5-20-2022

Development of a Rural Childcare Professionals Advisory Board Focused on Mental and Physical Wellbeing

Danae Dinkel
University of Nebraska at Omaha, dmdinkel@unomaha.edu

John Rech
jprech@unomaha.edu

Natalie Hanna

Denita Julius

Jennifer Bauman

See next page for additional authors

Authors

Danae Dinkel, John Rech, Natalie Hanna, Denita Julius, Jennifer Bauman, Tonya Hood-Hytrek, and Matthew Bice

Development of a Rural Childcare Professionals Advisory Board Focused on Mental and Physical Wellbeing

Danae Dinkel, Ph.D., Associate Professor at University of Nebraska at Omaha in Omaha, Nebraska, United States.

John P. Rech, M.A., Ph.D. student at University of Nebraska at Omaha in Omaha, Nebraska, United States.

Natalie Hanna, Licensed childcare provider in Kearney, Nebraska, United States

Denita Julius, Licensed childcare in Chadron, Nebraska, United States

Jennifer Bauman, Licensed childcare provider in Chadron, Nebraska, United States
.

Tonya Hood-Hytrek, Child Care Food Program consultant for Family Service in Lincoln, Nebraska, United States

Matthew R. Bice, Ph.D., Associate Professor at University of Nebraska at Kearney in Kearney, Nebraska, United States.

Submitted 15 September 2021, revised 7 April 2022, accepted 20 April 2022.

Dinkel, D., Rech, J.P., Hanna, N., Julius, D., Bauman, J., Hood-Hytrek, T., Bice, M.R. (2022) Development of a Rural Childcare Professionals Advisory Board Focused on Mental and Physical Wellbeing. *Progress in Community Health Partnership*s. (Forthcoming.)
20 May 2022

ABSTRACT

Background. Childcare providers have high rates of stress and obesity, which can have an impact on the care they provide for children. Limited research has described strategies for including childcare providers in the development of wellbeing initiatives, especially in rural areas.

Objective. To describe the creation and acceptability of a rural childcare advisory board focused on childcare providers' wellbeing as well as the acceptability of a wellbeing summit implemented by the board.

Methods. A collaborative model guided the actions of the advisory board. Acceptability of the board and the summit were assessed via surveys.

Results. Key factors contributing to the success of the advisory board included flexibility around the COVID-19 pandemic, evening meetings, and group text messaging. Both the advisory board and wellbeing summit were deemed acceptable.

Conclusions. Future efforts are focused on offering an annual statewide wellbeing summit and other interventions. Work is needed to identify sustainable funding sources.

KEYWORDS: Work, Education, Sociology and Social Phenomena, Community health partnerships, Health promotion, Healthy People Programs, Mental Health, Physical Fitness, Rural Health, Rural Population, Occupations, Caregivers

Background

The early years of human development (0-5 years) are the building blocks for lifelong health.[1] With approximately two-thirds of children under age 6 receiving some form of non-parental childcare, the quality of this care including the childcare providers who care for children during this time is essential.[2] Unfortunately, childcare providers experience high levels of mental and physical health concerns including stress, anxiety, depression, overweight/obesity, and physical inactivity.[3,4] In some cases these rates exceed the national averages among working age adults.[3,4] This is due to a variety of occupational health risks within the childcare profession, such as long work hours; low financial compensation; and physically demanding tasks and job duties.[5] Childcare providers own mental and physical health is important as it is linked to the quality of care they provide to children.[4,7,8] For example, childcare providers who experience significant stress are less likely to engage with children in sensitive and responsive ways.[7] Thus, there is an overwhelming need to improve the mental and physical health of childcare providers across the United States, not only to improve their own wellbeing but also to improve the quality of care children receive.[3]

One population of childcare providers especially in need are those in rural areas. Childcare providers located in rural areas face additional disparities compared to their urban counterparts in managing stress and improving physical health.[6] Further, previous research has found that rural childcare providers may have decreased access to resources and professional development opportunities.[9–11] Nebraska is a primarily rural state in the United States with approximately 3,000 licensed childcare facilities of which approximately 46% reside in rural counties.[12] The health of the childcare profession in Nebraska has shown to be no different in comparison to the national averages for childcare providers on health concerns such as

depression, stress, and anxiety.[13] Further, a recent statewide survey concerning COVID-19 found over 20% of childcare providers reported difficulties performing their work duties due to their physical health.[14] Additionally, over 40% reported they either almost never or only sometimes were able to take part in physical activities they enjoyed such as brisk walking, yoga, or group exercise.[12,15] Importantly, providers have reported a desire to have additional resources and training on how to support their personal health and wellbeing.[9] While previous research has reported on efforts to develop community partnerships with rural communities, minimal research has explored how to develop these relationships with childcare providers across an entire state.[16]

Advisory boards are one commonly used strategy intended to develop a working network of people who share a common interest to bring about feasible change including adoption or development of programs and interventions.[17] Advisory boards have been used in a variety of professions, including childcare.[18–21] Yet there is a limited amount of literature on the development and use of an advisory board in the childcare profession to address childcare providers' own health and wellbeing – especially representing multiple rural areas across a primarily rural state.[22] A statewide advisory board can help serve several purposes including: 1) providing an opportunity to interact and network with others in diverse geographic locations, especially in rural areas; and 2) developing initiatives and policies that can apply across the state and not just one specific area. Literature on the development and activities of a statewide rural childcare advisory board is needed to provide others with an understanding of how to work collaboratively to develop and adapt efforts that fit the needs and interests of childcare providers in a large geographic area.

Objectives

This paper primarily describes the creation of a rural statewide childcare advisory board, the use of the board to carry out action items to promote provider mental and physical wellbeing, and the members acceptance of their involvement on the board. [23,24] Advisory board members expressed their interests in developing a health summit tailored specifically to their own health and wellbeing. Thus, we also describe the acceptability of a health and wellbeing summit implemented by the advisory board.

Methods

The advisory board members consisted of rural childcare providers (n=5) from across the state who worked with researchers from the state's university system (n=2). Prior to developing the board, only the researchers had worked together previously. After the advisory board was created, the development of activities was carried out by following the evidence-based principles of a collaborative cycle model which included: 1) stakeholder involvement and commitment, 2) shared vision of the future, 3) knowledge transfer, and 4) protecting time and space.[24] This model was selected through a mutual decision making process among the advisory board members and the researchers. The model focuses on the ideology of learning while doing by maximizing the involvement of community stakeholders through sharing and reflecting ideas and values to bring about feasible change for the community of interest.[23,24]

Development of the Rural Childcare Provider Advisory Board

Through previous research efforts, two researchers recognized the importance of and need to focus on childcare providers' mental and physical wellbeing. This led to identifying opportunities to work with childcare providers, specifically in rural areas who are at greater need of professional development opportunities.[9,10] A grant opportunity arose for researchers' to

engage rural stakeholders on a topic of the researchers' choice. A grant was submitted and accepted to take part in the initiative. Personnel from the grant helped identify rural childcare providers across the state who were interested in the topic of childcare provider wellbeing to form an advisory board.

Once all members were identified, the group (childcare providers and researchers) met to identify a method to work together and mutually decided to guide their work following the collaborative cycle model.[23,24] Based on the high rates of health concerns and expressed interests among childcare providers, the group collaboratively identified the best first step to support childcare providers' mental and physical wellbeing – a summit focused on training childcare providers on their own wellbeing. To further encourage collaboration and participants' buy-in, a team name was chosen, "Team Super Providers," to create a collective group identity. Creating a name immediately established ownership and started the team building process. Advisory board members were paid $1,000 for the initial year-long commitment (Fall 2019-Fall 2020).

Acceptability of the Advisory Board

Since evaluation efforts were deemed as programmatic, institutional review board (IRB) approval was not needed as specified by the lead authors' IRB board. An evaluation assessment to obtain feedback on the acceptability of participation on the board was sent to members after meeting for 9 months (Summer 2020). The assessment consisted of three open-ended questions. Questions consisted of asking about why they were originally interested in participating in the advisory board, what they hoped to accomplish through participating, and how they felt their participation in the advisory board impacted their profession.

Acceptability of the Health and Wellbeing Summit

A feedback survey was sent to summit attendees via email one month following the summit. The delayed assessment approach was used to allow participants adequate time to reflect on the summit experience and time to implement acquired tools. The survey contained 15 multiple choice questions asking attendees about their overall satisfaction, experience, and perceived improvements in wellbeing obtained at the summit. Three open-ended questions were asked about how they implemented the tools they learned after the summit as well as suggested improvements and topics of interest for future summits.

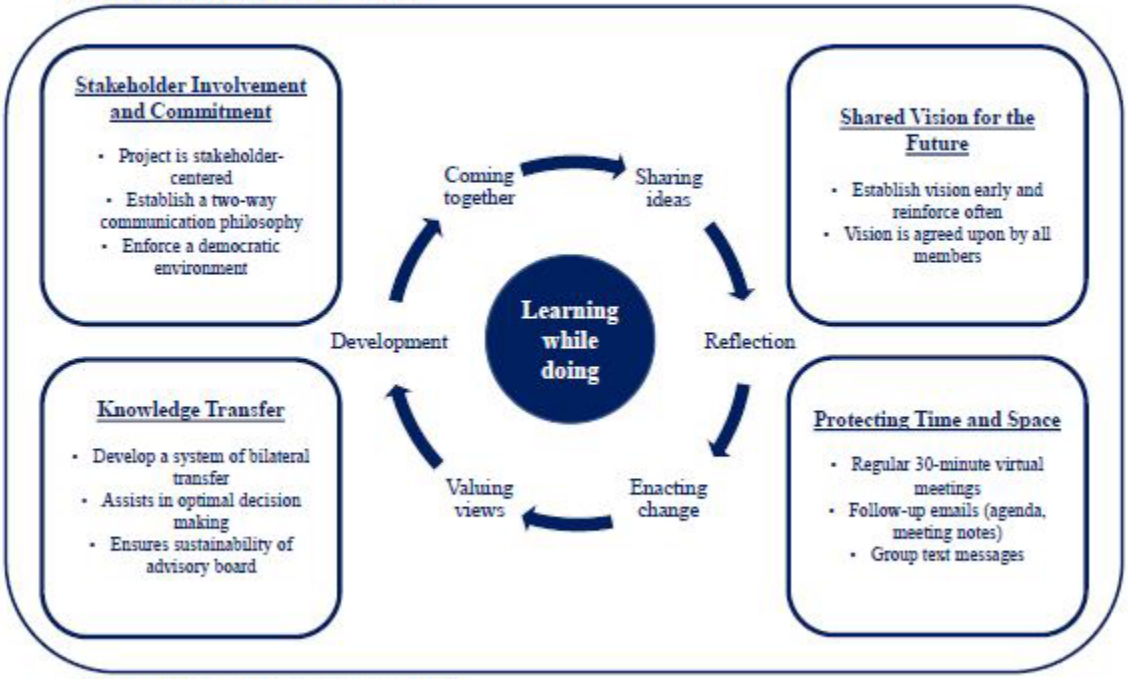
Data Analysis

Data from open ended questions were reviewed for consistency following a thematic analysis approach. Frequencies of survey responses were calculated using Excel.

Results

Collaborative Cycle Model. The following describes the application of the model principles through the development of activities by the advisory board (Figure 1).

Figure 1. Adapted collaborative cycle model and principles used for implementation of a rural childcare advisory board



*Adapted from Bryant et al., 2012

Stakeholder Involvement and Commitment. To ensure the group was stakeholder-centered, the two researchers decided that only they would participate and not include additional researchers or students to avoid overwhelming the childcare providers with a more "research heavy" perspective and presence. An open two-way communication philosophy was adopted for both formal and informal inquiries to protect the commitment of the advisory board members.[25] The intent was to provide a democratic environment that encouraged members to freely share their opinions, ideas, and criticism with one another.[26] The collaborative approach was especially evident when the group decided to pursue funding for the summit to keep costs low for attendees. Providers were active participants in reaching out to their contacts in the early childhood community to secure sponsors for the summit and raised a majority of the sponsorship funds. Further, as the COVID-19 pandemic pushed back the original date of the summit (Fall 2020 to Fall 2021), board buy-in

was evident as members continued to meet well past their initial one-year commitment. Once the summit was able to be held, advisory board members took charge of a majority of the organization while at the summit including checking people in, introducing speakers, handling door prizes, and general hosting of the summit.

Shared Vision for the Future. During the recruitment process, providers received a one-page handout of the topic idea for the advisory board developed by the researchers. Due to this, a shared vision focused on childcare providers health and wellbeing was easily developed by the group. The shared vision continued as board members independently recruited additional like-minded individuals to be a part of the board. While the researchers initially set out to brainstorm interventions that could be implemented, conversations between the group brought to surface the need for immediate training opportunities focused on childcare providers' own wellbeing, as almost all existing training focused on the care of children. The need for this was increased due to the lack of in-person training and increased stress due to the COVID-19 pandemic.

Knowledge Transfer. Another key feature of the advisory board was the bilateral knowledge transfer between providers and researchers. For instance, knowledge transfer from providers to researchers occurred through providers sharing challenges they faced as it related to administrative duties, daily tasks, and impact of being in the profession. Given the providers' experiences in their profession, they were able to share knowledge with researchers on a variety of critical pieces. First, providers shared potential topics and identified a keynote speaker that could meaningfully speak about mental and physical wellbeing within their profession. The speaker was a wellness and self-care educator who used her own experiences as well as her education in fitness and human services to teach others how to prioritize self-care.

Second, providers shared their desire and need for social interaction with one another. Due to this, the board decided to limit the size of the summit to 50 providers, to make it a workshop-style format, and provide an overnight stay option to encourage socialization and networking. Further, providers believed the summit should occur in-person as so many trainings were being moved online. They felt this would best meet the needs of providers' mental and physical wellbeing. Thus, the group decided to wait to hold the summit until it could safely be held in person in order to provide the needed social interaction.

Additionally, providers voiced concerns of selecting an appropriate location. Board members reported that many providers were not willing to travel across the state due to the length of travel time. This led the group to identify a camp setting centrally located within the state. The camp had hotel-like accommodations and plenty of space for the summit as well as outdoor space (e.g., fire pits) which could allow for plenty of opportunities for socialization.

As for knowledge transfer from researchers to providers, researchers contributed by providing structure and administration with organizing the summit and completing the processes necessary to host an education summit such as ensuring that the summit was approved for continuing education credits. Researchers also shared knowledge concerning potential programs and funding opportunities to enhance the impact of the advisory board. For example, one of the researchers learned of a for-profit company who had worked with childcare centers to offer programming around mindfulness and yoga activities for childcare providers and the children in their care. The advisory board indicated their interest in this program and the researchers identified a local funding opportunity and worked with the for-profit company and the advisory board to submit a grant to conduct a 4-month pilot of the program.

Protecting Time and Space. Designating time and space to meet was essential to sustain the engagement of the providers. We used both synchronistic and asynchronistic meeting strategies.

Regularly scheduled virtual meetings. To facilitate provider involvement and idea generation, the group prioritized regular meetings and communication. Due to the nature of childcare providers work and the unforeseen COVID-19 pandemic, we established a regular monthly meeting time in the evening that worked with providers commitments and their geographic locations which span two different time zones in Nebraska. Researchers led meetings, developed agendas, and kept meeting minutes. The meetings occurred virtually via Zoom and lasted 30 minutes on average. Providers were able to take part in discussion in a variety of ways either by video, phone, or the chat function. Table 1 provides a sample of our meetings and objectives for each meeting. When the summit had to be delayed due to the COVID-19 pandemic, these meetings were critical to check-in with the advisory board as well as to update on the status of when the summit might be able to be held and other grant-writing efforts.

Group text messaging. Additionally, to facilitate regular communication between meetings, a group text was set up on Remind.com due to challenges with some providers being able to access group chats with different cell phone services. Remind.com is typically a site used by teachers and families to communicate in which teachers can send one message to all families. We were able to setup the account as a group chat so that all members could respond to one another. This helped to overcome the challenge of having different cell phone services.

E-mails. Initially, emails were the primary source of communicating mass messages including meeting minutes, summary of discussions, and served as a record of conversations.

Eventually the group transitioned from emails to text messages as the main follow up mechanism to ensure more expedited communication as not all board members checked their email frequently.

Acceptability of the Advisory Board. Advisory board members' responses to the survey assured the researchers that the members were passionate about health and wellbeing in the childcare field. For example, one board member mentioned she wanted to be involved because she was happy to share her ideas and work with other like-minded individuals focused on wanting to help the health and wellbeing of childcare providers. Providers hoped to accomplish "networking with other like-minded professionals" and participating on the board helped to "reinforce my passion [for the] profession" and "… it has given me something to look forward to." Generally, responses were optimistic and hopeful on the efforts to improve childcare providers' health and wellbeing.

Acceptability of the Health and Wellbeing Summit. Despite the challenges of the COVID-19 pandemic which limited group size, we had 31 providers from across the state attend the summit. The summit focused on introducing the importance of self-care; learning about stress resiliency, compassion fatigue, and limbic calming; mastering mental triggers; creating intention; and understanding movement and journaling for self-care. Of those that completed the one-month post survey (n=18), most childcare providers expressed that they had an enjoyable experience (79%), reported they felt engaged by the presenter (89%), gained personal or professional growth (79%), and felt better equipped to live a healthier lifestyle (93%). One attendee mentioned: "I love that it focused on bettering US and how that improves our program!" Another provider stated that a tool she learned "to pursue my personal health more in depth in order to serve my clients better." A little over half (55%) said they had implemented at least one

of the mindfulness strategies learned from the summit such as using deep breathing techniques and meditation or journaling. Importantly, 85% stated they would like to attend the summit in the future. Suggestions for future improvements and topics of interest included building positive work environments, extending the length of the summit, and discussing more strategies for self-care.

Barriers and Solutions. While the group has had some great successes, there has also been several challenges along the way. One of the challenges was variable attendance. Due to family responsibilities, changes in employment, and other family-related duties during the evening, some providers and researchers were unable to attend regularly and three of the original board members stopped attending. To help overcome this, researchers began to send reminders the day of or day before the meeting. Importantly, this did present opportunities for others to take on leadership roles in planning the summit, which strengthened the relationships between these advisory board members and the researchers who were able to consistently attend. Further, existing board members recruited additional members – childcare providers and representatives of key organizations who support childcare providers within the state. Today, the board consists of four childcare providers, two researchers, and two representatives of organizations who serve childcare providers. Importantly, none of these members were offered payment to continue to engage with the group.

Virtual communication was an excellent tool but also served as a barrier. Rural broadband internet access and connectivity issues resulted in a few advisory board members having to join meetings from their phone. This limited their ability to review documents or websites on a shared screen and only being able to contribute to discussions via chat. Rural internet connection is a problem in many rural spaces; however, we attempted to bridge this

barrier by actively monitoring and sharing anything written in the chat, sending summary emails with notes and associated documents discussed on the live call as well as updates via the group texting platform.

An additional barrier was the COVID-19 pandemic. As mentioned previously, the summit was scheduled for August of 2020 and the group was in the process of fundraising from community partners when the pandemic hit in early 2020. Due to the pandemic, the summit was moved back twice. Even with another increase in the COVID-19 levels, which limited some individuals from attending even after registering, we were able to hold the summit in person in August of 2021. Importantly, due to the advisory boards' relationships with the organizations who agreed to help fund the summit, we continued to receive financial support despite having to move back the summit twice.

Conclusion

Based on our preliminary evaluation, the advisory board appeared to be acceptable by the board members and the initial activity of the board – the wellbeing summit – was acceptable by attendees. Overall, the advisory board has been a mutually beneficial activity for both childcare providers and researchers. Key factors contributing to the success of the advisory board following the collaborative cycle model included sharing knowledge, flexibility around the COVID-19 pandemic, consistent meeting times in the evening, and group text messaging for communication.

The advisory board continues to be an active group building long term plans. Currently, the advisory board is in the process of planning next year's summit to be held in the Fall of 2022 with plans for additional evaluation. The well-received summit by childcare providers across the state is being used as a springboard for future initiatives and the board continues to grow in

participation. As evidence of our continued efforts, the group received a grant to pilot the aforementioned mindfulness and yoga program in rural Nebraska. The program and related data collection is currently under way. Our long-term goal is to continue to offer the summit on an annual basis and identify programmatic efforts that once found to be effective can receive sustained funding through state organizations in order to make significant improvements in Nebraska childcare providers' mental and physical health and wellbeing.

References

1. World Health Organization. Guidelines on physical activity, sedentary behaviour and sleep: For children under 5 years of age [online 2019]. Available from: https://apps.who.int/iris/handle/10665/311664.

2. National Center for Education Statistics. Enrollment of 3-, 4-, and 5-year-old children in preprimary programs, by age of child, level of program, control of program, and attendance status: Selected years, 1970 through 2015 [online 2016]. Available from: https://nces.ed.gov/programs/digest/d16/tables/dt16_202.10.asp?current=yes.

3. Lessard LM, Wilkins K, Rose-Malm J, Mazzocchi MC. The health status of the early care and education workforce in the USA: A scoping review of the evidence and current practice. Public Health Rev. 2020;41:2.

4. Linnan L, Arandia G, Bateman LA, Vaughn A, Smith N, Ward D. The health and working conditions of women employed in child care. International journal of environmental research and public health. 2017;14:10.

5. McGrath BJ. Identifying health and safety risks for childcare workers. AAOHN Journal. SAGE Publications; 2007;55:321–325.

6. Rural Mental Health Introduction. Rural Health Information Hub [online]. Available from: https://www.ruralhealthinfo.org/topics/mental-health.

7. Jeon L, Kwon K-A, Choi JY. Family child care providers' responsiveness toward children: The role of professional support and perceived stress. Children and Youth Services Review. 2018;94:500–510.

8. Hur E, Jeon L, Buettner C. Preschool teachers' child-centered beliefs: Direct and indirect associations with work climate and job-related wellbeing. Child & Youth Care Forum. 2016;45:451–465.

9. Snyder K, Rida Z, Hulse E, Dev D, Dinkel D. Exploring rural and urban Go NAP SACC trained child care providers perceptions and needs regarding the promotion of physical activity and healthy eating. Cogent Social Sciences. 2019;5(1):1650412.

10. Dinkel D, Dev D, Guo Y, et al. Comparison of urban and rural physical activity and outdoor play environments of childcare centers and family childcare homes. Family & Community Health. 2020;43:264–275.

11. Foster JS, Contreras D, Gold A, et al. Evaluation of nutrition and physical activity policies and practices in child care centers within rural communities. Childhood Obesity. 2015;11:56–512.

12. Welch GW, Svoboda E, Garrett A. Nebraska child care Market Rate Survey report 2019. Buffett Early Childhood Institute at the University of Nebraska. [online 2019] Available from: https://dhhs.ne.gov/Child%20Care%20Market%20Rate%20Surveys/2019%20Market%20Rate%20Survey%20Report.pdf

13. Roberts A, Gallagher K, Daro A, Iruka I, Sarver S. Workforce well-being: Personal and workplace contributions to early educators' depression across settings. Journal of Applied Developmental Psychology. 2019;61:4–12.

14. Buffett Early Childhood Institute at the University of Nebraska. COVID-19 Resources [online]. Available from: https://buffettinstitute.nebraska.edu/resources/covid-19.

15. Nebraska COVID-19 Early Care and Education Provider Survey II. Buffett Early Childhood Institute at the University of Nebraska [online 2020]. Available from: https://issuu.com/buffettearlychildhoodinstitute/docs/provider_survey_2_080420_final.

16. Parker E, Baquero B, Daniel-Ulloa J, et al. Establishing a community-based participatory research partnership in a rural community in the midwest. Prog Community Health Partnersh. 2019;13:201–208.

17. Powell BJ, Waltz TJ, Chinman MJ, et al. A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. Implementation Sci. 2015;10:21.

18. Alexander R, Estabrooks P, Brock D-JP, Hill JL, Whitt-Glover MC, Zoellner J. Capacity development and evaluation of a parent advisory team engaged in childhood obesity research. Health Promotion Practice. SAGE Publications; Epub. 2019; 13:1524839919862251.

19. Newman S, Andrews J, Magwood G, Jenkins C, Cox M, Williamson D. Community advisory boards in community-based participatory research [online 2011]. Available from: http://www.cdc.gov/pcd/issues/2011/may/10_0045.htm.

20. South Carolina Program for Infant/Toddler Care [online]. Available from: https://scpitc.org/.

21. Fiks AG, Cutler M, Massey J, Bell LM. Partnering with parents to create a research advisory board in a pediatric research network. Pediatrics. American Academy of Pediatrics 2018;142(5): e20180822

22. Loth KA, Shanafelt A, Davey CS, et al. Does adherence to child care nutrition and physical activity best practices differ by child care provider's participation in support programs and training? Children and Youth Services Review. 2019;105:104417.

23. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: Assessing partnership approaches to improve public health. Annual Review of Public Health. 1998;19:173–202.

24. Bryant W, Parsonage J, Tibbs A, Andrews C, Clark J, Franco L. Meeting in the mist: Key considerations in a collaborative research partnership with people with mental health issues. Work. IOS Press; 2012;43:23–31.

25. Gordon J, Hartman RL. Affinity-seeking strategies and open communication in peer workplace relationships. Atlantic Journal of Communication. Routledge; 2009;17:115–125.

26. Myers SA, Knox RL, Pawlowski DR, Ropog BL. Perceived communication openness and functional communication skills among organizational peers. Communication Reports. Routledge; 1999;12:71–83.

Table 1. Sample Advisory Board Meetings

Meeting Date & Time:	Objective(s) of Meeting:
Team Retreat	• Initial meeting • Develop team • Identify shared goal between board members and researchers • Build relationship between board members

9/11/19 - 8 PM CST	• Receive feedback on Aims of grant application
	• Discuss year-end goal of Health & Wellness Summit/Workshop
	  ○ Time of year/day
	  ○ Topics
	  ○ Cost
	  ○ Location

10/23/19 - 8 PM CST	• Review overview for potential funders • Continued discussion
12/4/19 - 8 PM CST	• Revise health summit overview & potential summit locations • Discuss potential speakers • Discuss format (conference vs. workshop)
1/15/20 - 8:30 PM CST	• Review draft e-mail for funders • Discussed best form of communication moving forward
1/29/20 - 8:30 PM CST	• Discuss logistics of summit location • Revised funding e-mail • Discuss strategy for contacting funders • Discuss ideas for registration, who can oversee this. Would be challenging with UNO and so looking at other options.
2/12/20 - 8:30 PM CST	• Additional follow-up questions with summit location • Discuss updates to funding and potential funding • Review spreadsheet of potential funders and who will contact specific people
3/4/20 - 8:30 PM CST	• Discuss updates on funding • Discuss delay of the Summit due to COVID-19
4/1/20 - 8:30 PM CST	• Discuss challenges of COVID-19 crisis • Decide on the delay of the Summit due to COVID-19 • Discuss potential grant funding
5/13/20 - 8:30 PM CST	• Discuss potential grant funding • Confirm new date of Summit in 2021
7/15/20 - 8:30 PM CST	• Update on grant funding, discuss when to start contacting additional funders