

10/4/16

**HOUSE AD HOC COMMITTEE ON
DIABETES TREATMENT IN CHILD CARE FACILITIES**

Report of Interim Meeting
Monday, September 26, 2016
House Hearing Room 4 -- 10:00 a.m.

Convened 10:15 a.m.

Recessed

Reconvened

Adjourned 11:43 a.m.

Members Present

Dr. Dawn Barcellona
Juliaette Chamberlain
Anne Dennis
James Emch
Representative Randall Friese
Kim Miller
Representative Heather Carter, Chair

Members Absent

Representative Kate Brophy McGee
Dr. Rachel Calendo

Agenda

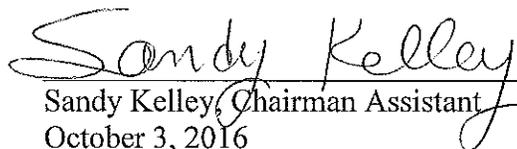
Attachment 1

Request to Speak

Attachment 2

Presentations

<u>Name</u>	<u>Organization</u>	<u>Attachments (Handouts)</u>
Karie Taylor, Assistant Director	Division of Child and Family Engagement, Arizona Department of Economic Security	3
Colby Bower, Assistant Director of Licensing	Arizona Department of Health Services	4, 5
	American Diabetes Association	6
Attendance		7


Sandy Kelley, Chairman Assistant
October 3, 2016

(Original attachments on file in the Office of the Chief Clerk; video archives available at <http://www.azleg.gov>)

Interim agendas can be obtained via the Internet at <http://www.azleg.state.az.us/InterimCommittees.asp>

ARIZONA HOUSE OF REPRESENTATIVES

Conv - 10:15 am

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

adj - 11:43 am

DIABETES TREATMENT IN CHILD CARE FACILITIES

Date: Monday, September 26, 2016

Time: 10:00 A.M.

→ **Place: ~~HHR1~~ HHR 4 (Note Room Change)**

AGENDA

1. Call to Order
2. Presentations:
 - Overview of Child Care Administration
Karie Taylor, Assistant Director, Division of Child and Family Engagement, Arizona Department of Economic Security
 - Review of Licensing Rules for Child Care Facilities
Colby Bower, Assistant Director of Licensing, Arizona Department of Health Services
3. Public Testimony
4. Committee Discussion and Next Steps
5. Adjourn

Members:

Representative Heather Carter, Chairman
 Representative Kate Brophy McGee
 Representative Randall Friese
 Dr. Dawn Barcellona
 Dr. Rachel Calendo

Juliaette Chamberlain
 Anne Dennis
 James Emch
 Kim Miller

9/24/16
9/23/16
JY

People with disabilities may request reasonable accommodations such as interpreters, alternative formats, or assistance with physical accessibility. If you require accommodations, please contact the Chief Clerk's Office at (602) 926-3032, TDD (602) 926-3241.

Information Registered on the Request to Speak System

House Diabetes Treatment in Child Care Facilities (9/26/2016)

3, Public Testimony

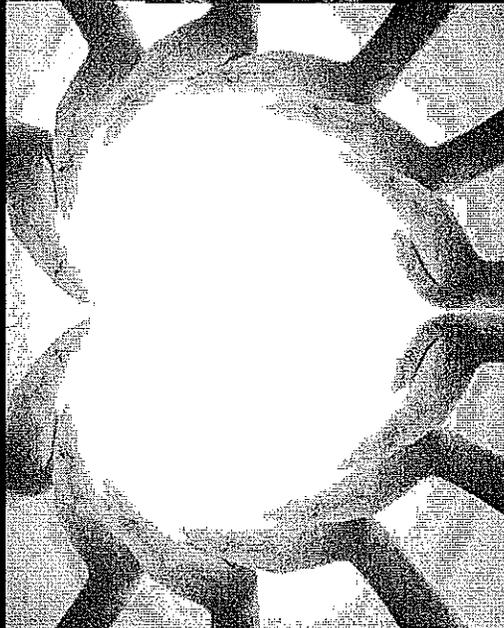
Support:

Julie Hoffman, representing self; Mary Villalpando, representing self; Rachel Sanchez, representing self; Cheryl Leight, representing self; Beth douthit, representing self; Kristi Pahnke, representing self; Elizabeth Gabriele, representing self; Suzanne Miller, representing self

All Comments:

Julie Hoffman, Self: Almost 19 years ago, I lost my full-time federal job and could not find adequate childcare for my 18 month old daughter who was newly diagnosed with type 1 diabetes. It's shocking that this many years later, we still cannot get proper childcare.; Cheryl Leight, Self: I am a parent of a child with Type 1. I have found that taking the time to educate our teachers, staff, and providers has always been the key to a successful and safe school environment. The knowledge and know how has always led to empowerment.; Beth douthit, Self: I am a parent of a Type 1 child and I support any legislation supporting the ADA position on diabetes in child care settings.

Arizona Department of Economic Security Child Care Administration



Child Care Administration

House AD Hoc Committee on Diabetes
Treatment in Child Care Facilities |

September 26, 2016

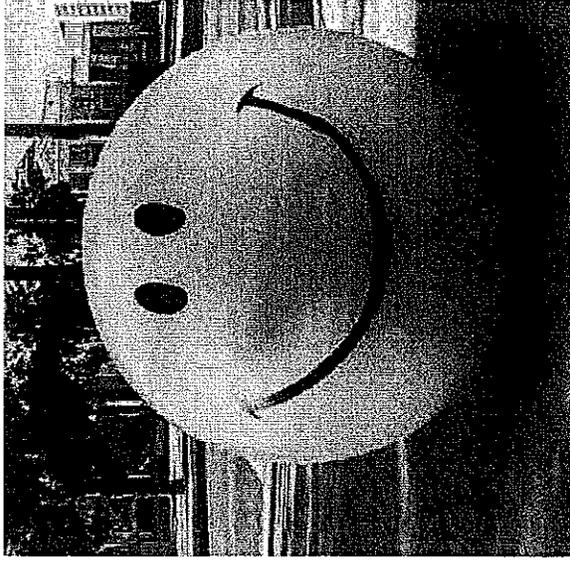
Karie Taylor, DCFE Assistant Director



Presentation Overview



- Child Care Administration Mission and Overview
- Child Care Funding and Eligibility Categories
- DES Child Care Provider Types and Numbers
- Child Care Resource & Referral
- Child Care for Children with Special Needs
- Identifying and Supporting Child Care Providers to Care for Children with Special Needs



Child Care Administration Mission and Overview



Child Care Administration



Mission

Child Care Administration supports the well-being and economic independence of Arizona families by providing quality child care assistance and developing quality child care services.

Overview



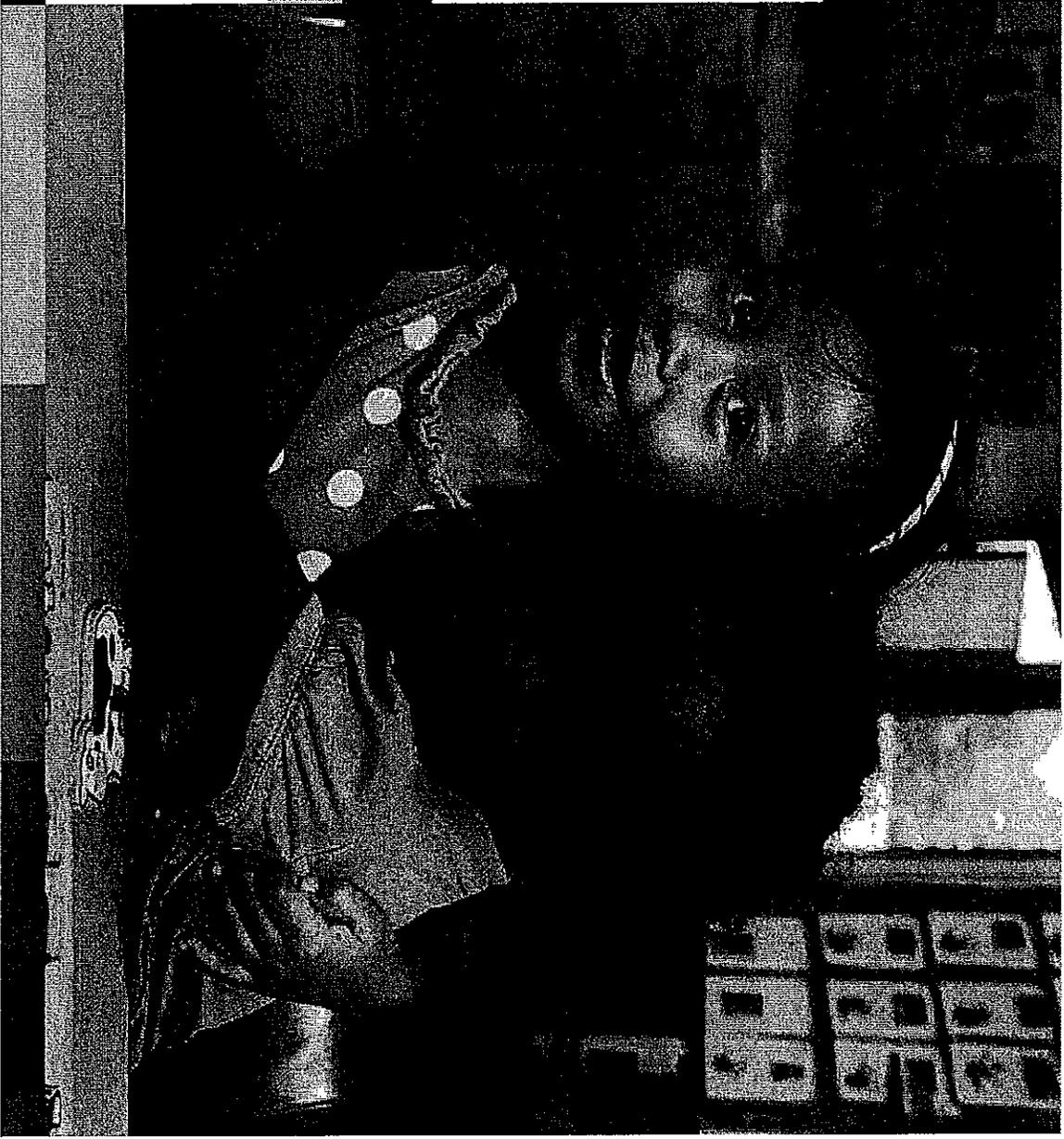
- The Child Care Administration (CCA) assists eligible families with child care costs, enabling parents to participate in employment and specific education and training activities related to employment
- The program is required to improve the quality of child care services across Arizona through the provision of quality contracts, statewide coordination, and collaboration of various child care and early childhood development initiatives

Overview



- Families may chose from a variety of child care providers including
 - Department of Health Services(DHS) licensed child care centers
 - DHS-certified child care group homes
 - DES-certified small family child care homes
 - Non-certified relatives (excluding those referred by DCS)

Child Care Funding and Eligibility Categories



Child Care Funding



• **Child Care and Development Fund (CCDF)**

- Awarded by the U.S. Department of Health and Human Services (DHHS) FFY 2016 award = \$125.7M
- **Mandatory (FFY 16: \$19.8M)**
- Awarded each federal fiscal year, and available for two years

Child Care Funding



- **Matching (FFY 16: \$37.6M)**
 - Formula driven grant, and is based on the number of children under the age of 13 in Arizona relative to the national total of children under the age of 13
 - Fluctuates annually and is matched at the Federal Medical Assistance Percentages (FMAP) rate, currently being met by the FTF MOU
 - MOE requirement of \$10 million annually, currently being met by a Memorandum of Understanding (MOU) with First Things First (FTF)
- Arizona FFY 2016 FMAP is 68.92% requiring \$16,957,109 in state matching funds

Child Care Funding



- **Discretionary (FFY16: \$68.2M)**
- 100% Federal funds
- Awarded based on a formula consisting of:
 - The young child factor
 - The school lunch factor
 - Allotment proportion factor
- Requires that a specific allocation of CCDF Discretionary funds are expended on targeted populations, Infant & Toddler

DES Child Care Fund Sources



- Child Care and Development Fund (CCDF)
 - CCDF FFY 2016 award = \$125.7M
 - CCDF is the main fund source for CCA with the Child Care Subsidy SLI being appropriated over \$95M
 - CCDF is also appropriated in DES operating, the Department of Child Safety (DCS) and the Department of Health Services (DHS) for a total of \$135.7M statewide
- TANF- CCA is currently appropriated \$2.7M in the subsidy line for child care subsidies
- SSBG – Helps child care providers qualify to participate in the Child and Adult Care Food Program

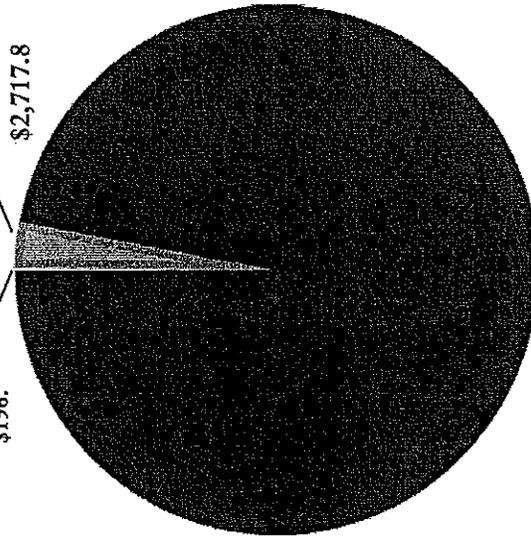
FY 2017 Child Care Subsidy Funding

DES Child Care Subsidy

Total: \$98,396.6

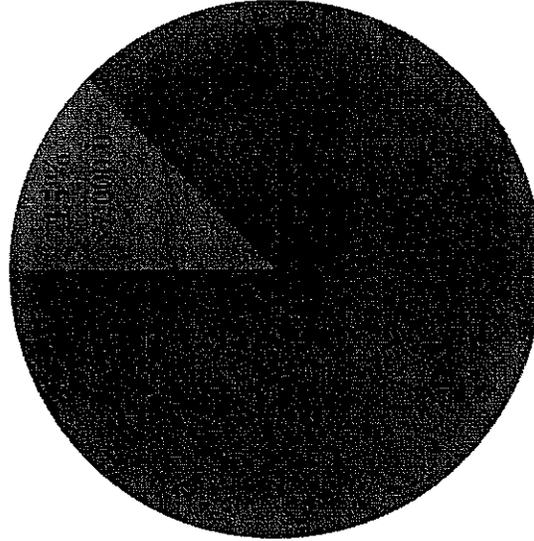
SSBG 0.2%
\$196.

2.8%
\$2,717.8



DCS Child Care Subsidy

Total: \$45,159.4



TANF

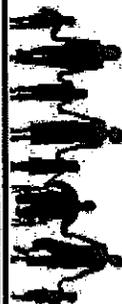
CCDF

SSBG

GF

Title IV-E

Match Funding Requirements & State Agency Partners



CCDF Match & Maintenance of Effort (MOE)

	FFY 2013	FFY 2014	FFY 2015 Projected
FFY	27,908,237	26,141,676	25,329,188
	94.0%	92.4%	92.3%
DHS	1,707,142	1,679,910	1,576,584
	5.7%	5.9%	5.7%
DES	90,791	476,652	548,203
	0.3%	1.7%	2.0%
Total	29,706,170	28,298,238	27,453,975

- MOE Requirement: \$10,032,936
- FTF (MOU)
 - Provides \$30M in Match and MOE expenditures for FFY 2016
- Matching Requirement has decreased from FFY13 to FFY15 due to a decrease in the CCDF matching grant award. The CCDF grant award in total has increased since FFY13 due to an increase in the CCDF discretionary award

Match Funding Requirements



- **First Things First (FTF)**
 - Provides information that allow DES to claim expenditures made by FTF for CCDF matching and MOE purposes not to exceed \$30M
- **The Department of Health Services (DHS)**
 - Monitors and licenses child care centers and family child care group homes
 - Maintains a record of complaints and provide information concerning licensing and regulatory requirements, licensure/certification status of providers, and rules and policies relative to child care services

Child Care Client Categories



- **Temporary Assistance for Needy Families (TANF)**
 - Federally mandated; includes families with an open TANF Cash Assistance case and parents participating in the DES Jobs program
 - TANF lifetime limit applies for child care subsidy
- **Transitional Child Care (TCC)**
 - Federally mandated; serves families transitioning off of TANF Cash Assistance for parents with incomes at 85% State Median Income or below (initial eligibility is 165% of the FPL)
 - Limit of 24 months after Cash Assistance ends

Child Care Client Categories



- **Low Income Working (LIW)**
- Non-federally mandatory population includes parents with incomes at or below 85% State Median Income (initial eligibility is 165% of the FPL)
 - Families with incomes of 165% FPL or less to accept or maintain employment
 - Families with incomes of 165% FPL or less unable to provide child care due to domestic violence, homelessness, a physical, mental, emotional or medical condition, participation in a drug treatment or drug rehabilitation program or court ordered community restitution (priority given to families with 100% FPL or less)
 - Teenaged custodial parents under 20 years of age to complete high school diploma/equivalent or remedial education activities
 - Parent, legal guardian or caretaker relative for approved education and training if working at least a monthly average of 20 hours/week
- 60-month cumulative lifetime limit per child

Child Care Client Categories



- **Department of Child Safety (DCS)**
 - Non-Federally mandated population. State of Arizona mandated population for children with DCS involvement and includes in-home and out-of-home placements





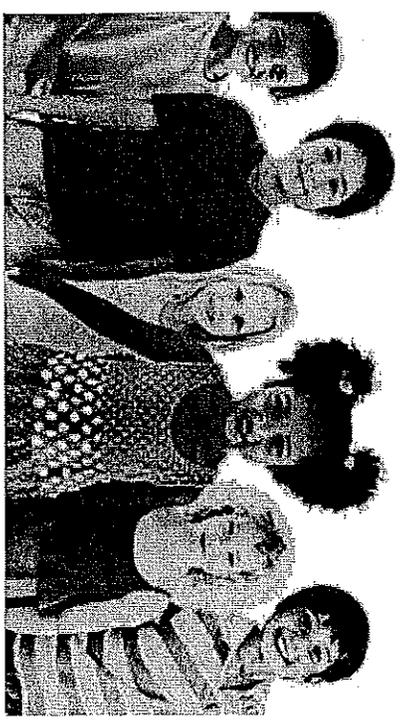
DES Child Care Providers



DES Child Care Providers



- DHS Licensed Centers – 1326
- DHS Certified Group Homes – 213
- DES Certified Homes – 525
- DES Non Certified Home Providers - 900



DES Certified Home Provider



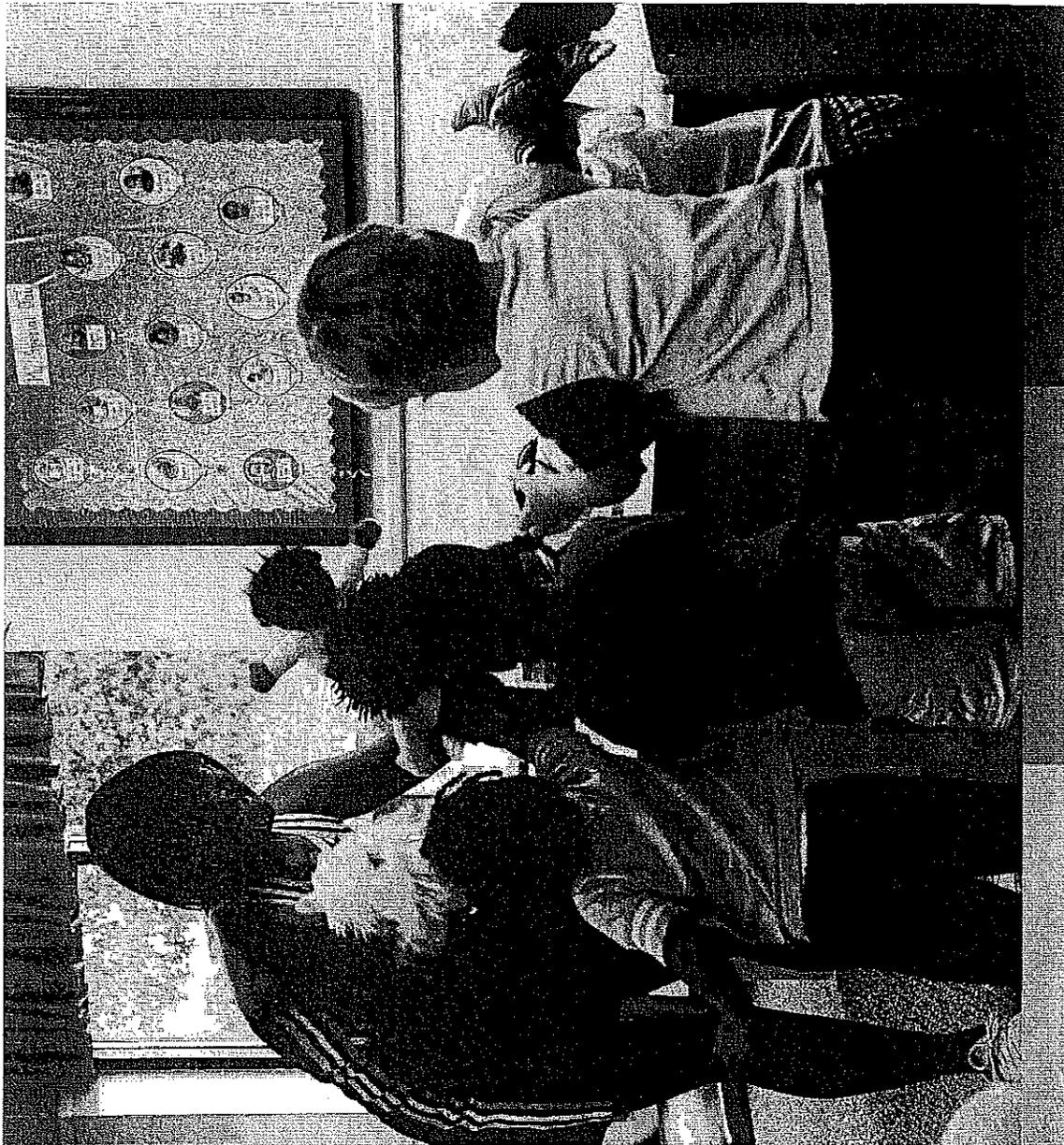
- Certified Family Child Care Home
 - Maximum of 4 children, 1:4 or 1:6 with providers own children included
 - Receives 12 hours of Health and Safety Training
 - Health and safety monitored by DES through regular home inspections at least 2 times per year
 - Cannot refuse to care for children with special needs

Non Certified Relative Provider



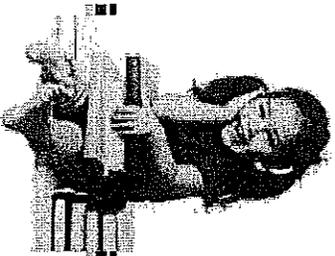
- 18 years of age or older
- Meet the relative provider definition
- Attend an orientation
- Obtain a valid Fingerprint Clearance Card
- Pass a DCS Background Check
- Follow the DES child care discipline policy
- Follow the requirements on the DES Child Care Provider Agreement
- Maintain the required records
- Agree to care for no more than four children for compensation





Child Care Resource and Referral





Child Care Resource and Referral



- Provides no cost, no fee services to families throughout Arizona who need assistance locating child care
- Encourages child care providers to list with the service and educates the public about the importance of high quality childcare
- Website (azchildcare.org) is maintained by CCR&R contractors and provides Internet referrals to child care providers, as well as significant consumer education information for the public





Child Care Resource and Referral



- Provides a quarterly newsletter that presents information on training opportunities for child care providers, recognizes trainers and lists information on community events and relevant news for Arizona's child care community

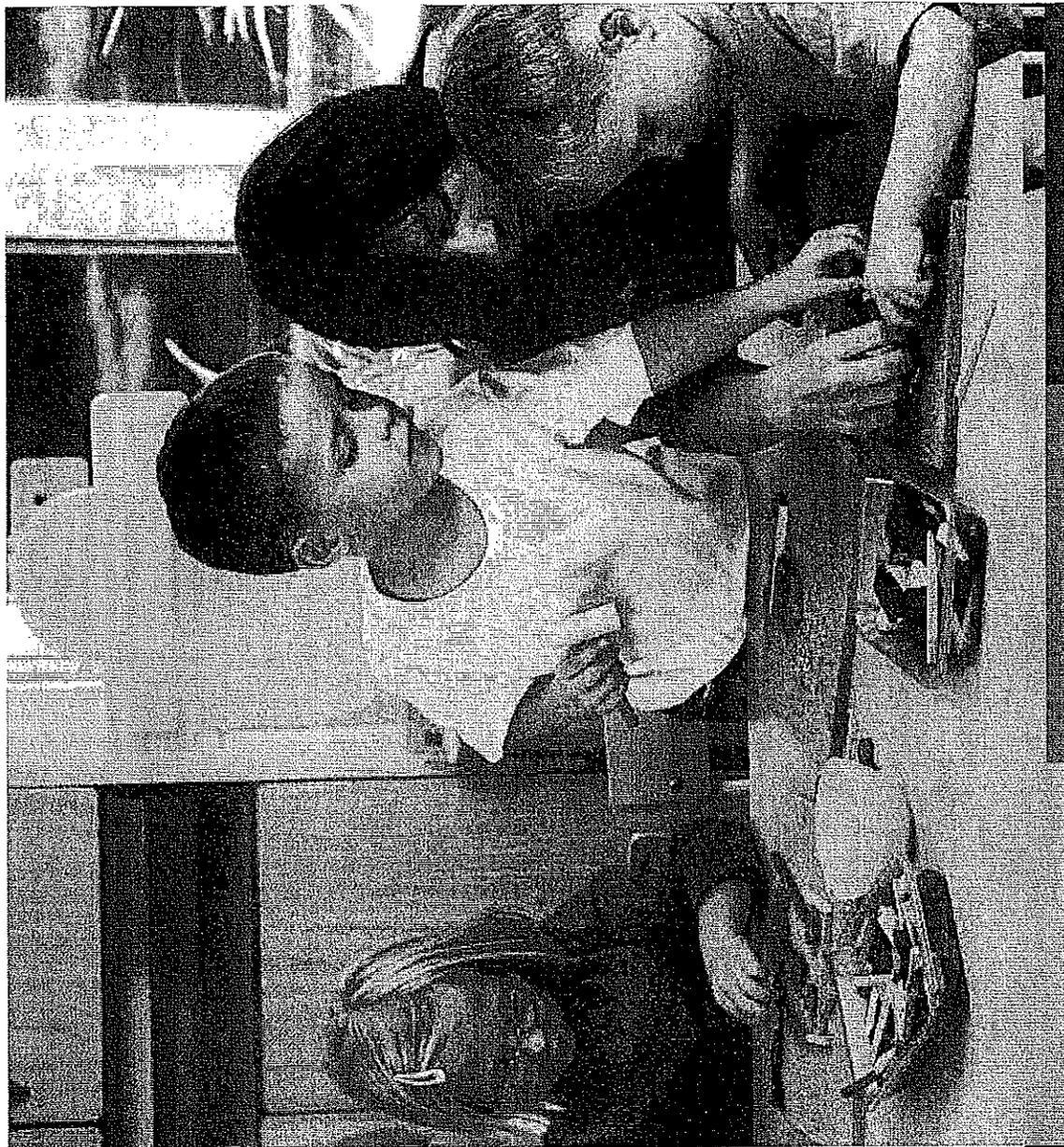


DES Child Care Providers



- Must Register with CCR&R
- CCR&R collects some data from child care providers related to their experience/training/ability to serve children with special needs





Child Care for Children with Special Needs



Section 504 of the Rehabilitation Act



Purpose :

A civil rights law to prohibit discrimination on the basis of disability in programs and activities, **public and private**, that **receive federal financial assistance**.

<http://dredf.org/advocacy/comparison.html>

Section 504 of the Rehabilitation Act

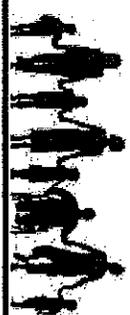


Who is Protected:

Any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment or (3) is regarded as having such an impairment. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks.

<http://dredf.org/advocacy/comparison.html>

American with Disabilities Act



Purpose:

A civil rights law to prohibit discrimination solely on the basis of disability in employment, public services and accommodations.

<http://dredf.org/advocacy/comparison.html>

Americans with Disabilities Act (ADA)



Who is Protected:

Any individual with a disability who: (1) has a physical or mental impairment that substantially limits one or more life activities; or (2) has a record of such impairment; or (3) is regarded as having such an impairment. Further, the person must be qualified for the program, service, or job.

<http://dredf.org/advocacy/comparison.html>

Americans with Disabilities Act Amendments Act (ADAAA)



From the American Diabetes Website

<http://www.diabetes.org/>:

What is the Americans with Disabilities Act Amendments Act?

The Americans with Disabilities Act Amendments Act (ADAAA) is a law that was passed in 2008. It amends the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 to make sure that people with diabetes and many other conditions are protected by these laws.

Americans with Disabilities Act Amendments Act (ADAAA)



From the American Diabetes Website <http://www.diabetes.org/>:

How does the ADAAA affect people with diabetes?

The ADAAA makes it clear that Congress intends for people with conditions such as diabetes to be covered by the law and protected from discrimination on the basis of their diabetes. The ADAAA lists endocrine function as an example of a major life activity covered by the law. Since nearly everyone with diabetes is substantially limited in their endocrine system functioning, nearly everyone with diabetes will be eligible for ADAAA protection.

DES Policies and Procedures



- DES Policies and Procedures apply to DES contractors
 - Both the Americans with Disabilities Act and Section 504 of the Rehabilitation Act (Section 504) apply to DES contractors. (DES 1-01-12 Americans with Disabilities Act Title II: Non discrimination on the basis of Disability for Program, Services, and Activities)
 - Includes child care home providers [individuals who provide child care to 4 or fewer children A.R.S. § 46-801(6)] who provide services to DES Child Care clients, and DES contracted providers (including those institutions licensed by the Arizona Department of Health Services)
 - Must meet the definition of a “disability” under these two acts

**Identifying and
Supporting Child Care
Providers to Care for
Children with Special
Needs**



Reported Barriers to serving children with Special Needs



- Lack of Adequate Training and Confidence
 - Related to behaviors, specific diagnoses (e.g., Autism, Down syndrome, diabetes, physical disabilities)
 - Administration of medications, injections, tube feedings
- Lack of Resources
 - Need for increased staffing to supervise and support

Serving Children with Diabetes



Self-Reported Data filed with the CCR&R that they will serve children with Diabetes:

- 1,871 of 3,161 total providers statewide
- 1,455 of 2,106 DHS Licensed Child Care Centers
- 406 of 1,006 DHS Certified Group Homes or DES Certified Homes
- 899 of 1,215 of DES Contracted, DHS Licensed Child Care Centers report they will serve children with Diabetes in their program.
- 290 of 678 of DES Contracted, DHS Certified Group Homes or DES Certified Family Child Care Homes

DES Efforts to Support Inclusion



- ADES/CCA is committed to ensuring that all families have access to quality child care while they work, go to school, or participate in employment training
- To support the opportunity for **all** eligible families and their children to participate in quality child care, those DES Providers that are nationally accredited or have a Quality First Star Rating of Three (3), Four (4) or Five (5) stars, will receive an **enhanced rate** for providing inclusive child care to children who meet the ADES/CCA family eligibility requirements for child care subsidies
- Effective start date for the Special Needs Program and the Enhanced Rate is **October 1, 2016**

DES Efforts to Support Inclusion



A child with special needs must have a documented disability as defined below:

- A child under the age of three who is eligible for the Arizona Early Intervention Program www.azed.gov/azeip (IDEA, Part C services) and has an Individualized Family Service Plan (IFSP); or
- A child between the ages of three and 12 who is eligible for Special Education Services (IDEA, Part B services) and has an Individualized Education Plan (IEP) <http://www.azed.gov/special-education/> ; or
- A child over the age of three who is eligible for the Division of Developmental Disabilities and has an Individualized Support Plan (ISP) <https://des.az.gov/services/disabilities/developmental-disabilities; or>

DES Efforts to Support Inclusion



A child with special needs must have a documented disability as defined below:

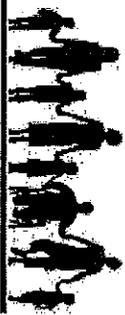
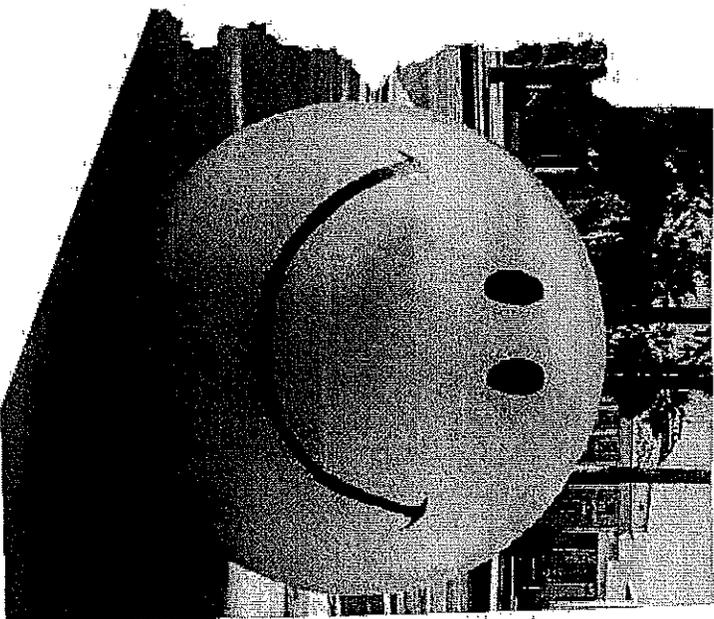
- A child who has a 504 Plan under Section 504 of the Rehabilitation Act and the American with Disabilities Act
<http://www2.ed.gov/about/offices/list/ocr/504faq.html>; or
- A child under the age of 13 with a diagnosis by a licensed physician, certified psychologist or a certified behavioral health specialist with a physical, cognitive and/or a psychosocial condition that substantially limits the child's ability to perform age-appropriate activities; or
- Others, as approved by ADES

Opportunities



- Opportunities to coordinate efforts with ADHS, Office for Children with Special Health Care Needs (OCSHCN)
- Partner across agencies and/or programs to assist child care providers to have the information and training to care for children with special needs, including children with Type 1 Diabetes

Thank You!



Reference



Public Health Licensing Overview

September 26, 2016

Presenting to

Diabetes Treatment in Child Care Facilities Ad Hoc Committee
Colby Bower | Assistant Director



ARIZONA DEPARTMENT
OF HEALTH SERVICES

Health and Wellness for all Arizonans

Public Health Licensing at a Glance

- 38,126 Licenses + 2,502 Complaints Investigated
 - Health Care Institutions (Hospitals, Residential, OTC’s, etc.)
 - Child Care Facilities
 - DD Group Homes
 - Licensed Professional Midwives
 - Speech and Language Professionals
- Vital Records
 - 86,413 births registered in CY2015
 - 54,853 deaths registered in CY2015
- Medical Marijuana
 - 100,000+ Card Holders
 - 100 Dispensaries
- 200 Professional Staff



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Health and Wellness for all Arizonans

Tools for the Public

- azcarecheck.com
 - Provides complaint and survey results
- azhealth.gov/licensing
 - Provider databases; complaint forms; GIS maps of providers
- azhealth.gov/annual-report
 - ADHS annual report



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Tools for the Public

ARIZONA DEPARTMENT OF HEALTH SERVICES
Health and Wellness for All Arizonans

HOME ABOUT US SERVICES A-Z INDEX CONTACT US

Public Health Licensing Protecting and Regulating Health & Child Care Services

Arizona Home - Public Health Licensing - Home

- Home
- Enforcement Action Search
- Online Complaint Forms
- Provider & Facility Database
- Map of Licensure Facilities
- Child Care Facilities Licensing
- Long Term Care Facilities Licensing
- Medical Facilities Licensing
- Residential Facilities Licensing
- Special Licensing
- Medical Marijuana

Feedback & Support

Home

Important Notice: COVID-19 Updates 4/15/20
Find links to the new public health complaints forms.

Complaint
Online Complaint Forms
A growing list of Public Health Complaint forms are available online to complete forms.

AZ Care Check
A searchable database of licensed providers and facilities.

Child Care Facilities Licensing
Licensing and regulation for child care facilities and the implementation of the Employment First Program.

Long-Term Care Facilities Licensing
Licensing, rules and enforcement for long-term care facilities for the disabled (Nursing Home).



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Health and Wellness for all Arizonans

Tools for the Public

Public Health Licensing
Protecting and Regulating Health & Child Care Services

ADHS Home | Public Health Licensing | Provider & Facility Databases

Provider & Facility Databases

In our mission to provide continuous delivery of efficient, timely, responsive, and quality consumer services, Licensing Services is providing citizens with databases of various health care facilities and providers.

The data tables below are updated on the first business day of the month, and provide a snapshot of licensed providers on the first day of the month. The exact date is contained within each file at the top of the file.

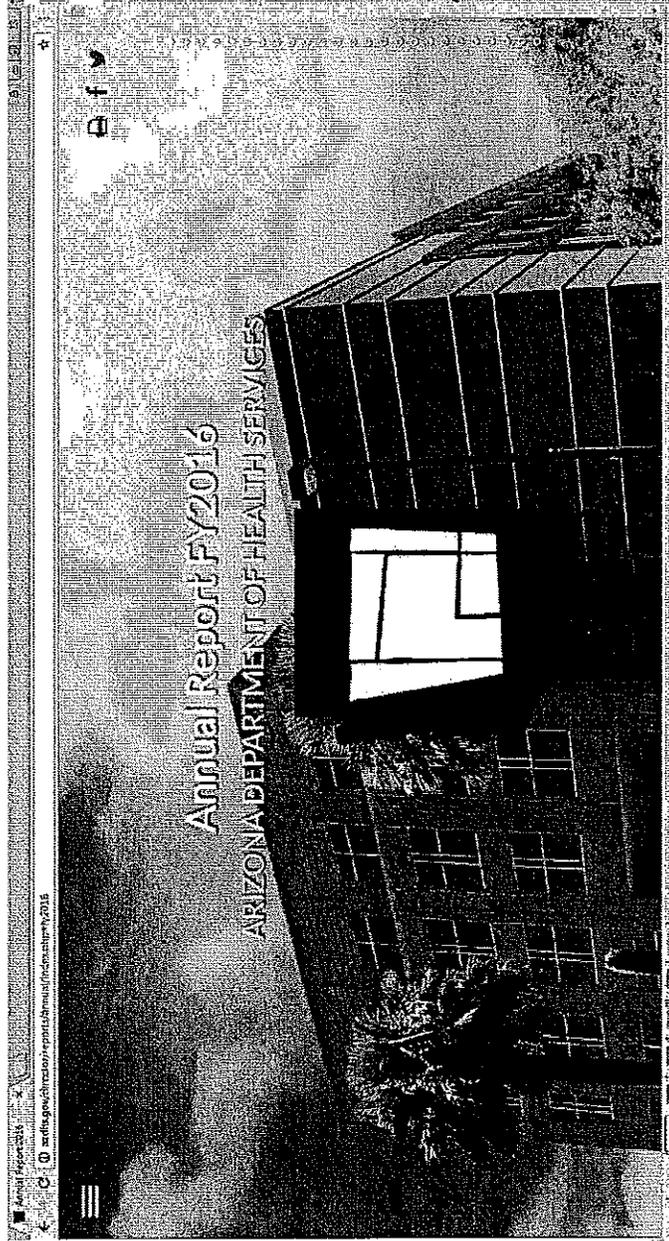
The tables listed below are provided in five formats:

- Access (Excel)
- Excel (Zip)
- Database (Zip)
- Delimited File (XML)
- PDF (Last)

Type of Provider	Access	Excel	Database	Delimited	PDF
All Licensed Providers	Download	Download	Download	Download	Download
All Medicaid Certified Providers	Download	Download	Download	Download	Download
Child Care Providers	Download	Download	Download	Download	Download
CNA Certified Laboratory Facilities	Download	Download	Download	Download	Download
Domestic Violence Treatment Providers	Download	Download	Download	Download	Download
Full Service Providers	Download	Download	Download	Download	Download

Home | Public Health Licensing | Provider & Facility Databases

Tools for the Public



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Child Care Licensing Overview

- Child Care Center = More than 10 kids for compensation
- Child Care Group Home = 5 or more kids for compensation;
No more than 10 kids.
- Public Schools are child care centers, operated by the school district
- Limit on # kids determined by square footage and staffing ratios



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Child Care Licensing Overview

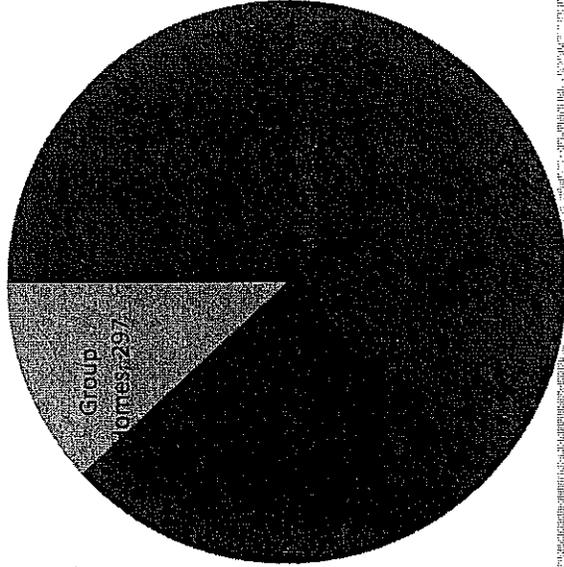
- Centers are inspected at least annually
- Homes are inspected at least twice annually
- Rules are found in A.C.C. Title 9 - Chapter 3 and Chapter 5



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Child Care Licensing



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Relevant Child Care Rules

- “Health care provider” means a physician, physician assistant, or registered nurse practitioner
- “Medication” means a substance prescribed by a physician, physician assistant, or registered nurse practitioner or available without a prescription for the treatment or prevention of illness or infestation.



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Relevant Child Care Rules

- **R9-5-516 “Medications”**
- Requires provider to have a written statement whether they administer prescription or nonprescription medication
- If medications are offered:
 - Identify who is responsible
 - Must have written authorization from parent or **health care provider**
 - Must have instructions, dosage, frequency, reason, date of authorization, etc.
 - Allow for injections after receiving written authorization from a **health care provider**



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Relevant Child Care Rules Big Picture

- ADHS rules do not prohibit the administration of insulin or any medication to enrolled children.
- Providers must be able to tell parents/guardians if they will administer medication.
- If a child care home or center wants to administer medication of any kind, there are administrative rules that cover the safe administration of medication.



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Survey

- ADHS sent the survey electronically to 1,914 providers
- ADHS received 542 responses

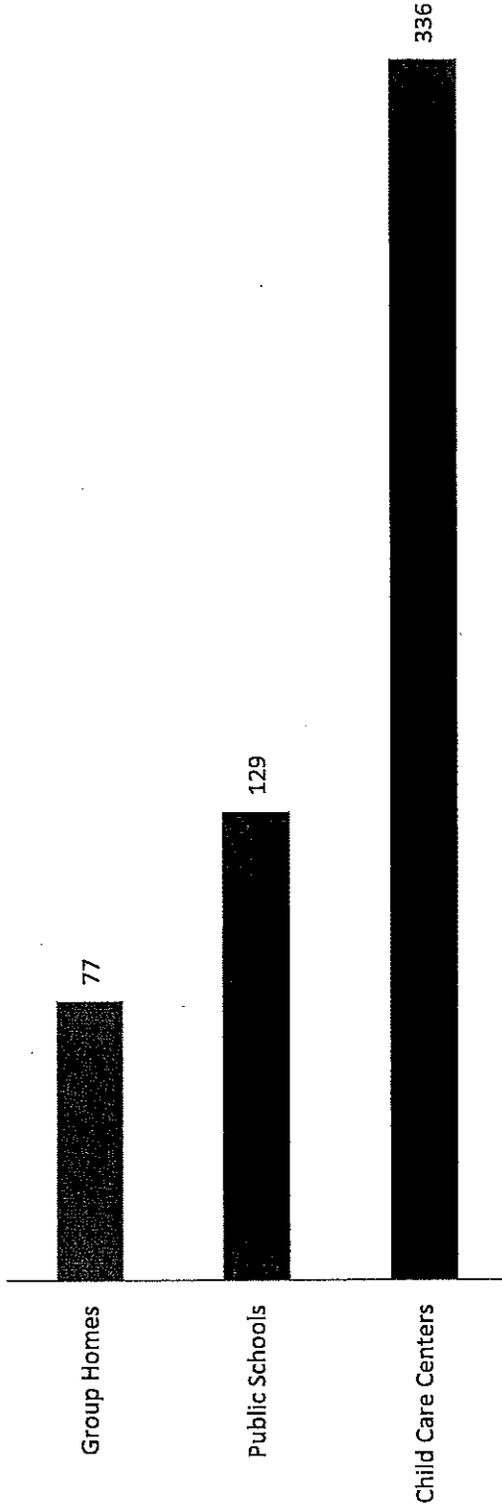


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Survey Results

Facility Type Responding

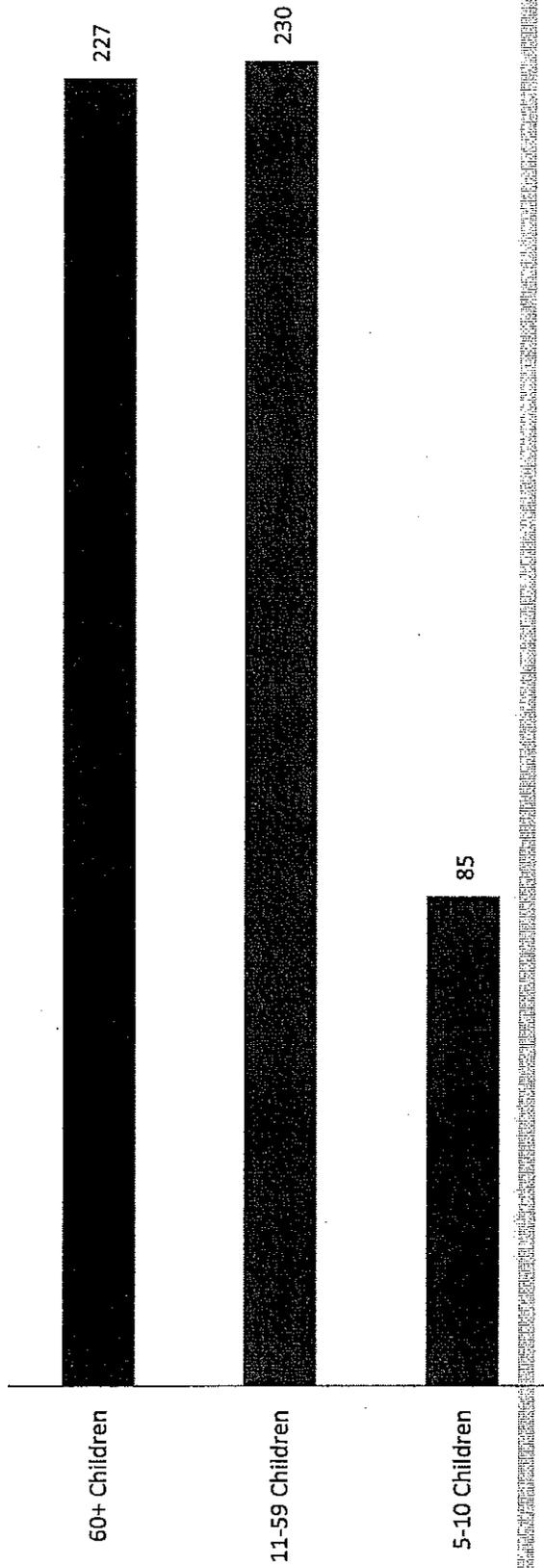


ARIZONA DEPARTMENT
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Health and Wellness for all Arizonans

Survey Results

Capacity

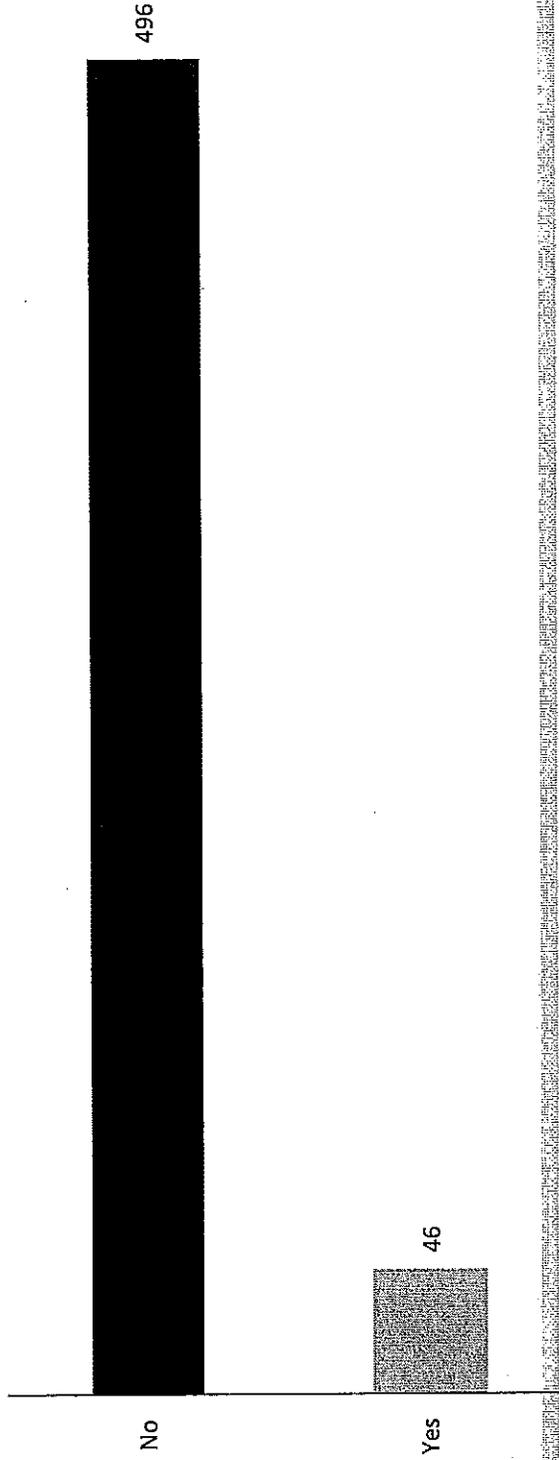


**ARIZONA DEPARTMENT
OF HEALTH SERVICES**

Health and Wellness for all Arizonans

Survey Results

Care for Children with Diabetes?

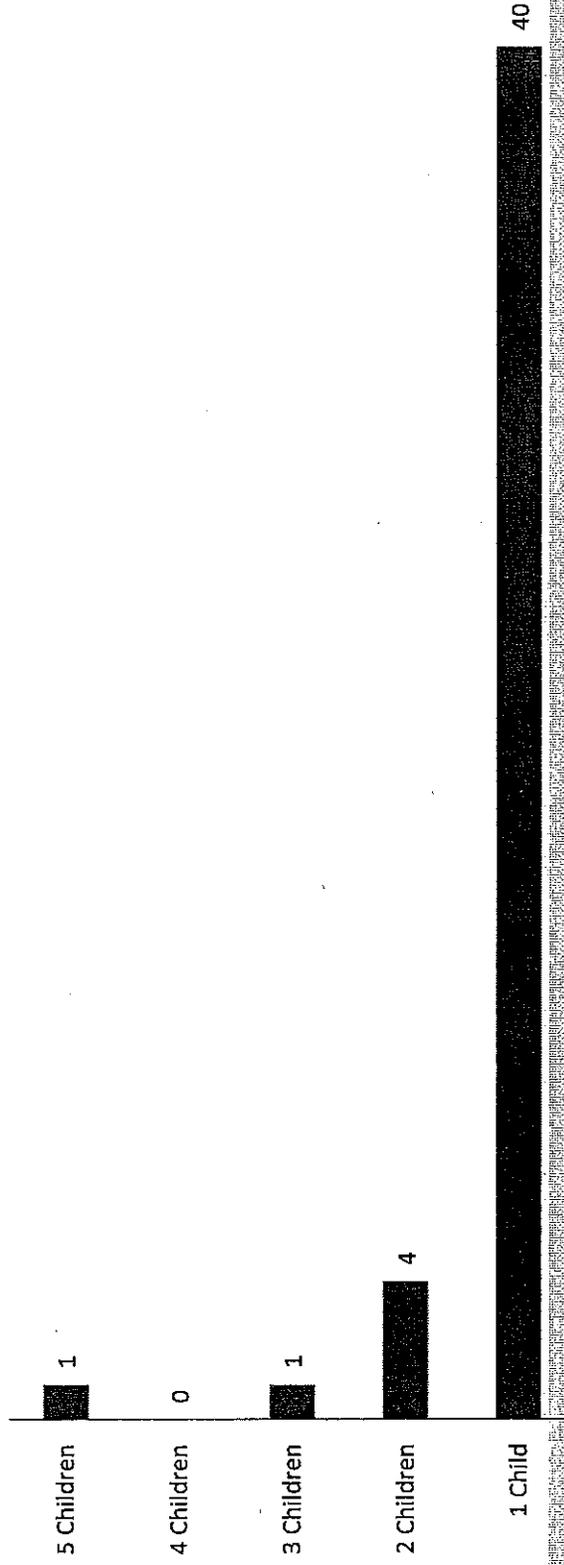


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Health and Wellness for all Arizonans

Survey Results

of Children Receiving Care

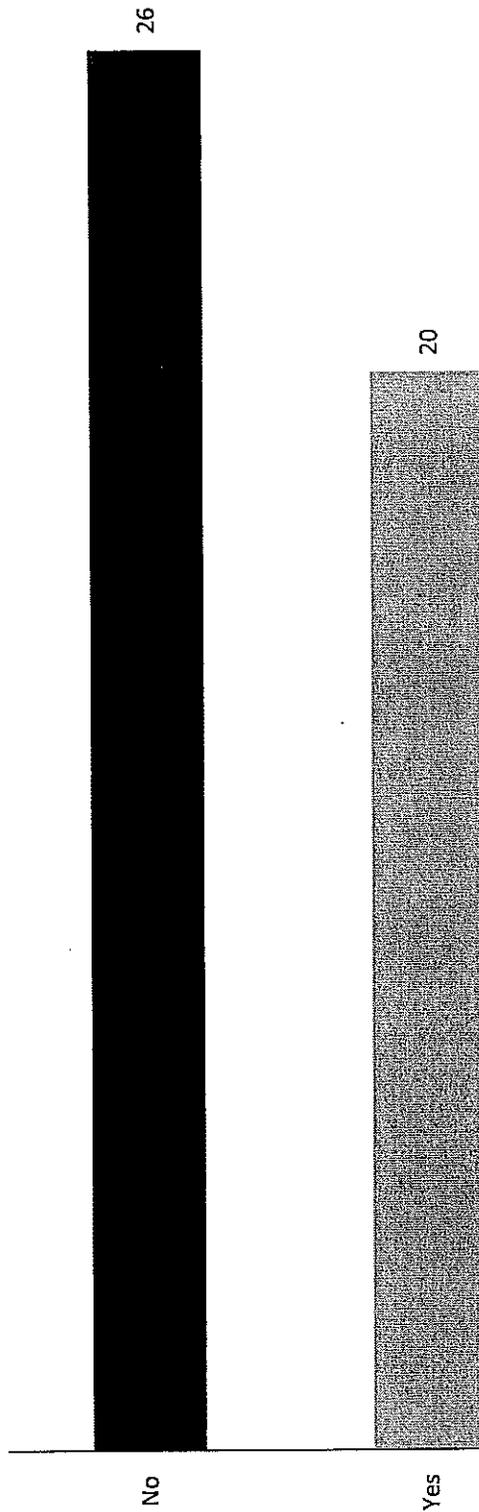


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Health and Wellness for all Arizonans

Survey Results

Offer Glucose Testing?

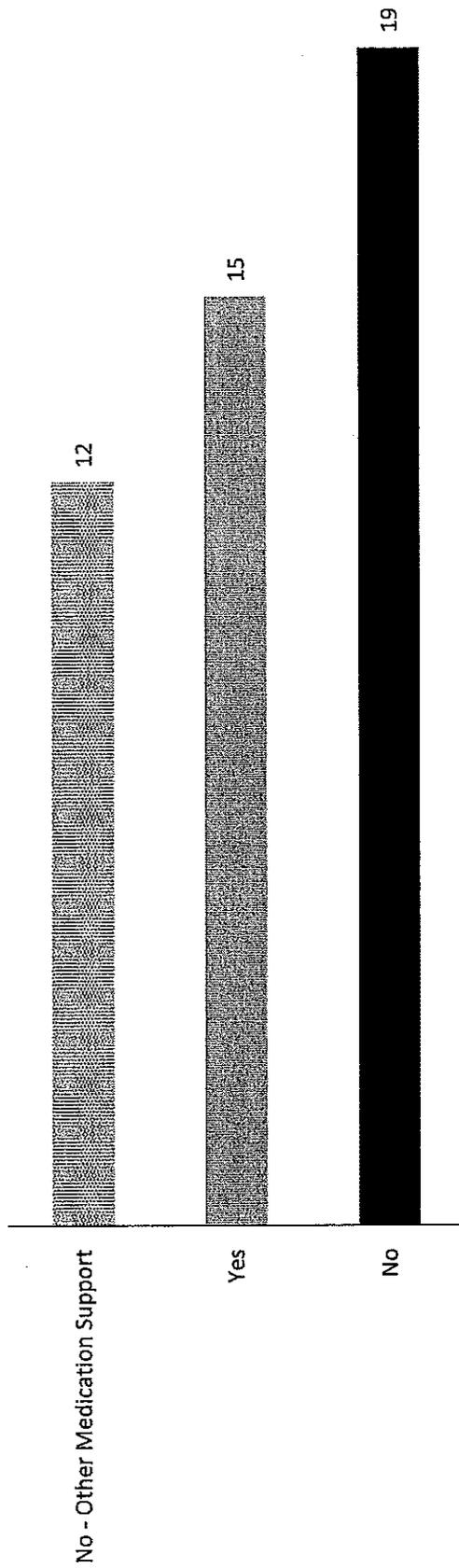


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Health and Wellness for all Arizonans

Survey Results

Medication Support, Including Insulin?



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Other Care Responses

- Children have a pump and know how to do their own testing
- We watch the child do glucose testing and the insulin as necessary
- We do not inject children (2)
- Glucose monitoring is needed for low blood sugar
- Parent gives insulin
- Children administer themselves
- Medications
- Insulin pump so staff assures that they have carbs entered correctly
- We could assist with self administration of medication
- Student wears a monitor that distributes insulin
- Parent is called if a diabetic episode occurs

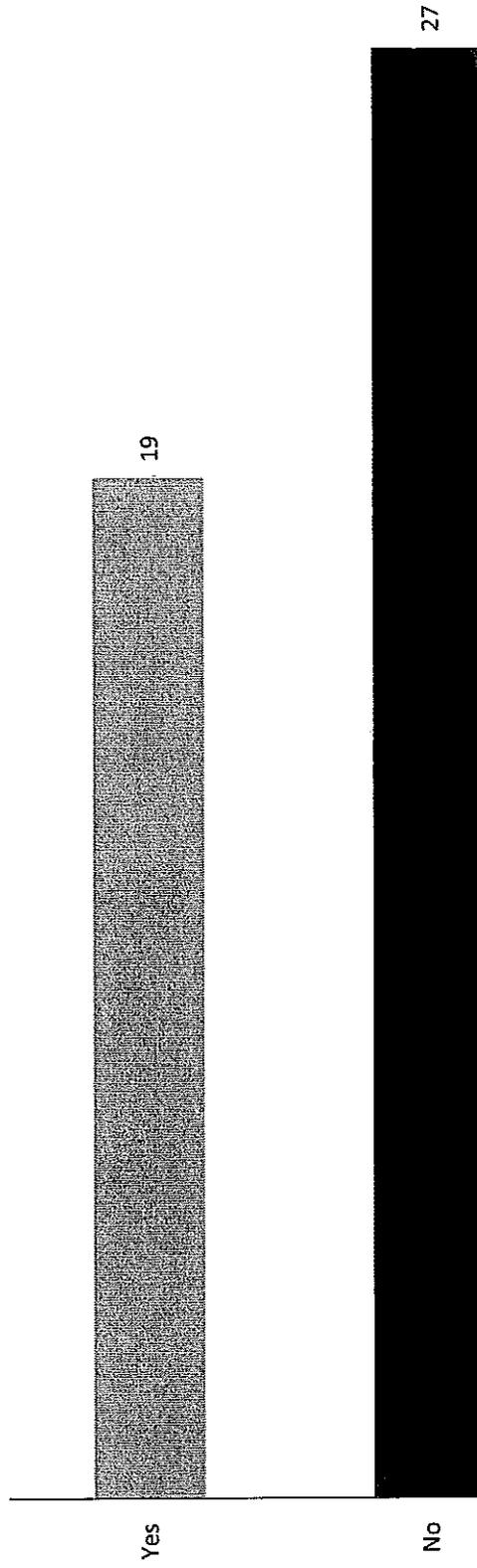


ARIZONA DEPARTMENT
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Health and Wellness for all Arizonans

Survey Results

Share Information with ADA?

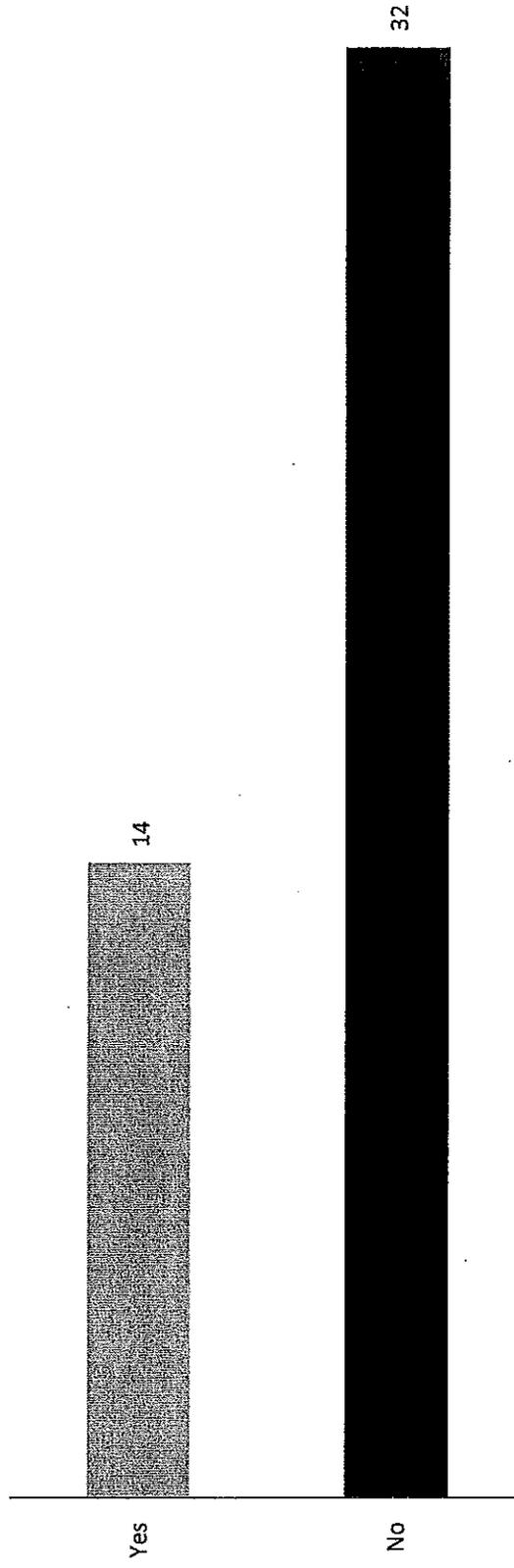


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Survey Results

Management of Type 1?



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Survey Results

Specify the Type of Care You Provide

Answer Choices	Responses
Our staff is trained on administering insulin to the enrollee and we have designated staff to administer	7
We assist and or perform blood glucose finger tests for our enrollees	10
We count carbs and follow the enrollees diabetes medical management plan	10
Our staff is trained on the signs and symptoms of hypoglycemia and hyperglycemia and treat following the dmmp	12
Our staff is trained on administering Glucagon and we have designated staff to administer this emergency medication to the enrollee	6
Total Respondents: 14	

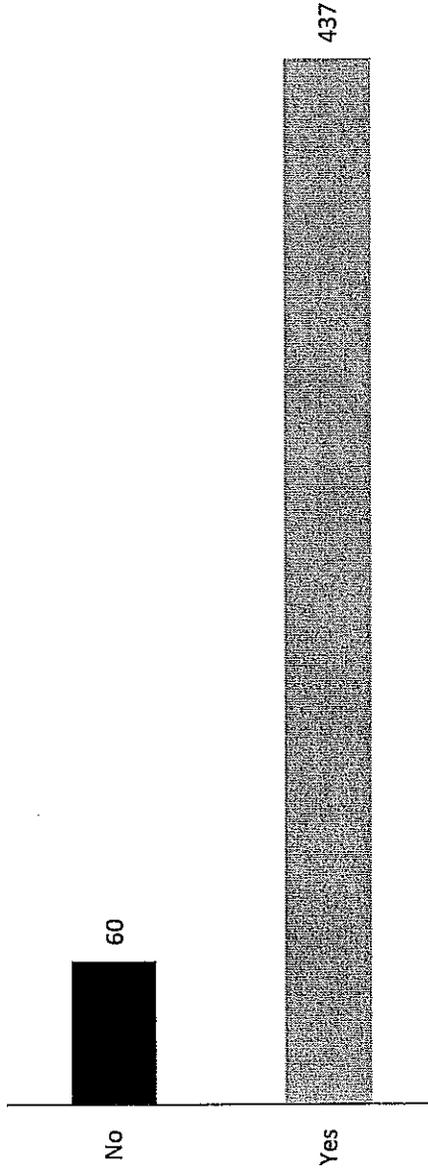


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Survey Results

Consider Providing Care if Trained?

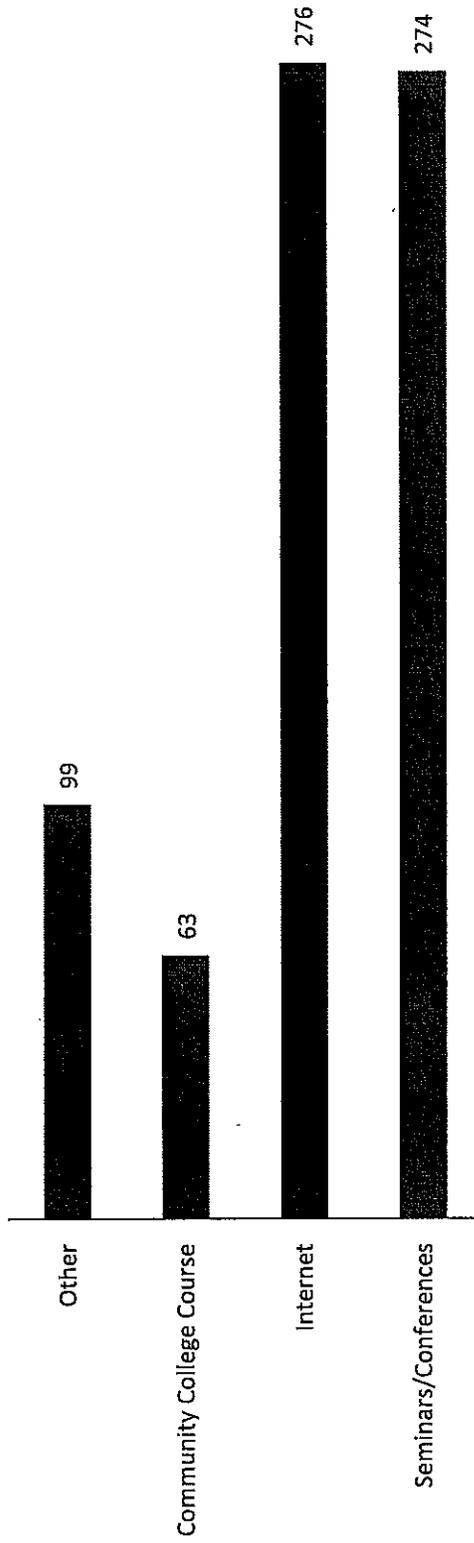


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Survey Results

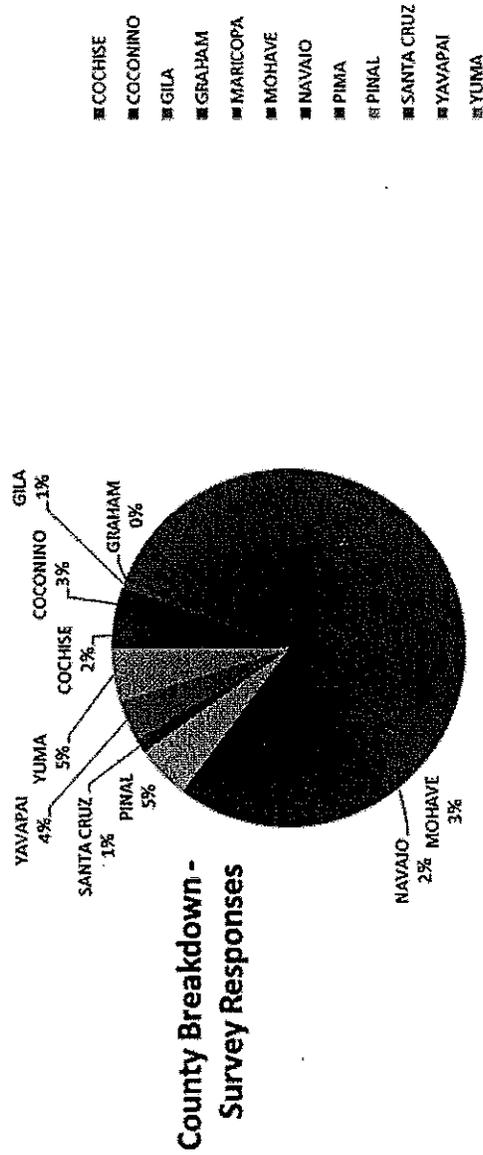
How to Receive Training Preferences



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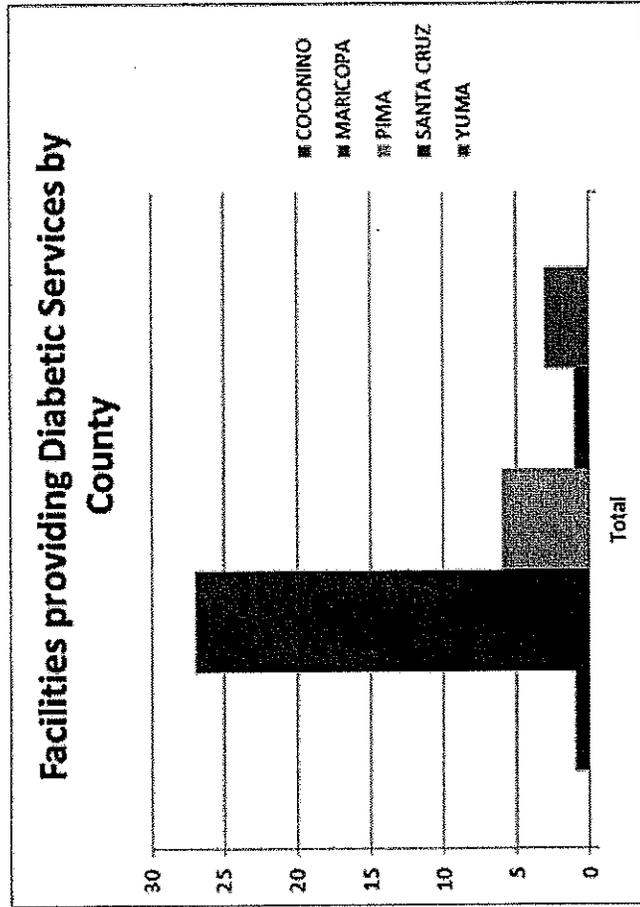
Survey Results by County



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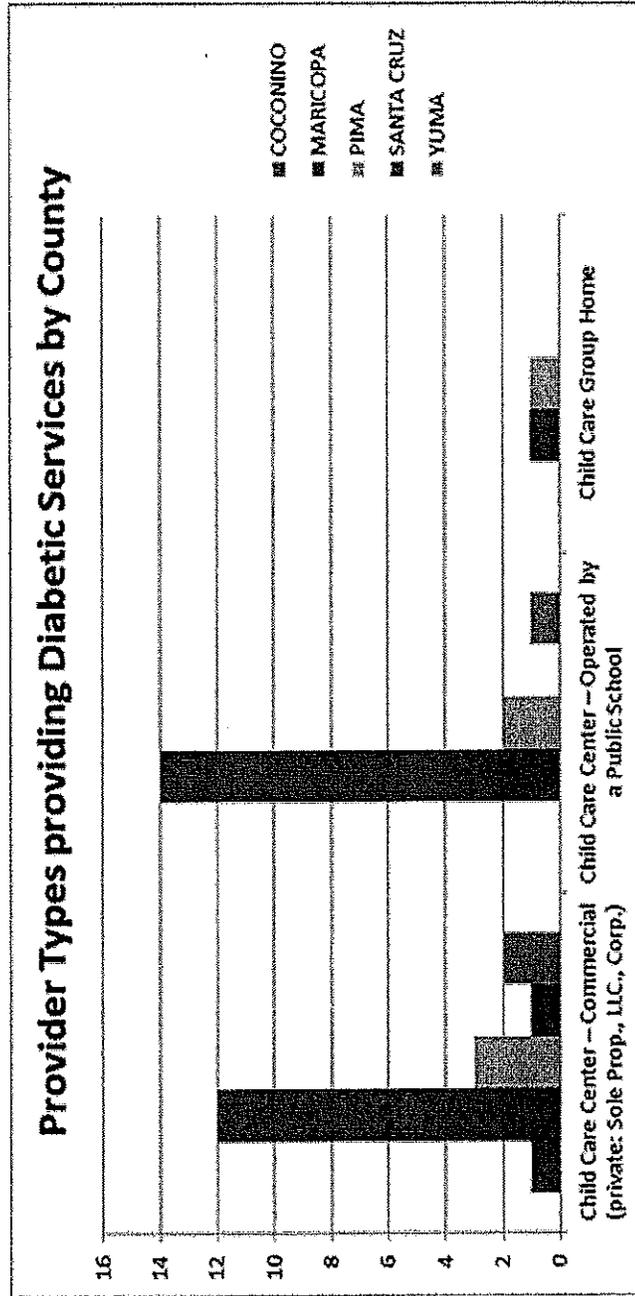
Survey Results by County



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Health and Wellness for all Arizonans

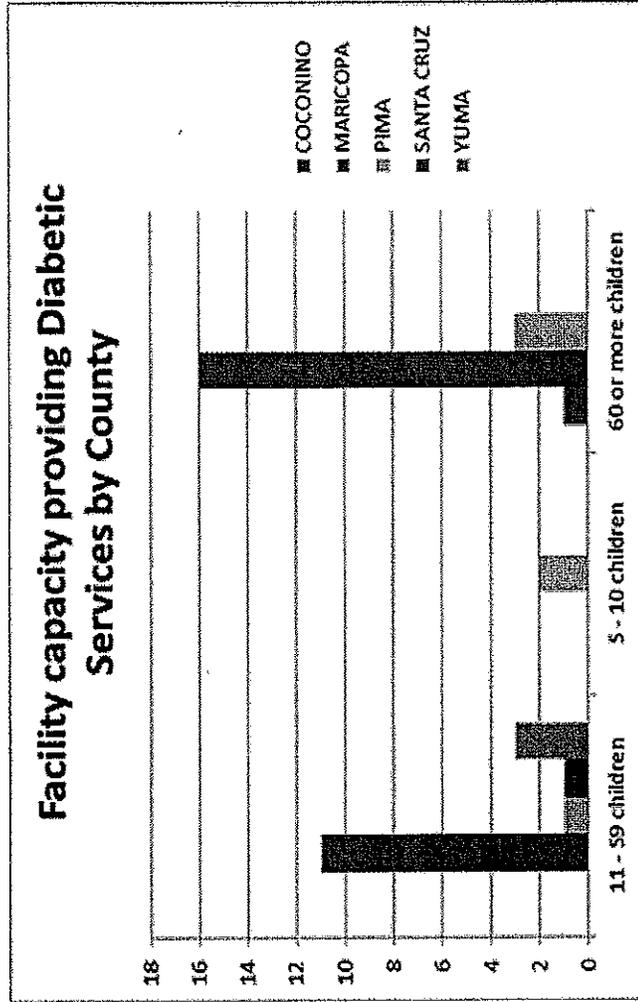
Survey Results by County



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Health and Wellness for all Arizonans

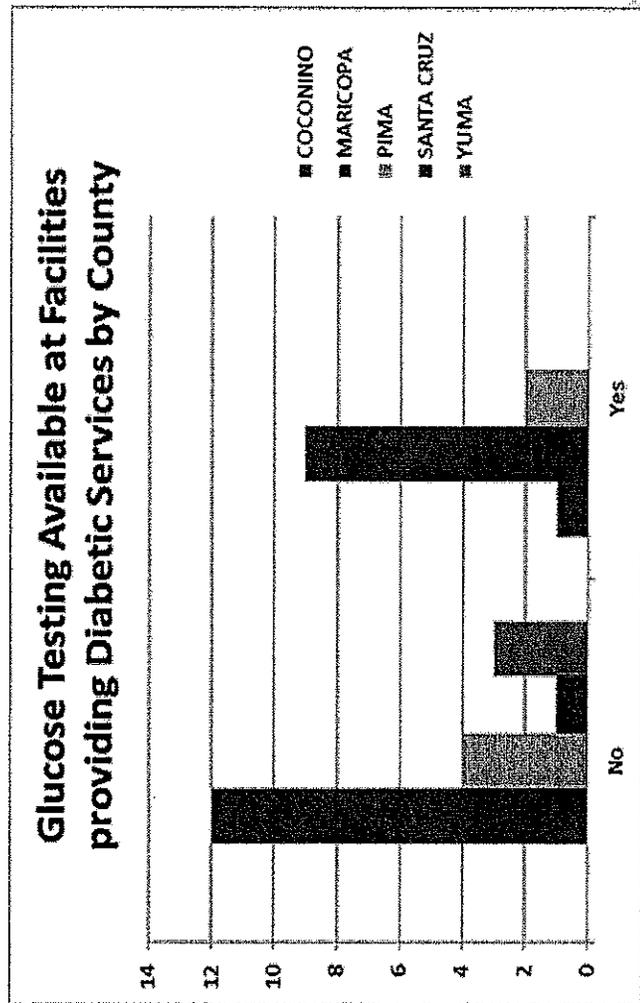
Survey Results by County



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Health and Wellness for all Arizonans

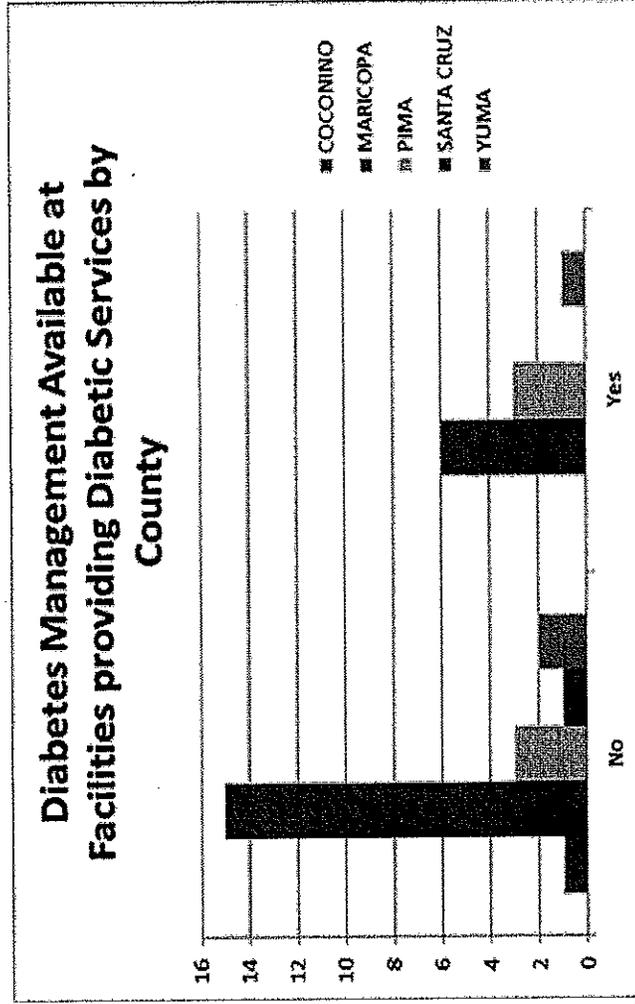
Survey Results by County



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Health and Wellness for all Arizonans

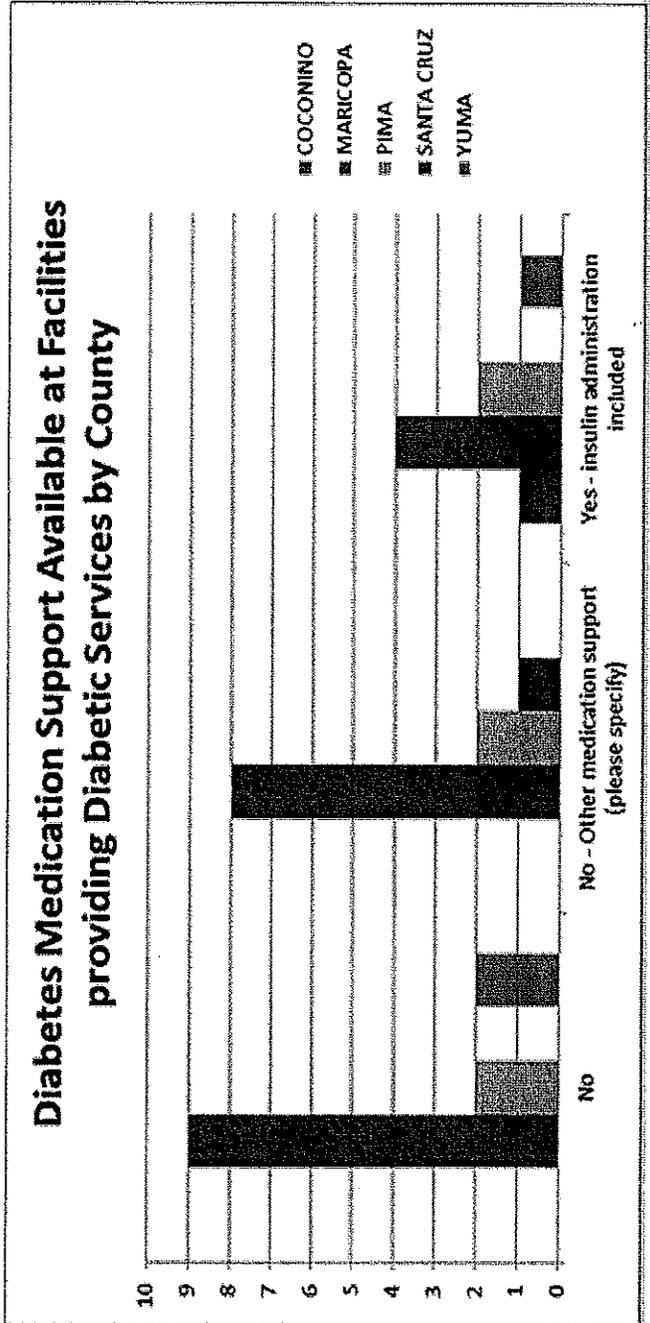
Survey Results by County



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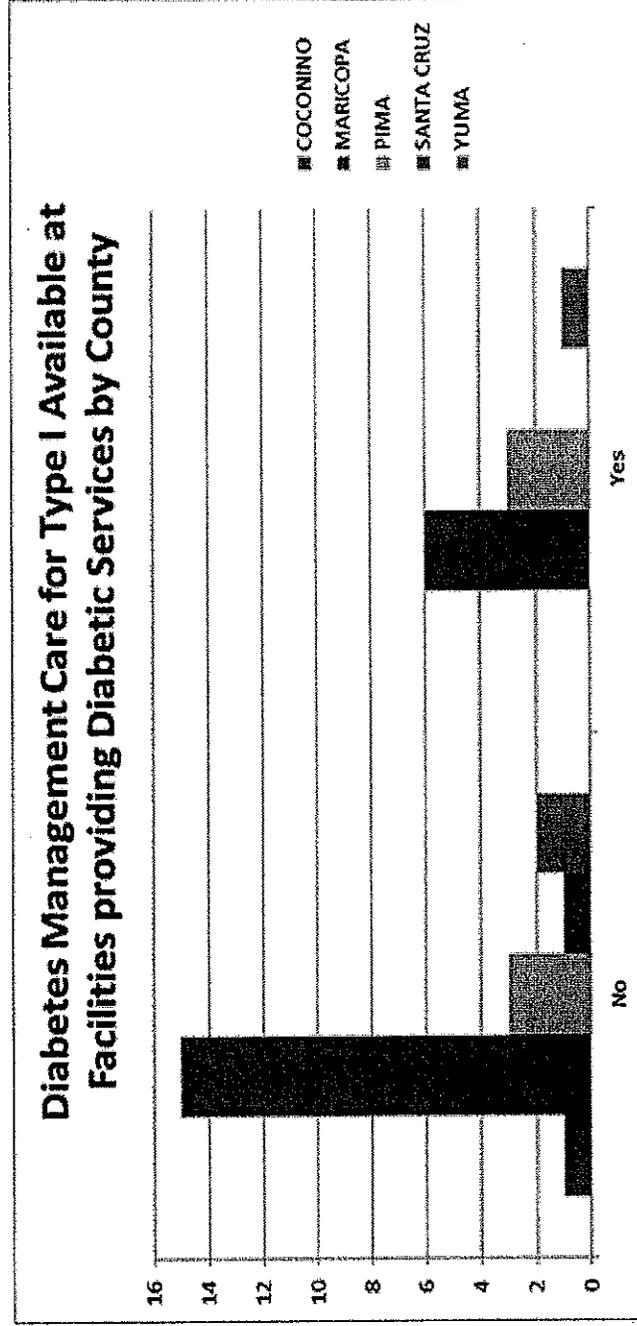
Survey Results by County



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Survey Results by County



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THANK YOU

Colby Bower | Assistant Director

colby.bower@azdhs.gov | 602-542-1032

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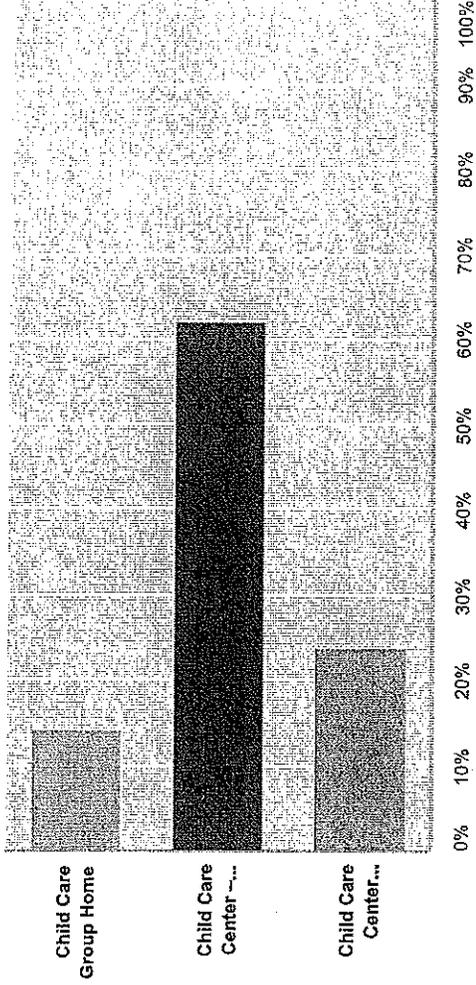


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Health and Wellness for all Arizonans

Q3 Please select the appropriate facility type:

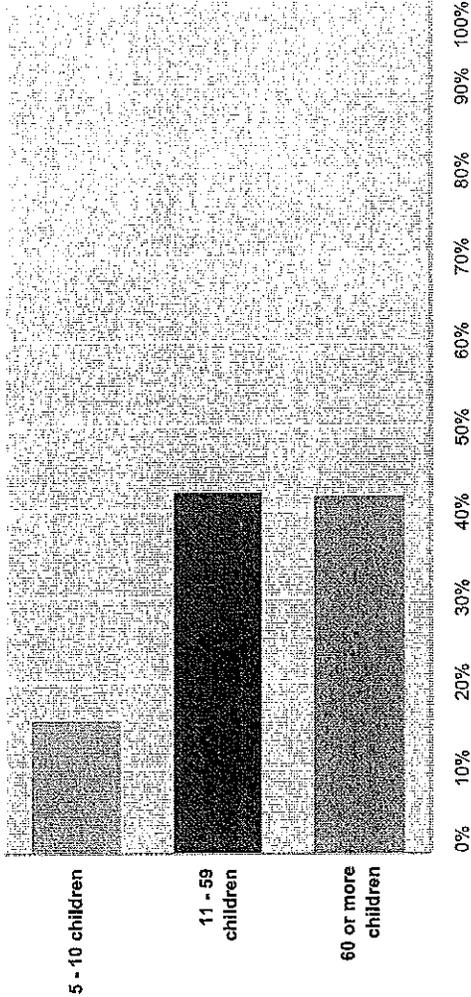
Answered: 542 Skipped: 0



Answer Choices	Responses
Child Care Group Home	77
Child Care Center – Commercial (private: Sole Prop., LLC., Corp.)	336
Child Care Center –Operated by a Public School	129
Total	542

Q4 Please indicate the capacity for your center:

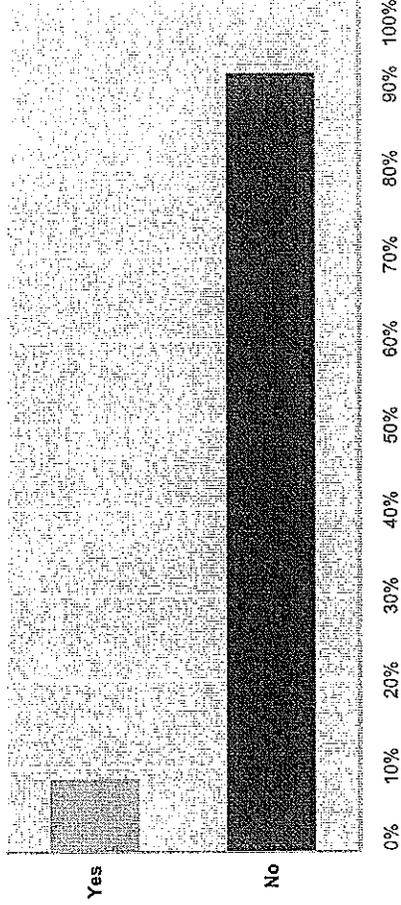
Answered: 542 Skipped: 0



Answer Choices	Responses
5 - 10 children	85
11 - 59 children	230
60 or more children	227
Total	542

Q5 Does your center care for children with diabetes?

Answered: 542 Skipped: 0



Answer Choices	Responses
Yes	46
No	496
Total	542

Q6 How many children do you care for with diabetes?

Answered: 46 Skipped: 496

Average 1.23 kids per facility

Max: 5

Min: 1

Median: 1

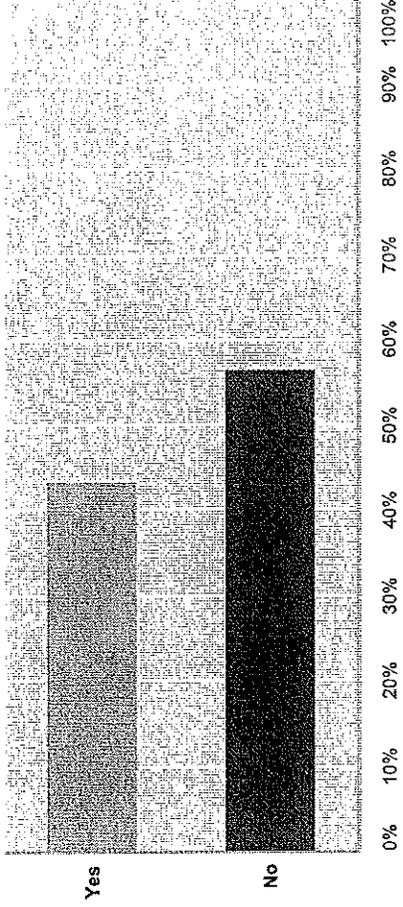
#	Responses	Date
1	1	9/13/2016 1:05 PM
2	1	9/13/2016 10:25 AM
3	1	9/12/2016 3:27 PM
4	1	9/12/2016 12:24 PM
5	1	9/12/2016 12:23 PM
6	1	9/8/2016 9:27 AM
7	1	9/8/2016 8:53 AM
8	1	9/7/2016 12:26 PM
9	2	9/7/2016 10:27 AM
10	1	9/7/2016 10:25 AM
11	1	9/6/2016 6:12 PM
12	1	9/6/2016 5:05 PM
13	1	9/6/2016 1:22 PM
14	1	9/6/2016 12:22 PM
15	1	9/6/2016 12:20 PM
16	1	9/6/2016 12:19 PM
17	1	9/6/2016 12:10 PM
18	1	9/6/2016 12:05 PM
19	1	9/6/2016 12:02 PM
20	1	9/6/2016 11:35 AM
21	3	9/6/2016 11:25 AM
22	1	9/6/2016 11:10 AM
23	2	9/6/2016 11:08 AM

OCCL Diabetes Care

24	1	9/6/2016 11:06 AM
25	1	9/6/2016 10:55 AM
26	1	9/6/2016 10:52 AM
27	1	9/6/2016 10:19 AM
28	2	9/6/2016 10:17 AM
29	1	9/6/2016 10:14 AM
30	1	9/6/2016 10:13 AM
31	1	9/6/2016 9:56 AM
32	1	9/6/2016 9:38 AM
33	1	9/6/2016 9:27 AM
34	1	9/6/2016 9:17 AM
35	1	9/6/2016 8:29 AM
36	1	9/6/2016 8:28 AM
37	1	9/6/2016 8:28 AM
38	1	9/6/2016 8:28 AM
39	1	9/6/2016 8:25 AM
40	5	9/5/2016 12:20 PM
41	1	9/5/2016 10:57 AM
42	1	9/4/2016 6:42 PM
43	1	9/4/2016 4:37 PM
44	2	9/4/2016 4:25 PM
45	1	9/4/2016 3:50 PM
46	1	9/4/2016 12:20 PM

Q7 Do center staff do glucose testing of diabetic children (finger prick)?

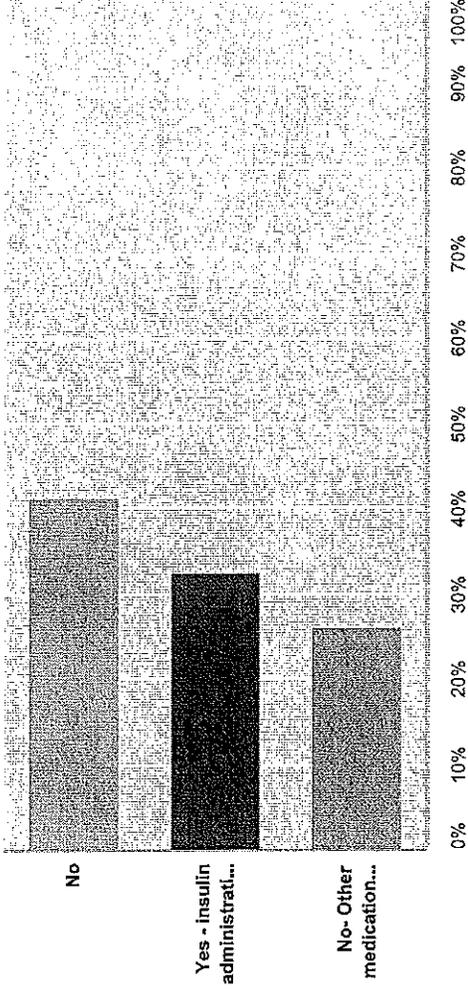
Answered: 46 Skipped: 496



Answer Choices	Responses
Yes	20
No	26
Total	46

Q8 Do center staff provide medication support - including insulin administration?

Answered: 46 Skipped: 496



Answer Choices	Responses
No	41.30%
Yes - insulin administration included	32.61%
No- Other medication support (please specify)	26.09%
Total	46

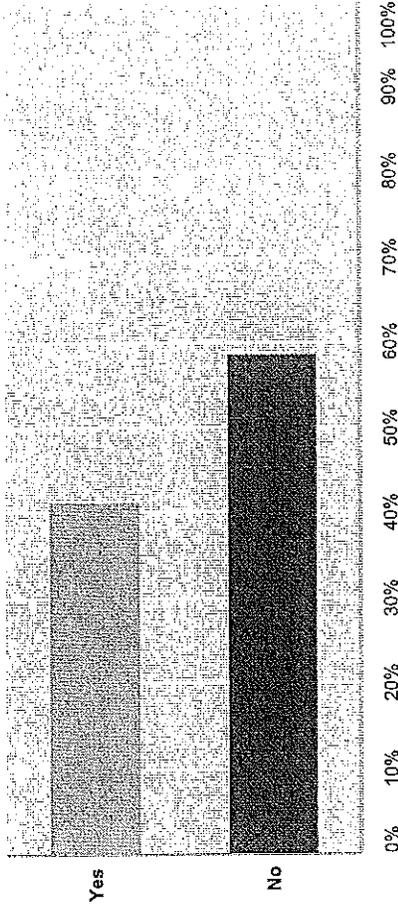
#	No- Other medication support (please specify)	Date
1	Children have a pump and know how to do their own testing	9/7/2016 10:27 AM
2	We watch the child do the glucose testing and the insulin admin as necessary.	9/6/2016 5:05 PM
3	We do not inject children	9/6/2016 12:20 PM
4	We do not inject children	9/6/2016 12:19 PM
5	glucose monitoring if needed for low blood sugars	9/6/2016 12:10 PM

OCCL Diabetes Care

6	parent gives insulin	9/6/2016 12:05 PM
7	children admistrate themselves	9/6/2016 11:25 AM
8	medications	9/6/2016 11:08 AM
9	Insulin pump so staff assures that they have carbs entered correctly	9/6/2016 11:06 AM
10	We could assist with self administration of medication	9/6/2016 10:52 AM
11	Student wears a monitor that distributes insulin	9/6/2016 10:19 AM
12	We have an LPN on our campus who follows GESD guidelines for giving meds. At this point in time, the parent is called if the child experiences a diabetic episode and administers any testing needed. We are waiting for the parent to bring in the diabetic care plan from her doctor and appropriate medical supplies.	9/6/2016 8:28 AM

Q9 As a diabetic provider for children, would you like your center's information given to the ADA for publication?

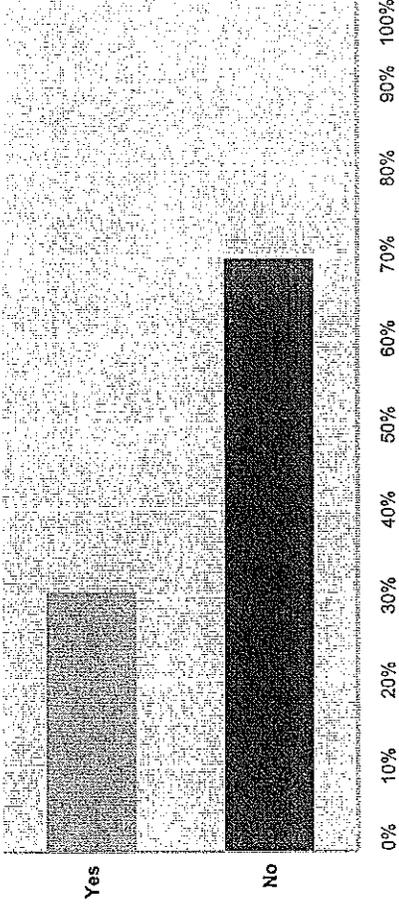
Answered: 46 Skipped: 496



Answer Choices	Responses
Yes	19 41.30%
No	27 58.70%
Total	46

Q10 Do you currently offer diabetes management care to youth with type 1 diabetes enrolled in your program?

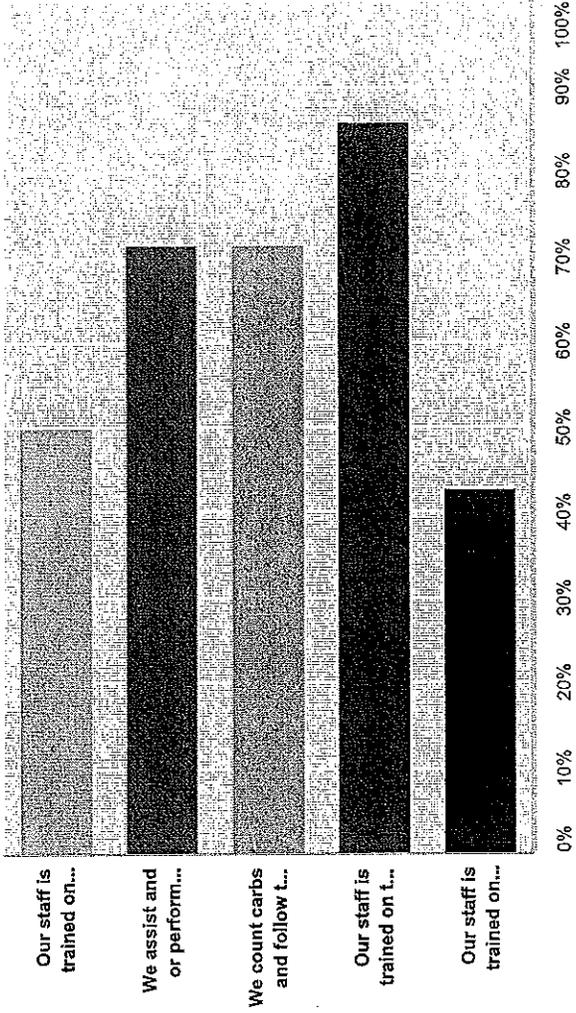
Answered: 46 Skipped: 496



Answer Choices	Responses
Yes	14
No	32
Total	46

Q11 Please specify what type of care you offer:

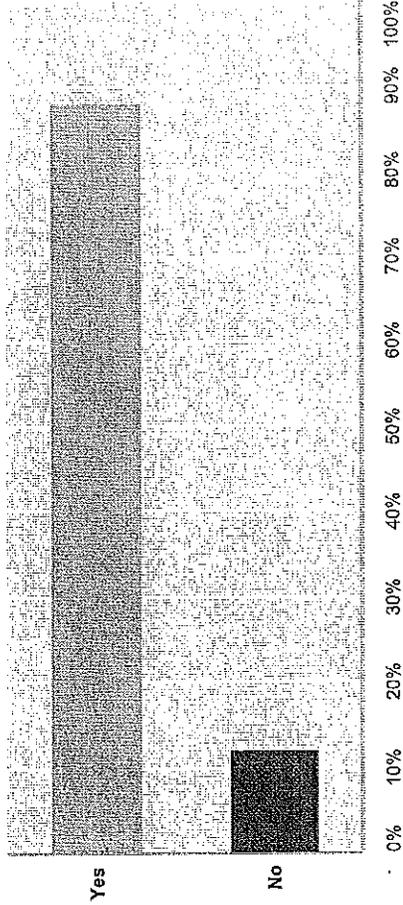
Answered: 14 Skipped: 528



Answer Choices	Responses
Our staff is trained on administering insulin to the enrollee and we have designated staff to administer	7 50.00%
We assist and or perform blood glucose finger tests for our enrollee	10 71.43%
We count carbs and follow the enrollee's diabetes medical management plan (dmmp)	10 71.43%
Our staff is trained on the signs and symptoms of hypoglycemia and hyperglycemia and treat following the dmmp	12 85.71%
Our staff is trained on administering Glucagon and we have designated staff to administer this emergency medication to the enrollee	6 42.86%
Total Respondents: 14	

Q12 Would you consider caring for diabetic children if you could provide appropriate training for you staff?

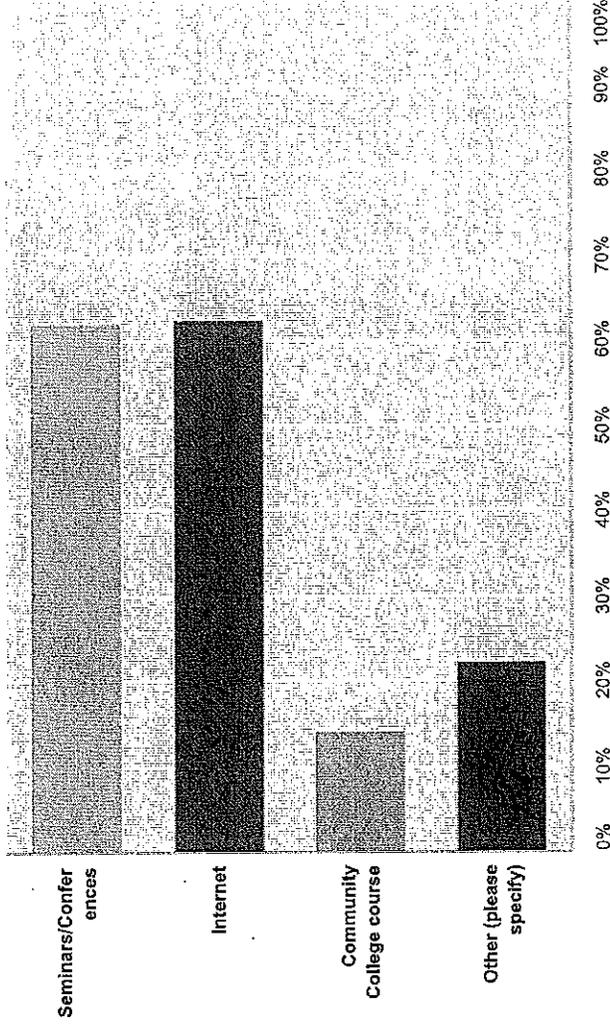
Answered: 497 Skipped: 45



Answer Choices	Responses
Yes	437
No	60
Total	497

Q13 How would you like to receive training (check all that apply)?

Answered: 442 Skipped: 100



Answer Choices	Responses
Seminars/Conferences	274
Internet	276
Community College course	63
Other (please specify)	99
Total Respondents: 442	

#	Other (please specify)	Date
1	in house staff training	9/14/2016 2:39 PM

OCCL Diabetes Care

2	Our Health Services dept. does the training.	9/13/2016 1:15 PM
3	Our Health Services dept. does the training.	9/13/2016 1:15 PM
4	Our Health Services dept. does the training.	9/13/2016 1:14 PM
5	Our Health Services dept. does the training.	9/13/2016 1:13 PM
6	Our Health Services dept. does the training.	9/13/2016 1:11 PM
7	O	9/13/2016 1:11 PM
8	Our Health Services dept. does the training.	9/13/2016 1:10 PM
9	Our Health Services dept. does the training.	9/13/2016 1:09 PM
10	Our Health Services dept. does the training.	9/13/2016 1:07 PM
11	Our Health Services dept. does the training.	9/13/2016 1:07 PM
12	Onsite	9/12/2016 10:15 AM
13	We currently do not have any diabetic children enrolled. We do provide services when an enrolled child is diabetic.	9/12/2016 9:29 AM
14	Thru Pima County Health	9/12/2016 8:54 AM
15	webinars	9/12/2016 7:32 AM
16	We do except students with Diabetes but at this time we do not have any enrolled.	9/9/2016 12:46 PM
17	TUSD's Health Services provides training for our staff when we have a diabetic child	9/9/2016 12:08 PM
18	TUSD's Health Services provides training for our staff when we have a diabetic child	9/9/2016 12:07 PM
19	TUSD's Health Services provides training for our staff when we have a diabetic child	9/9/2016 12:06 PM
20	TUSD's Health Services provides training for staff when we have a child that is diabetic.	9/9/2016 12:03 PM
21	Nurse consultant	9/9/2016 8:18 AM
22	We have a registered nurse on staff who would provide care for diabetic children, however, we don't have any enrolled at this time.	9/8/2016 4:40 PM
23	There are so many reasons why this is not safe for all children in care. The challenge of medication over teething tablets & asthma children with medical consent, letters, authorizations, and training we did to provide quality care for these medical issues and still were sited. Plus hiring a CNA to provide onsite care. Additionally Liability insurance in AZ believes AZDHS does not want CCGH to care for any children labeled with medical issues and refuses to issue liability insurance to programs. If you provide any form of medical care within your program, you have an extremely limited number of liability insurance providers and you pay center rates not CCGH rates. According to liability insurance brokers it is based on the way AZDHS writes the citations. Their hands are tied. Talk to Farmers, State Farm, & GEICO. Good luck. The ASCC food program has done alot to help with nutrition along with QF FTF.	9/8/2016 12:26 PM
24	I currently don't have children with diabetes, but our agency provides training for us in the event we do have a child with diabetes. I would also be interested in more training via internet training or conference.	9/8/2016 8:48 AM
25	Nurse coming in to do training.	9/8/2016 6:59 AM
26	Someone coming to our center and training the entire staff	9/7/2016 5:55 PM
27	parent training or nurse training	9/7/2016 5:23 PM

OCCL Diabetes Care

28	nurse, health specialist and parent	9/7/2016 5:23 PM
29	Someone come to our facility and train us.	9/7/2016 3:58 PM
30	Training at our site by a Medical Staff Professional	9/7/2016 12:55 PM
31	We have a RN on staff who would handle this. We do not have a current student with diabetes.	9/7/2016 11:54 AM
32	Someone come into our center to train staff	9/7/2016 9:56 AM
33	Schedule training	9/7/2016 9:24 AM
34	training class	9/6/2016 7:04 PM
35	Training at our facility	9/6/2016 4:17 PM
36	Nurse health consultant	9/6/2016 4:05 PM
37	District Lead Nurse provides training when needed	9/6/2016 3:44 PM
38	District Lead Nurse provides training when needed	9/6/2016 3:43 PM
39	District Lead Nurse provides training when needed	9/6/2016 3:39 PM
40	Our District Lead Nurse provides training when needed	9/6/2016 3:36 PM
41	We have a nurse on staff but not at each site.	9/6/2016 3:24 PM
42	We have a nurse on staff but not at each site.	9/6/2016 3:23 PM
43	We have a nurse on staff but not at each site.	9/6/2016 3:23 PM
44	On-site workshop	9/6/2016 2:39 PM
45	We have a registered nurse on staff who will perform all duties if we have a child with diabetes enroll	9/6/2016 2:31 PM
46	HANDS ON	9/6/2016 2:23 PM
47	I have had charter school students that were diabetic, in past year and we received training from a juvenile diabetic association.	9/6/2016 2:23 PM
48	The school nurse has always provided the care for diabetic students in the school, including preschool/PreK and has inserviced the staff on signs of hypo/hyperglycemia. We currently have no students with diabetes.	9/6/2016 1:39 PM
49	on-site via direct hands-on training	9/6/2016 1:39 PM
50	Person coming in and giving us a class.	9/6/2016 12:46 PM
51	FY1 - we haven't had a diabetic child in years, but we would provide care and accommodate if we had someone who needed it.	9/6/2016 12:28 PM
52	in-house training	9/6/2016 12:18 PM
53	trained health care professional is preferred	9/6/2016 12:17 PM
54	training at our facility	9/6/2016 12:16 PM
55	trainings	9/6/2016 11:45 AM
56	Staff training at site	9/6/2016 11:39 AM

OCCL Diabetes Care

57	In house training session	9/6/2016 11:35 AM
58	Health care professional on-site	9/6/2016 11:23 AM
59	hands-on training with nurse consultant	9/6/2016 11:16 AM
60	In-house Training	9/6/2016 10:41 AM
61	workshop	9/6/2016 10:30 AM
62	if given guidelines I could teach the course to my staff. I've been diabetic most of my life and worked at a summer camp for kids with diabetes for many years.	9/6/2016 10:30 AM
63	through cpc	9/6/2016 10:29 AM
64	ANY TRAINING	9/6/2016 10:27 AM
65	on site pd	9/6/2016 10:10 AM
66	A one day training and received a training certificate for it.	9/6/2016 9:58 AM
67	-on site	9/6/2016 9:42 AM
68	Trainings for our own Nurse Practitioner	9/6/2016 9:36 AM
69	webinar - dvd training	9/6/2016 9:29 AM
70	We have onsite register nurses/medical assistant who can train our staff or administer insulin	9/6/2016 9:27 AM
71	Workshops	9/6/2016 9:17 AM
72	Training from nurses	9/6/2016 9:17 AM
73	We've had in the past a diabetic consultant with parents	9/6/2016 9:16 AM
74	We would care for children with diabetes, but currently we do not have a child with this problem.	9/6/2016 9:14 AM
75	We would care for them now but none have enrolled.	9/6/2016 9:06 AM
76	Specialists within the agency	9/6/2016 8:59 AM
77	We have a RN on our campus who could provide training	9/6/2016 8:39 AM
78	on-site	9/6/2016 8:26 AM
79	child's doctor & parents	9/6/2016 8:08 AM
80	ON-SITE TRAINING FOR ALL STAFF	9/6/2016 7:46 AM
81	Training on school site	9/5/2016 11:51 PM
82	Demonstration by health professional	9/5/2016 9:58 PM
83	Would not want the responsibility of a child with diabetes.	9/5/2016 6:21 PM
84	webinars	9/5/2016 12:14 PM
85	teacher in-service on-site	9/5/2016 10:04 AM

OCCL Diabetes Care

86	Have an inservice where someone comes to the facility and trains our staff.	9/4/2016 9:40 PM
87	Parent training	9/4/2016 9:02 PM
88	on site direct hands on training	9/4/2016 4:18 PM
89	Public nurse	9/4/2016 3:54 PM
90	Webinars	9/4/2016 3:28 PM
91	Registry Workshop qualified instructor	9/4/2016 2:50 PM
92	on site workshop for providers	9/4/2016 2:48 PM
93	Health nurse on site training	9/4/2016 1:41 PM
94	The school will provide training	9/4/2016 1:10 PM
95	One on one training	9/4/2016 1:07 PM
96	Hands on	9/4/2016 1:05 PM
97	N/A	9/4/2016 12:19 PM
98	Child care resources	9/4/2016 11:44 AM
99	Workshops	9/4/2016 11:31 AM



Care of Young Children With Diabetes in the Child Care Setting: A Position Statement of the American Diabetes Association

Diabetes Care 2014;37:2834–2842 | DOI: 10.2337/dc14-1676

Linda M. Siminerio,¹
 Anastasia Albanese-O'Neill,²
 Jane L. Chiang,³ Katie Hathaway,³
 Crystal C. Jackson,³
 Jill Weissberg-Benchell,⁴ Janel L. Wright,⁵
 Alan L. Yatvin,⁶ and Larry C. Deeb⁷

Diabetes is a relatively common chronic disease of childhood (1); however, capturing prevalence data in children with type 1 and type 2 diabetes has been challenging. The comprehensive SEARCH for Diabetes in Youth (SEARCH) study has made significant strides in better understanding disease prevalence in the pediatric population. A recent SEARCH study found that 1.93 per 1,000 youth (aged <20 years) were diagnosed with type 1 diabetes (2), an increase of 21.1% from 2001 to 2009, with increases seen in all ethnic groups but with non-Hispanic whites disproportionately affected (3). For type 2 diabetes, the SEARCH study reported a prevalence of 0.46 per 1,000 youth (aged 10–20 years), an increase of 30.5% from 2001 to 2009 in all ethnicities (3). As youth rarely die of diabetes, the increase in prevalence is most likely attributed to increased incidence.

An annual increase of 2.3% in type 1 diabetes incidence has been reported in children, with children aged <5 years experiencing the greatest increase relative to all children (4). As type 2 diabetes is rarely seen in children younger than 10 years of age (3), this Position Statement will primarily focus on type 1 diabetes. The primary objective of this Position Statement is to explain that young children (aged ≤5 years) are a vulnerable population and have unique diabetes management needs. Our goal is to describe the diabetes management recommendations in the child care setting. The child care setting includes day care, camp, and other programs where young children with diabetes are enrolled. This Position Statement is meant to guide child care providers in caring for young children with diabetes and is not intended to provide specific advice on the medical management for this population. While Position Statements contain evidence-based recommendations, all of the information that pertains to young children is expert opinion only. For more detailed information on the medical management of type 1 diabetes in children, please refer to the American Diabetes Association's (ADA's) "Standards of Medical Care in Diabetes—2014" (5) and "Type 1 Diabetes Through the Life Span: A Position Statement of the American Diabetes Association" (6).

UNIQUE CHALLENGES FOR THE YOUNG CHILD

Infants, toddlers, and preschool-age children (≤5 years of age) are enrolled in the more than 330,000 child care programs across the country (7). These children wholly depend on adults for most, if not all, aspects of their care. Pediatric health care providers, parents/guardians, and child care staff must work together to ensure that young children with diabetes are provided with the safest possible child care environment. This collaboration is essential to achieve a seamless transition in care from home to the child care setting.

Managing type 1 diabetes in young children in child care programs presents unique challenges due to the young child's developmental level. The limited communication and motor skills, cognitive abilities, and emotional maturity of young children can challenge even the most experienced child care provider. For example, young children with hypo- or hyperglycemia may or may not exhibit abnormal behavior or irritability. As erratic behavior is typical in this age-group, the child care provider may not recognize hypo- or hyperglycemic symptoms and may miss

¹University of Pittsburgh Diabetes Institute, Pittsburgh, PA

²Department of Pediatrics, University of Florida College of Medicine, Gainesville, FL

³American Diabetes Association, Alexandria, VA

⁴Northwestern University Feinberg School of Medicine, Ann and Robert H. Lurie Children's Hospital of Chicago, Chicago, IL

⁵Alaska Department of Labor, Anchorage, AK

⁶Popper & Yatvin, Philadelphia, PA

⁷Florida State University College of Medicine, Tallahassee, FL

Corresponding author: Jane L. Chiang, jchiang@diabetes.org.

This Position Statement was reviewed and approved by the Professional Practice Committee in July 2014 and approved by the Executive Committee of the Board of Directors in July 2014.

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the fact that the behavior is caused by low or high blood glucose levels that may require treatment.

The diabetes regimen must be adapted quickly to the child's dynamic growth and development. As the child develops and desires greater autonomy, child care providers and parents/guardians may face challenges with the toddler's refusal to cooperate with his or her diabetes care regimen (8). Once the child enters the prekindergarten years, he or she may begin to be able to participate in his or her own care by indicating food preferences, checking blood glucose, and choosing a finger-prick or injection site. With further cognitive and physical development, he or she may verbalize symptoms and become more cooperative, but the child still needs constant supervision and blood glucose monitoring to detect hypo- or hyperglycemia. The age at which children are able to perform self-care tasks is variable and depends on the individual child's capabilities, but self-care is not expected from the young child and the parent/guardian or other caregiver *must* provide diabetes management and perform associated diabetes care tasks such as blood glucose monitoring and insulin administration (5,8) (Table 1).

Language barriers, ethnic and cultural practices, limited resources and support, geography (rural vs. urban setting), and health literacy and capabilities must also be considered in developing the care plan.

Another challenge in the child care setting may be staff turnover and ensuring that trained staff members remain available. Regardless, the child care program must be prepared to provide needed care to the child, and parents and health care providers play a pivotal role in partnering with the child care staff.

Key Points

- The safety, health, and well-being of the child as he or she transitions from home to the child care setting are achieved through effective collaboration between the diabetes health care provider, parents/guardians, and child care staff.
- Adults must provide most, if not all, of the diabetes care to young children because of their limited motor, cognitive, and communication skills as well as

other abilities that are necessary to participate in self-management.

- As the child grows older and becomes closer to school age, he or she may participate in care tasks as appropriate for the individual child, but adult supervision must always be present.
- Challenges in the child care setting include staff turnover, language barriers, ethnic and cultural practices, limited resources and support, geography (rural vs. urban setting), and health literacy and capabilities.

DIABETES CARE

The Diabetes Control and Complications Trial (DCCT) showed a significant link between blood glucose control and a slower onset and progression of diabetes complications in adults and adolescents, with improved glycemic control decreasing the risk of micro- and macrovascular complications (5,9,10). Although the DCCT did not include young children (the lower age limit at enrollment was 13 years), the general message—optimize blood glucose control while avoiding hypoglycemia—has been clinically applied to young children. Furthermore, recent data from cross-sectional neuroimaging studies in young children appear to reinforce the importance of aiming for blood glucose levels in range and avoiding hypo- and hyperglycemia (11).

Nutrition and Physical Activities

The parent/guardian remains primarily responsible for determining and providing healthy food choices for the child. The parent/guardian should educate the staff on general information on the carbohydrate content of the food, regardless of whether it is provided by the parent/guardian or child care program. If a child care program provides the meals and snacks, the parent/guardian and the child care provider should work together to determine appropriate food choices and portion sizes for the child. The child care program should ensure that the child eats the appropriate amount of food that is being covered by insulin in accordance with the diabetes medical management plan (DMMP). See the section on DMMP for further details.

For children who regularly attend child care programs for longer durations or where meals or snacks and physical activity are part of the daily schedule,

sufficient staff should receive comprehensive training in diabetes management and be prepared to provide diabetes care as needed. At least one staff member should be available at all times to help with food decisions, blood glucose monitoring, and insulin administration.

Increased sensitivity in caring for the child around special occasions (such as parties/celebrations), physical activities, or illnesses is particularly important. The child should be allowed to participate in celebrations, but special considerations may be required to accommodate the child's diabetes needs. Effective communication between the child care staff and the parent/guardian to anticipate the adjustments (e.g., administering additional insulin to account for the birthday cake) will enable the young child to feel included. Resources are available to parents/guardians, child care providers, and health care providers to assist with this education and training (12–15).

Children who participate in programs for only a few hours may consume snacks and not meals; therefore, insulin administration may not be required in the child's DMMP. However, at a minimum, in order to facilitate safe diabetes care in all child care programs, child care staff must have a basic understanding of diabetes; be able to check blood glucose levels; be able to prevent, recognize, and treat hypoglycemia; be able to handle diabetes emergencies; and know who to contact for help (12–14,16).

Hypoglycemia

For the very young child, the diabetes management priority is the prevention and management of hypoglycemia and the avoidance of wide fluctuations in blood glucose levels. Parents/guardians face the perpetual struggle of balancing the risk of long-term complications from hyperglycemia with the fear of acute hypoglycemia, all while trying to facilitate a "normal" childhood. More notably, parents worry about the possibility of cognitive deficits and/or death if a severe hypoglycemic event is undetected and untreated. Therefore, hypoglycemia prevention is critical. Child care staff should be educated on how to prevent and recognize hypoglycemia by monitoring the child's food consumption, activity, and behavior and confirming a suspected low with blood glucose monitoring (5,8,17). Parents/guardians should provide specific

Table 1—Major developmental issues and their effect on diabetes in children and adolescents

Developmental stages (ages)	Normal developmental tasks	Type 1 diabetes management priorities	Family issues in type 1 diabetes management
Infancy (0–12 months)	Developing a trusting relationship or bond with primary caregiver(s)	Preventing and treating hypoglycemia Avoiding extreme fluctuations in blood glucose levels	Coping with stress Sharing the burden of care to avoid parent burnout
Toddler (13–26 months)	Developing a sense of mastery and autonomy	Preventing hypoglycemia Avoiding extreme fluctuations in blood glucose levels due to irregular food intake	Establishing a schedule Managing the picky eater Limit-setting and coping with toddler's lack of cooperation with regimen Sharing the burden of care
Preschooler and early elementary school (3–7 years)	Developing initiative in activities and confidence in self	Preventing hypoglycemia Coping with unpredictable appetite and activity Positively reinforcing cooperation with regimen Trusting other caregivers with diabetes management	Reassuring the child that diabetes is no one's fault Educating other caregivers about diabetes management
Older elementary school (8–11 years)	Developing skills in athletic, cognitive, artistic, and social areas Consolidating self-esteem with respect to the peer group	Making diabetes regimen flexible to allow for participation in school or peer activities Child learning short- and long-term benefits of optimal control	Maintaining parental involvement in insulin and blood glucose management tasks while allowing for independent self-care for special occasions Continuing to educate school and other caregivers
Early adolescence (12–15 years)	Managing body changes Developing a strong sense of self-identity	Increasing insulin requirements during puberty Diabetes management and blood glucose control becoming more difficult Weight and body image concerns	Renegotiating parent and teenager's roles in diabetes management to be acceptable to both Learning coping skills to enhance ability to self-manage Preventing and intervening in diabetes-related family conflict Monitoring for signs of depression, eating disorders, and risky behaviors
Later adolescence (16–19 years)	Establishing a sense of identity after high school (decisions about location, social issues, work, and education)	Starting an ongoing discussion of transition to a new diabetes team (discussion may begin in earlier adolescent years) Integrating diabetes into new lifestyle	Supporting the transition to independence Learning coping skills to enhance ability to self-manage Preventing and intervening with diabetes-related family conflict Monitoring for signs of depression, eating disorders, and risky behaviors

strategies, if needed, to help the child care staff address the individual child's specific needs. Routine blood glucose monitoring at prespecified times may help to detect hypoglycemia before it manifests with acute symptoms in the child.

Hyperglycemia

Although hypoglycemia is a significant concern, hyperglycemia should be managed as well. The child may experience frequent urination (polyuria), which may be confused with "heavy diapers" or "wetting accidents," a common occurrence in this age-group anyway. A child care provider unfamiliar with diabetes and polyuria may not realize that the child is hyperglycemic, requiring

insulin, and instead may feed the child or give him or her juice, inadvertently aggravating hyperglycemia. Untreated hyperglycemia may lead to ketone production, which may be measured by checking urine ketones.

The ADA has previously recommended higher blood glucose targets for young children in an effort to prevent hypoglycemia. However, the ADA has recently adjusted its target recommendations to an A1C of <7.5% in all pediatric age-groups (<19 years of age) but with the goal of achieving the best A1C possible without hypoglycemia. The new recommendation is a product of reduced hypoglycemia seen with newer rapid-acting insulin

analogs and improved glucose monitoring devices and the awareness of the potential impact of chronic hyperglycemia on the development of future long-term complications (6).

Blood Glucose Monitoring

Blood glucose monitoring allows child care providers to assess if a child is hypo- or hyperglycemic and perform appropriate interventions. Blood glucose levels need to be checked before meals/snacks, before physical activity, and when the child exhibits symptoms of hypo- or hyperglycemia. These symptoms may be subtle, especially in young children. For this reason, blood glucose needs to be checked more frequently in young children.

Continuous Glucose Monitors

Some children use a continuous glucose monitor (CGM) to record blood glucose levels. CGM results must be confirmed with blood glucose tests. Parents/guardians should discuss CGM management with child care providers. A basic understanding of CGM use is warranted, but detailed management should not be expected of child care providers. Safe monitoring must include the following recommendations:

1. Avoid community exposure to sharps and other medical waste.
2. Minimize trauma to the finger or relevant lancing site.

Blood lancing devices must not be reused, point-of-care devices should only be used for the designated child, and child care providers should use gloves when testing (8). The ADA's Safe at School program is a helpful resource to assist schools (18).

Insulin Administration

Children with diabetes who attend child care programs must have access to insulin, glucagon, and other medications to safely participate in the programs. Training child care staff on insulin administration is a critical component of diabetes management, especially for those caring for children who participate in daylong (4- to 8-h) programs and who will likely need insulin administered during the programs. For resources, please see RESOURCES for ADA's Safe at School program.

Glucagon

Glucagon may be indicated if a child has severe hypoglycemia and is unable to consume glucose or is having a hypoglycemic seizure. Although a glucagon kit requires a prescription, any individual may administer glucagon. Child care staff should be trained in the administration of glucagon or, if indicated, mini-dose glucagon (19). It is also important to ensure that the glucagon kits are not expired (5).

Key Points

- The DCCT showed that improved glycemic control decreases long-term diabetes complications in adolescents (≥ 13 years of age) and adults and helped establish intensive therapy as the standard of care. Although young children were not included in the study, the same principles apply to this age-group.

- Regardless of the amount of time the child spends in the child care setting, staff should monitor carbohydrate intake and understand the impact of carbohydrates and physical activity as set out in the child's DMMP.
- Trained child care staff should be available to meet the child's basic diabetes needs, including the recognition and treatment of hypo- and hyperglycemia, blood glucose monitoring, and insulin and glucagon administration.
- Diabetes management requirements may vary depending on the length, frequency, and activities of the child care program.
- The key diabetes management priority for younger children is the prevention, recognition, and treatment of hypo- and hyperglycemia to keep the child safe and healthy.

DMMP

The child's written care plan, such as the DMMP, facilitates appropriate diabetes management and is essential to achieving optimal glycemic control. The DMMP contains the medical orders that are the basis for the provision of care in the child care setting and is the child's individual care plan. It is developed by the child's own diabetes health care provider with input from the parent/guardian. A sample DMMP for the child care setting may be found at the end of this document or at www.diabetes.org/childcare. The DMMP should address the specific needs of the child and provide instructions for each of the following:

1. Blood glucose monitoring, including the frequency and circumstances requiring blood glucose checks and the use of CGM systems;
2. Insulin administration including doses and administration times prescribed for specific blood glucose levels and for carbohydrate intake, the storage of insulin, and the use of the prescribed insulin delivery device, including syringe, pen, or pump;
3. Symptoms and treatment of hypoglycemia, including the administration of glucagon;
4. Symptoms and treatment of hyperglycemia, including insulin administration;
5. Urine or blood ketone checks and appropriate actions based on a child's ketone level.

The child care program needs to coordinate and arrange diabetes education provided by a diabetes health care professional and/or the parent/guardian at an appropriate level and with proper considerations for the child care staff. All staff members responsible for the child should have a basic knowledge of the child's diabetes, understand basic diabetes management, and know who to contact for help. Designated staff members who will be performing diabetes care tasks need advanced diabetes education that includes blood glucose monitoring, insulin and glucagon administration, monitoring of carbohydrate intake and physical activity, and recognizing and treating hyperglycemia (monitoring for excessive urination or thirst, allowing bathroom privileges, and administering insulin) and hypoglycemia (monitoring for sleepiness, lethargy, shakiness, or other symptoms and providing appropriate carbohydrate sources even if outside the allotted snack or meal time frames). Emergency treatment, including glucagon administration, should also be taught with clear instructions for the next steps if the interventions are unsuccessful (Table 2).

LAWS PROTECTING CHILDREN WITH DIABETES

Federal antidiscrimination laws, including the Americans with Disabilities Act (20) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (21), prohibit discrimination on the basis of disability. The Individuals with Disabilities Education Act (IDEA) requires pre-kindergarten programs to identify children with disabilities and to provide them with a free and appropriate education (22).

The Americans with Disabilities Act prohibits discrimination against people with disabilities by places of public accommodation, including camps and child care programs. This includes even a home-based setting, if the program is open to the public. Programs operated by religious organizations, such as a child care program run by a church, are not subject to the nondiscrimination obligations under federal law unless the program receives federal funds. Child care providers with obligations under the Americans with Disabilities Act must make reasonable

Table 2—Diabetes care tasks prescribed by DMMP to be provided by child care staff

Task	Frequency	Equipment/supplies (provided by parent/guardian)
Blood glucose monitoring	Before food intake and physical activity and when low or high blood glucose is suspected	Blood glucose meter, lancet, lancing device, test strips, CGM*
Insulin administration	Before or after food intake and to treat high blood glucose	Insulin, delivery device (pump, pen, syringe)
Food intake scheduling and monitoring	Snacks and meals provided and/or monitored to ensure food consumption is in accordance with insulin dosing	Food, carbohydrate information
Hypoglycemia treatment	Awareness that unusual behaviors after physical activity or insulin administration may signify hypoglycemia	Quick-acting carbohydrate and glucagon
Hyperglycemia treatment	Awareness that increased urination or drinking may signify hyperglycemia	Noncarbohydrate-containing liquid, insulin
Ketone monitoring	Check ketones if repeated blood glucose tests show elevation above target range or if the child is ill	Urine or blood ketone strips, ketone monitor

*This device may or may not be used by the child.

modifications to their policies and practices to enable a child with a disability, such as diabetes, to fully participate in the program unless the modifications impose an “undue hardship” or cause a “fundamental alteration” to the nature of the program (20,21,23). The child care program must conduct an individual assessment to determine whether or not it can meet the child’s needs without imposing undue hardship or fundamentally altering the program.

Section 504 prohibits discrimination on the basis of disability by any entity receiving federal funds—including religious organizations. Types of programs covered by Section 504 might include after-school child care programs offered by a public school system and child care programs run by universities. The obligations of a child care program subject to Section 504 are very similar to those obligations under the Americans with Disabilities Act, including a requirement to conduct an individualized assessment of a child’s needs. Both the Americans with Disabilities Act and Section 504 require programs to provide disability-related accommodations if they are necessary and reasonable. Many of the needed accommodations can be provided by the child care program without significant costs. Some accommodations that may be needed include having a trained employee who can perform blood glucose checks, administer insulin and glucagon, recognize and promptly treat hypo- and hyperglycemia, and make sure the child consumes needed carbohydrates.

In addition, many states have laws that impact the provision of diabetes care in the child care setting. Even though federal laws provide protection for children with disabilities, such as diabetes, state laws, regulations, or policies and guidelines often affect whether nonnursing staff in the child care setting can administer medication, including insulin and glucagon, to a child with diabetes. Some states have specific child care rules that place requirements on child care programs to provide care to children with chronic illness, specify how staff must be trained, or specify whether and how medication may be administered to children. State laws cannot, however, lessen a child care program’s obligations under federal law.

Children with diabetes in child care programs still face discrimination despite the protections and requirements of federal and state laws. For example, some child care programs refuse to enroll a child with diabetes, and some programs refuse to allow a newly diagnosed child back into the program. Some centers will enroll a child only if the parent/guardian agrees to come to the center to provide needed care. Many other programs have “no injection” or “no medication” policies that do not consider the individual child’s needs. This type of treatment jeopardizes the health and safety of the child, and such blanket policies are unlawful. For more information and resources to help with diabetes management in the child care setting or if a child is experiencing discrimination in the child care setting, call

1-800-DIABETES (342-2382) or go to www.diabetes.org/childcare.

Key Points

- Federal and some state laws provide protections for children with diabetes in the child care setting.
- Despite federal and state laws, children in child care programs still face discrimination, jeopardizing their health and safety or making it difficult for them to enroll in child care.

KEY PRINCIPLES

Here, we reiterate the discussed concepts; however, the section is structured so that it outlines the legal principles and the roles and responsibilities of the individuals involved.

1. **Acceptance for enrollment.** Child care programs should not deny admission to a child based on diabetes or the need for diabetes care. The parent/guardian should share strategies for overcoming challenges specific to their child, such as poor communication or resistance to diabetes care tasks. If a child care center refuses to enroll or provide diabetes care to a child, it is important to determine the center’s concerns and see if the concerns can be addressed through education and training.
2. **Written care plans.** As stated previously, a written care plan, such as an individualized DMMP, should be developed by the child’s personal diabetes health care team in collaboration with the parent/guardian.
3. **Provision of care by child care staff.** After consulting with the parent/guardian and reviewing the child’s

current DMMP, the child care program should perform an assessment of the child's needs to determine how it will provide diabetes care. An identified group of child care staff who are willing to provide direct care for the child with diabetes should receive advanced training from a diabetes health care professional or the parent/guardian on routine and emergency diabetes care so that at least one staff member is always available to provide diabetes care.

- 4. Basic training for all staff in a child care setting.** The child care provider should work with the parents/guardians to arrange for training by a diabetes health care professional or the parent/guardian in basic diabetes education and identify additional training resources as needed. All child care staff members who are responsible for the child with diabetes should receive basic training that provides:

- 1) An overview of diabetes that includes information on how to recognize and respond to hypo- and hyperglycemia and
- 2) Instruction on identifying medical emergencies and contacting the right personnel with questions or in case of an emergency.

- 5. Advanced training for a small group of child care staff.** Advanced training provided by a diabetes health care professional or parent/guardian should include:

- 1) All components of basic diabetes training as listed above;
- 2) Instruction on how to perform blood glucose monitoring, insulin and glucagon administration, and urine and/or blood ketone checks;
- 3) Training on the recognition and treatment of hypo- and hyperglycemia; and
- 4) Basic carbohydrate counting/monitoring carbohydrates.

- 6. Instruction should include demonstration of the care tasks and a plan for ongoing training.** The number of staff members trained should be sufficient to ensure that at least one staff member who can provide routine and emergency diabetes care, such as insulin and glucagon administration, will be available at all times.

- 7. Participation in diabetes care should be allowed for capable children.** Child care programs should support the child in his or her development by allowing participation in diabetes tasks in accordance with the child's competencies, as outlined in the DMMP. A preschooler may be able to participate in his or her diabetes care by checking blood glucose or choosing a finger-prick or injection site, all under the supervision of an adult.

Key Points

- Child care centers should not deny admission on the basis of a child having diabetes.
- A written care plan with medical orders, such as a DMMP, should be provided by the diabetes care provider and parent/guardian to the child care setting.
- All child care staff responsible for the child with diabetes should receive basic training.
- Advanced, child-specific training should be provided to a small number of child care staff, and there should be at least one trained staff member available to provide care at all times.

RESPONSIBILITIES OF STAKEHOLDERS

- 1. The parent/guardian should provide the child care program with:**

- Information about diabetes management and training resources if needed
- A completed written care plan, such as a DMMP, signed by a child's diabetes health care provider
- Current and accurate emergency contact information including phone numbers for the parent/guardian and the child's diabetes health care provider
- All materials, equipment, supplies, insulin/medication, and food needed for diabetes management and ongoing monitoring of supplies for replenishment or replacement if expired
- An appropriate container for the disposal of sharps
- A method of communication between the parent/guardian and the child care program, such as a logbook or electronic diabetes management application

- Basic diabetes training (if needed) for all child care staff members who have responsibility for the child and advanced child-specific training for the designated child care staff members who are responsible for providing regular daily care to the child
- Information about factors that may impact blood glucose levels, such as the child's daily activity level, food intake prior to arrival at the center, and whether the child is experiencing an illness
- Consent to release confidential health information so that the child care program can communicate directly with the child's diabetes health care provider and direction on when such communication is appropriate

- 2. The child care program should:**

- Understand federal and state laws and regulations as they apply to children with diabetes
- Assess how the child care program will provide routine and emergency care after consulting with parent/guardian and reviewing the DMMP
- Recruit and designate staff who will be responsible for the provision of diabetes care to the child
- Work with parents/guardians to arrange for training for all staff members who have responsibility for the child and advanced child-specific training for designated child care staff members who are responsible for providing daily care to the child
- Provide secure and immediate accessibility of diabetes materials, equipment, supplies, insulin/medication, and food to trained staff members
- Provide support to all families of children in its care who are faced with language barriers and limited resources and be aware of and share community resources for families of children with diabetes
- Maintain accurate documentation of all diabetes care provided to a child in its care
- Collaborate with parents/guardians and/or diabetes health care providers to obtain current information about the care of children with diabetes

- Regularly communicate blood glucose results, insulin administration, treatment of hypo- and hyperglycemia, food intake, and physical activity using a logbook, electronic application, or other method provided by the parent/guardian
- Treat children with diabetes the same as other children, except to meet their diabetes needs
- Respect the child's and family's confidentiality and right to privacy

3. The child's diabetes health care provider should provide:

- A completed and signed written care plan containing medical orders, such as a DMMP, with updates as needed
- In conjunction with the parent/guardian, basic and advanced training to child care staff
- Availability to respond to questions about the child's care with parental consent
- Ongoing diabetes expertise and guidance as needed
- Advocacy, as needed, to ensure a child's needs are met while in the child care setting

Key Points

- Parents/guardians, child care staff, and the child's health care provider all play important roles in ensuring appropriate care of the child with diabetes in a child care program. Each has specific roles and responsibilities to ensure that the child is maintained in a healthy and safe child care environment.

CONCLUSION

It is well understood that young children with diabetes have unique needs. Young children require a carefully thought-out, proactive diabetes care plan and not a reactive one (i.e., crisis management) that must be developed with the health care provider, parents/guardians, and child care staff. Unfortunately, despite all the best efforts of the parents/guardians, care may be suboptimal in the child care setting. For those instances, there are federal laws that protect the rights of the young child. Violation of these rights may be subject to legal action. Recommended resources for parents are listed below. We encourage parents/guardians of young children

with diabetes to share this Position Statement with their child care providers. Ensuring the long-term health of and providing the best care to these young children should be of paramount importance.

RESOURCES

- American Diabetes Association. Child Care Setting tools (including Child Care DMMP): www.diabetes.org/childcare and www.diabetes.org/forparentsandkids.
- American Diabetes Association. Safe at School resources and information: www.diabetes.org/safeatschool.
- American Diabetes Association. Diabetes Care Tasks at School: What Key Personnel Need to Know: www.diabetes.org/schooltraining.
- National Diabetes Education Program. Helping the Student with Diabetes Succeed: A Guide for School Personnel (2010): http://ndep.nih.gov/media/Youth_NDEPSchoolGuide.pdf.

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References

1. Torpy JM, Campbell A, Glass RM. Chronic diseases of children. *JAMA* 2010;303:682
2. Pettitt DJ, Talton J, Dabelea D, et al. Prevalence of diabetes in U.S. youth in 2009: the SEARCH for Diabetes in Youth study. *Diabetes Care* 2014;37:402–408
3. Dabelea D, Mayer-Davis EJ, Saydah S, et al. Prevalence of type 1 and type 2 diabetes among children and adolescents from 2001 to 2009. *JAMA* 2014;311:1778–1786
4. Vehik K, Hamman RF, Lezotte D, et al. Increasing incidence of type 1 diabetes in 0- to 17-year-old Colorado youth. *Diabetes Care* 2007;30:503–509
5. American Diabetes Association. Standards of Medical Care in Diabetes—2014. *Diabetes Care* 2014;37(Suppl. 1):S14–S80
6. Chiang JL, Kirkman MS, Laffel LMB, Peters AL. Type 1 diabetes through the life span: a position statement of the American Diabetes Association. *Diabetes Care* 2014;37:2034–2054
7. Child Care Aware of America. Child Care Resource and Referral Agencies for Child Care Aware of America's 2012 State Fact Sheet Survey [Internet]. Arlington, VA. Available

from <http://www.naccrra.org/>. Accessed 3 June 2014

8. Peters AL, Laffel L (Eds). *American Diabetes Association/JDRF Type 1 Diabetes Sourcebook*. Alexandria, VA, American Diabetes Association, 2013
9. Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993;329:977–986
10. Diabetes Control and Complications Trial Research Group. Effect of intensive diabetes treatment on the development and progression of long-term complications in adolescents with insulin-dependent diabetes mellitus: Diabetes Control and Complications Trial. *J Pediatr* 1994;125:177–188
11. Barnea-Goraly N, Raman M, Mazaika P, et al. Alterations in white matter structure in young children with type 1 diabetes. *Diabetes Care* 2014;37:332–340
12. American Diabetes Association. Diabetes care in the school and day care setting. *Diabetes Care* 2014;37(Suppl. 1):S91–S96
13. American Association of Diabetes Educators. Management of children with diabetes in the school setting [Internet]. Chicago, IL, American Association of Diabetes Educators, 2012. Available from http://www.diabeteseducator.org/ProfessionalResources/position/position_statements.html. Accessed 3 June 2014
14. National Diabetes Education Program. Helping the Student with Diabetes Succeed: A Guide for School Personnel. Bethesda, MD, National Institutes of Health (NIH publication no. 10-5217, revised September 2010)
15. American Diabetes Association. Diabetes Care Tasks at School: What Key Personnel Need to Know [Internet]. Alexandria, VA, American Diabetes Association, 2008. Available from www.diabetes.org/schooltraining. Accessed 3 June 2014
16. International Diabetes Federation. Global IDF/ISPAD Guideline for Diabetes in Childhood and Adolescence. Brussels, Belgium, International Diabetes Federation, 2011
17. Seaquist ER, Anderson J, Childs B, et al. Hypoglycemia and diabetes: a report of a workgroup of the American Diabetes Association and The Endocrine Society. *Diabetes Care* 2013;36:1384–1395
18. American Diabetes Association. Safe at School [Internet]. Alexandria, VA, American Diabetes Association. Available from <http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school>. Accessed 25 June 2014
19. Haymond MW, Schreiner B. Mini-dose glucagon rescue for hypoglycemia in children with type 1 diabetes. *Diabetes Care* 2001;24:643–645
20. Americans with Disabilities Act of 1990. 42 U.S.C. 12181-12189
21. Rehabilitation Act of 1973. 29 U.S.C. 794
22. Individuals with Disabilities Education Act. 20 U.S.C. 1400 et seq
23. Rapp JA, Arent S, Dimmick BL, Gordon K, Jackson C. *Legal Rights of Students with Diabetes*. 2nd ed. Alexandria, VA, American Diabetes Association, 2009

Child Care Diabetes Medical Management Plan



YOUR RIGHTS. ONE VOICE.

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____
 Parent or Guardian Name(s)/Number(s): _____
 Diabetes Care Provider Name/Number: _____
 Diabetes Care Provider Signature: _____ Date: _____
 Location of diabetes supplies at child care facility: _____

Blood Glucose Monitoring

Target range for blood glucose is: 80-180 Other _____
 When to check blood glucose: before breakfast before lunch before dinner before snacks
 When to do extra blood glucose checks: before exercise after exercise when showing signs of low blood glucose
 when showing signs of high blood glucose other _____

Insulin Plan: Please indicate which type of insulin regimen this child uses (check one):

Insulin Pump Multiple Daily Injections Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): Regular Apidra Humalog Novolog NPH
 Lantus Levemir Mix Other _____

Plan A: Insulin Pump*

- Always use the insulin pump bolus wizard: Yes No
 If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
- Blood glucose must be checked before the child eats and will (check one):
 Be sent to the pump by the meter
 Need to be entered into the pump
- The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
- After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
- Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

Plan B: Multiple Daily Injections

- Child will receive a fixed dose of _____ long-acting insulin at _____ Yes No
- Follow blood glucose monitoring plan above.
- Use _____ insulin for meals and snacks. Insulin dose for food is _____ unit(s) for meals **OR** _____ unit(s) for every _____ grams carbohydrate.
 Give injection after the child eats.
- If blood glucose is above target, add correction dose to:
 Breakfast Snack
 Lunch Snack
 Other: _____
 Use the following correction factor _____ or this scale:
 _____ units if BG is _____ to _____
 _____ units if BG is _____ to _____
 _____ units if BG is _____ to _____
 _____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

C: Fixed Insulin Doses

- Child will receive a fixed dose of long-acting insulin? Yes No
 If yes, give child _____ units of _____ insulin at _____.
- Insulin correction dose at child care (_____ insulin)?
 Yes No
- If blood glucose is above target, add correction dose to:
 Breakfast Snack
 Lunch Snack
 Other: _____
 Use the following correction factor _____ or the following scale:
 _____ units if BG is _____ to _____
 _____ units if BG is _____ to _____
 _____ units if BG is _____ to _____
 _____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast-acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast-acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15 grams of carbohydrate as snack. Do not give insulin with this snack.
5. Contact the parent/guardian any time blood glucose is less than _____ mg/dL at child care.

Usual symptoms of hypoglycemia for this child include:

- Shaky Fast heartbeat Sweating
 Anxious Hungry Weakness/Fatigue
 Headache Blurry vision Irritable/Grouchy
 Dizzy Other _____

1. If you suspect low blood glucose, check blood glucose.
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
 - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
 - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardians. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

Usual symptoms of hyperglycemia for this child include:

- Extreme thirst Very wet diapers, accidents
 Hungry Warm, dry, flushed skin Tired or drowsy
 Headache Blurry vision Vomiting**
 Fruity breath Rapid, shallow breathing
 Abdominal pain Unsteady walk (more than typical)

**If child is vomiting, contact parents immediately

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
 - urine blood (parent will provide training)
2. If ketones are moderate or large, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
Contact parent if ketones are trace or small: Yes No
3. Children with high blood glucose will require additional insulin if the last dose of Insulin was given 3 or more hours earlier. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar-free fluids as tolerated.
5. You may also:
 - Provide carbohydrate-free snacks if hungry
 - Delay exercise
 - Change diapers frequently/give frequent access to the bathroom
 - Stay with the child

Diabetes Dictionary

Blood glucose - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The blood glucose level is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

Bolus - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator - A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction factor - The drop in blood glucose level, measured in milligrams per deciliter (mg/dL), caused by each unit of insulin taken. Also called **insulin sensitivity factor**.

Diabetic ketoacidosis (DKA) - An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Fixed-dose regimen - Children with diabetes who use a fixed-dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct hyperglycemia.

Glucagon - A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia - Excessive blood glucose, greater than 240 mg/dL for children using an insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA)**.

Hypoglycemia - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

Insulin pump - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

Multiple daily injection regimen - Multiple daily insulin regimens typically include a basal, or long-acting, insulin given once per day. A short-acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 diabetes - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

Physician Signature _____



ARIZONA STATE LEGISLATURE
 Fifty-second Legislature - Second Regular Session

INTERIM COMMITTEE ATTENDANCE RECORD

COMMITTEE ON Diabetes Treatment in Child Care Facilities Ad Hoc

CHAIRMAN: Rep. Heather Carter VICE-CHAIRMAN: N/A

DATE	9/26/16	1/16	1/16	1/16	1/16
CONVENED	10:15 am	m	m	m	m
RECESSED					
RECONVENED					
ADJOURNED	11:43 am				
MEMBERS					
Dr. Dawn Barcellona	✓				
Rep. Kate Brophy McGee	exc				
Dr. Rachel Calendo	exc				
Juliaette Chamberlain	✓				
Anne Dennis	✓				
James Emch	✓				
Rep. Randall Friese	✓				
Kim Miller	✓				
Rep. Heather Carter, Chairman	✓				

✓ Present --- Absent exc Excused