children with medical and technological dependencies. It was scheduled to open in 2003 and is to be licensed as a childcare center. It is also subject to a series of more stringent requirements developed by the task force that brought it into being.

A few states (Nebraska, Iowa, Vermont) allow families to receive the support of Medicaid waivers when their children with medical needs are attending childcare. This model, in which extra supports may accompany the child into a setting selected by the family, would seem to be very compatible with our understanding of the zone of medical complexity.

**Issues Related to Boards of Nursing or Nurse Practice Acts.** Childcare providers have sometimes run afoul of rules designed to restrict certain activities to trained medical professionals. The Board of Nursing (BON) policies—and the closely related Nurse Practice Acts (NPA)—

appear to have two major implications for the childcare field. The first implication is that certain procedures may be disallowed for nonmedically-certified staff (see Note). This means that even with parental authorization, the willing childcare provider or teacher may not lawfully conduct the procedure. In Kansas, the BON and NPA regulations disallow providers from giving medications. The same could have occurred in New York but for a recent legislative act that temporarily waived the NPA provisions pending the crafting of a long-term solution. In California, NPA restrictions also have led to the passage of two recent pieces of legislation, as discussed previously, making it lawful for childcare providers to conduct the finger-prick test for blood glucose and to administer nebulizers, provided they arrange for proper training, put into place emergency procedures, and comply with certain specific provisions.

The overall result of the NPA restrictions has been a wide variety of rules instituted in various states. For instance, providers in Wyoming who receive the new medication training may administer nebulizers and the finger-prick test for blood glucose, but under no circumstances may they give injections, such as for insulin or an allergic reaction. Only nurses may give injections.

The second implication of BON and NPA rules are that even when nurses are working with childcare providers or teachers, they must be careful in their conduct. The various state rules define when a nurse may or may not delegate (teach and authorize someone to conduct) a procedure, and in general these rules require nurses to be very conservative about the circumstances in which they delegate to persons who are not medically certified. In many states, nurses must avoid giving direct instruction on how to work with any specific child on any specific procedure, because it would be inappropriate delegating and could jeopardize her or his nursing license. If a parent has trained a childcare provider to work with his or her child, however, the nurse may observe and offer feedback. The nurse may also provide presentations, demonstrations, and literature relating to a procedure as it is generally conducted, so long as she or he does not directly train someone to work with a particular child.

In Louisiana, CCHCs are trained not to solicit instructions directly from physicians, which would cause nurses to unnecessarily increase their professional liability. Instead, they may provide general information and training and work to empower the childcare providers to speak with physicians as well as parents to develop child-specific plans. In Montana, Child Care Plus and Healthy Child Care Montana are working with the state BON to clarify regulatory issues in advance of setting up a statewide network of CCHCs. In New Hampshire, the state BON revised its rules regarding delegation of procedures in 2001 to (a) remove barriers to the training of nonmedically-certified persons in early childhood pro-

grams and other settings and (b) facilitate the participation of children with special health-care needs in these settings. For certain procedures, such as the use of Epi-pens, however, the BON advised nurses to make sure that the parents conducted the training, with the nurses offering resources and support.

Some states, such as Oregon, have instituted BON rules that offer greater flexibility than do other states. Procedures that are considered “special tasks of nursing” may be taught and delegated to staff members without medical credentials if several conditions are met. These include, but are not limited to, the following:

- the child’s condition is stable and predictable,
- a registered nurse (RN) determines how frequently the child’s condition must be reassessed,
- the RN evaluates the ability of the unlicensed person to perform the task and documents the rationale for delegating the task to this person.

How do staff of licensed centers and providers become familiar with the nursing regulations in their own states? Many are not even aware of them, and in states such as California, Kansas, and New York, some of them have been caught by surprise by conducting procedures that were legally reserved to nurses. Many state childcare regulatory frameworks contain no rules relating to the nursing profession, leaving it to providers to navigate the potential discrepancies and gaps between childcare regulations and BON/NPA rules. Arizona is one of the few states that address it more directly. The childcare regulations explicitly refer providers to the BON to learn which procedures (e.g., insertion of gastrostomy tubes) may be carried out only by qualified health-care personnel. It is then left to the childcare personnel to be guided by the ADA as to what obligation they have to provide a service that is restricted to a nurse. Contracting for such services is obligatory when doing so is a “reasonable accommodation,” but not when the cost would create an “undue burden.”

## DISCUSSION

In this study, we found and described a wide variety of state-level policies that have an impact on the way children with medical needs may or may not be able to have those needs addressed within the context of a licensed childcare setting. We divided these policy issues into six different themes in order to better describe them. This categorization may appear to bring some logic and coherence to the picture. From the perspective of the parents

of such children who want to use childcare—or the perspective of childcare providers wishing to meet their obligations to such families while complying with relevant laws and regulations in their respective states—the picture is usually chaotic and unclear. What the consumer or childcare provider encounters is an almost ubiquitous fragmentation. In most states, there is no one place to contact to be sure that one has grasped the implications of childcare licensing, Nurse Practice Acts, and the civil rights protections of the ADA. Almost astonishing to us was the number of times that well-placed agency administrators responsible for childcare licensing acknowledged their ignorance regarding the specific implications of the NPAs and the ADA. In at least two states (Kansas and New York), key decision makers have had to work furiously to avoid major crises involving the conflict between nursing regulations and commonplace childcare practices regarding the dispensing of medications.

Many states have revised their regulations to avoid stigmatizing children with disabilities and to be consistent with the ADA, but most of them have not inserted explicit references into their revised regulations so that providers will recognize where the ADA does come into play. The updated District of Columbia regulations (Government of the District of Columbia, 2001; in final draft form when this article was written) suggest a better approach to this problem. In reference to medications, they state, “The child development facility shall set its own policy regarding administering medications with the exception of medications covered under the Americans with Disabilities Act” (p. 116). Because the ADA does not include any list of medications, providers subject to the regulations might remain confused as to the meaning of the reference to “medications covered” under the ADA. In the ADA, *disability* is defined as an impairment in one or more life functions. If a physician has found a young child to be in need of medicine on a daily basis due to a chronic condition (and not just, for example, a temporary cough), then a life function such as blood circulation, breathing, or digestion may be in jeopardy without it. It is through this chain of reasoning that the dispensing of a medication would be covered as a “reasonable modification” under the ADA, even if a childcare center had a policy of not giving medications (such as cough syrup) to its other enrollees. It would be helpful if the governments of the District of Columbia and the states offered this kind of explanation in a handout to providers, if not in the actual text of the regulations.

Families and providers in states that have adopted restrictive standards regarding who is allowed to dispense medications need similar explanations. In a state with this kind of policy, a family whose child has a chronic health condition may choose a center in which no staff member is currently certified to give medications. Arranging certifica-

tion (and preferably for more than one person, to cover absences) could take some planning. To keep these new policies from becoming a barrier to inclusion, all stakeholders need to be prepared for this kind of scenario.

In Arizona, some effort appears to have been made to use the regulatory process to replace fragmentation with coordination. This state’s childcare regulations stipulate that when a child has a special health-care need that is covered in an IEP or IFSP, the childcare provider is required to “review and adopt” these plans. This at least ensures that there is some knowledge among childcare providers (if not actual coordination) about these other systems that are serving the very same children and some consistency in practice across diverse systems. For a child who has a special health-care need but no such prior plan from early intervention or special education effort, Arizona’s approach also requires a simple step that may be a good model for other states: The center or home must convene a meeting with the child’s health-care provider and family and develop a plan. Arizona’s childcare regulations are also one of the few that directly acknowledge nursing regulations and suggest their importance to the childcare licensees. In these regulations providers are explicitly referred to the BON to learn which procedures may be carried out only by qualified health-care personnel. Providers must be guided by the ADA as to what obligations they have to provide a service that is restricted to a nurse. Other states would do well to examine Arizona’s efforts to ensure that childcare providers are functioning with knowledge of the other laws and systems that come into play when they are addressing children’s health-care needs.

We must emphasize an insight we introduced at the beginning of our presentation of the results of this study. Our discussions with study respondents and our encounters with regulations and practices across the fields of childcare, nursing, and early intervention led us to unpack the phrase “children with medically complex needs” and recognize that there was no fixed population accurately captured by it. We believe that a more useful frame for policymakers trying to serve the needs suggested by this phrase would be the “zone of medical complexity.” Some children will never leave this zone; others will never enter it. Many will move back and forth across the boundary suggested by this phrase, however, and neither a carefully calibrated assessment nor a well-chosen diagnostic label will guarantee that care providers know in advance which child will be in need of an extra level of medical monitoring or intervention. The commitment of our field to keep children with special learning needs in natural environments should impel policymakers not to confine medical supports to a narrow range of settings but to offer as much latitude as possible for the deployment of those services into a wide range of settings.



## NOTE

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

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