Exclusion of Mildly Ill Children From Childcare

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Your schedulers fit in Suzy, a 24-month-old girl who has eye discharge, for a same-day appointment at 2 p.m. Mother states Suzy has had a runny nose and mild cough for the past 2 days but is acting fine. She was “kicked out” of the childcare center at 10 a.m. that day because the caregivers noted some yellowish discharge from the eyes. Mom was instructed to take Suzy to the doctor to get her diagnosed and treated, and to get a signed note from you before she could return to care.

The exam shows scant yellow eye discharge without injected conjunctivae, and mild nasal congestion. You decide to write a return-to-care note and not to prescribe any topical antibiotics. Mom is very thankful that you worked her into your busy schedule, but frustrated that she had to miss work for this problem. You think to yourself, “There are several things wrong with this interaction! What are we doing here?”

This scenario unfolds in outpatient practices and emergency departments every day. In this article, we describe the extent of childcare illness and unnecessary exclusion practices, raise awareness of current guidelines, and discuss strategies for pediatric health providers to address this important issue.

SCOPE OF THE PROBLEM

Demographics

Two-thirds of all children in the United States younger than the age of 6 years now require nonparental childcare services as a result of an increased number of working parents, single parents, and socioeconomic necessity. Welfare reform has increased work requirements for parents with young children and contributed to the increasing number of poor and minority families requiring...
UNNECESSARY EXCLUSIONS

Some CCC exclusions are necessary, especially if the child cannot participate adequately in activities or if he or she requires more care than staff can provide while still maintaining adequate staffing ratios. An ill child who cannot safely or appropriately attend childcare should be with a parent. Many studies, however, show a large proportion (33% to 100%) of exclusions is unnecessary, i.e., they do not meet accepted exclusion guidelines. In a state without childcare exclusion guidelines, for every one child appropriately excluded, six children were inappropriately excluded. Clearly, substantial work needs to be done to improve unnecessary childcare exclusion practices.

INAPPROPRIATE HEALTH CARE UTILIZATION

Parents without adequate paid sick leave may seek medical evaluation when their child becomes ill to avoid wage or job loss. Some health care visits appear to result from exclusion policies that may mandate a doctor’s note or diagnosis before a child can return to childcare. Eighty percent of parents of children excluded from childcare report they would not have scheduled the visit if it had not been required by childcare policies. Although parents recognize the nonurgent nature of their child’s condition, they may use the emergency department to get their child back into childcare in a timely manner. Childcare providers (CCPs) may also pressure parents to place children on antibiotics before returning to childcare.

EFFORTS TO ADDRESS THIS PROBLEM

Policy

Developing childcare exclusion and return-to-care guidelines has been both challenging and controversial. The American Academy of Pediatrics (AAP) has developed numerous references and materials on this subject targeted toward pediatric health providers and CCPs. The AAP and the American Public Health Association (APHA) developed national guidelines for exclusion criteria based on the best available evidence in 1992, with revisions in 2002 and 2011. The AAP’s Red Book is another source of exclusion and return-to-care criteria. In 2004, the AAP produced “Managing Infectious Diseases in Child Care and Schools,” revised in 2009, with content that was specifically written for CCPs in simple, user friendly language. Exclusion and return-to-care criteria are also presented in handouts that can be copied and given to parents, pediatric health providers, or CCPs.

Training

Despite the existence for nearly 2 decades of national guidelines, their adoption at the state level has been slow, and states’ guidelines remain substantially variable. Presence of state guidelines alone, without any mechanism for ongoing childcare training, does not appear to improve CCPs’ illness management and exclusion decisions. To address the lack of knowledge and use of the guidelines, the AAP has developed an online CCP training; however, it is too early to determine how widely adopted and effective this curriculum will be. In addition, a Pedialink e-learning module is under construction on the AAP website.

REASONS FOR EXCLUSION

Although infectious disease outbreaks such as E. coli, Shigella, and Salmonella are more common in childcare settings, most childcare illnesses are minor in severity. Children with runny nose, cough, and sore throat make up 79% of episodes of illness in childcare attendees, followed by fever (16%); gastroenteritis (11%); earache (7%); rash (6%); and pinkeye (1%). Children with fever, gastroenteritis, rash, and pinkeye have disproportionately more days absent than would be suggested by the incidence of these symptoms, probably due to stricter exclusion criteria for these conditions.

PROPER EXCLUSION PROTOCOLS

Pediatricians’ knowledge about the AAP’s exclusion policies is low (61%) and no better than parents’ and CCPs’ knowledge. Regardless of the condition, any ill child should be excluded if CCPs determine that the child:

• Is unable to participate in activities.
• Requires more care than staff can provide while maintaining safe staffing ratios for the other children.
These two general exclusion criteria allow CCPs to act in the best interest of the ill child and other children under their care.\textsuperscript{32}

**RATIONALE**

**Fever**
Most febrile children will not be able to participate in activities and will be excluded. Transient temperature rises, however, can occur due to vigorous exercise or viremia and are not associated with other symptoms. CCPs should avoid measuring temperatures unless the spike in temperature is associated with behavioral changes. Excluding febrile children is unlikely to reduce the spread of disease because pathogens are spread by asymptomatic children.\textsuperscript{36}

**Diarrhea**
Outbreaks of diarrhea can be difficult to control, especially if the child has spillage outside diapers or pants.\textsuperscript{9} Disease spread can be reduced with strict adherence to toileting and diaper changing procedures.\textsuperscript{37} Care for children with diarrhea, however, can be labor-intensive, potentially affecting safe staffing ratios; therefore, the provision regarding increased frequency of stooling over a child’s baseline was recently added to exclusion guidelines (see Table).

**Vomiting**
The spread of potentially infectious material in a vomiting child is very difficult to control. Children with more than one episode of vomiting should be excluded.

**Rash**
Causes are extensive and may include viral, fungal, and bacterial etiologies, as well as infestations, and chronic conditions such as eczema. An exclusion policy to cover all rashes is difficult. We immunize against harmful rash-causing bacterial and viral infections such as *Haemophilus influenzae* type b, *Streptococcus pneumoniae*, measles, and varicella. Immediate exclusions and mandated health visits are not necessary for a well-appearing child with a rash who does not have fever, oozing sores, or other symptoms. Exclusions and mandated visits for nonspecific viral exanthems, tinea corporis, and eczema are common, but not necessary.

**Bacterial conjunctivitis**
Bacterial conjunctivitis, or pink eye, typically resolves without treatment in 5 to 6 days, slightly sooner with topical antibiotic drops.\textsuperscript{38} Pink eye, like the common cold, is contagious, but exclusion is not indicated because there is no evidence that treatment reduces spread, and the child is usually not very ill. The high level of unfounded fear for this condition by CCPs leads to overdiagnosis, unnecessary treatment, and exclusion for conditions similar to Suzy’s (drainage but no conjunctivitis), nasolacrimal duct obstruction in infants, or conjunctivitis but no drainage (allergic conjunctivitis).

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### TABLE.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Exclude</th>
<th>Return to Care</th>
<th>Health Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Only if associated with behavior change or other signs of illness.</td>
<td>General exclusion criteria resolved.</td>
<td>Not required.</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Yes, if stool not contained in the diaper or if ‘accidents’ occur in toilet-trained children; or if two or more stools above baseline; or if blood or mucus in stool.</td>
<td>Once stool contained in diaper or toilet, frequency has reduced to &lt; 2 over baseline and general exclusion criteria resolved.</td>
<td>Yes, if blood or mucus in stool or there are signs of dehydration.</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Yes, if two or more episodes in 24 hours.</td>
<td>When vomiting ends and general exclusion criteria resolved.</td>
<td>Not required.</td>
</tr>
<tr>
<td>Rash</td>
<td>No, unless rash accompanied by behavior change, fever or drainage.</td>
<td>24 hours of antibiotics if indicated (impetigo or staph infection). General exclusion criteria resolved.</td>
<td>Not required if there is no drainage, behavior change or fever.</td>
</tr>
<tr>
<td>Pinkeye</td>
<td>No.</td>
<td>General exclusion criteria resolved.</td>
<td>Not required. Antibiotics are not required.</td>
</tr>
</tbody>
</table>

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WAYS TO LIMIT UNNECESSARY EXCLUSIONS

Every pediatric health provider can and should:

• Take care of the child. Make decisions regarding antibiotics, exclusion, and return-to-care based on what is best for the child. Avoid placing children on antibiotics solely to satisfy CCP or parent requests when antibiotics are clearly not indicated.

• Communicate with the parent about why their child is ill so often. Assure the parent that these illnesses cause faster immune system maturation and will lead to an overall decrease in infections as the child gets older, relative to other children raised at home.39,40

• Avoid vilifying the CCP for the exclusion. CCPs are acting in what they believe to be the best interest of the child in most cases, even though their decisions may at times not seem logical.

• Communicate with CCPs either by phone or in writing. Provide them with photocopies of the AAP policy on exclusion, contained in “Managing Infectious Diseases in Child Care and Schools.”32 Although the book must be purchased, the AAP allows copying the condition-specific “Quick Reference Sheets.”

• Educate CCPs. Often pediatric health providers are asked to evaluate excluded children to ensure they do not have a “communicable, infectious, or contagious” condition. Pediatric health providers may be asked for a note to affirm lack of contagion before returning. Discussion with CCPs should focus on whether the condition is harmful to others, rather than “contagious.” Children with the common cold are certainly contagious, but can return-to-care as soon as they can participate in activities. In contrast, a child with Shigella is also contagious, but should not return until two stool cultures 24 hours apart are negative, even if symptoms of diarrhea have resolved previously.32

• Become familiar with your state’s childcare exclusion guidelines.33 State guidelines may not agree with the AAP policy. For example, Pennsylvania recommends that children with “infectious conjunctivitis” be excluded;41 the AAP’s revised policy on bacterial conjunctivitis no longer requires exclusion or treatment.32

BECOME MORE INVOLVED

• Serve as a childcare health consultant. Start small by consulting for your own child’s CCP or the largest center near your practice. The AAP has excellent resources for child care health consultants.34

• Teach proper exclusion and return-to-care practices to CCPs using the AAPs free online curriculum.34

• Contact your state’s childcare administration and update exclusion criteria in the childcare licensing code.

CONCLUSION

In summary, children in childcare settings have more episodes of illness compared with children who stay at home. Exclusion practices do not always follow guidelines and are frequently unnecessary. Unnecessary exclusions can affect a family’s financial well-being and lead to inappropriate health care utilization. Pediatric health providers need to become familiar with AAP childcare exclusion guidelines, advocate for AAP policies at the state level, and clearly communicate with CCPs about safe and appropriate exclusion practices.

REFERENCES


