Child Care Bureau

Child Care Bulletin

Issue 30 Fall 2005

Two New HHS Programs Aim to Improve Health and Nutrition

The U.S. Department of Health and Human Services has launched two health and nutrition initiatives designed to provide information and outreach to minority and low-income communities.

An African American anti-obesity initiative will sponsor partnerships among the National Association for Equal Opportunity in Higher Education, the National Urban League, and the National Council of Negro Women to promote obesity prevention, education, public awareness, and outreach activities to African American communities across the country.

The Administration for Children and Families Office of Community Services' Community Food and Nutrition Program (CFN) is increasing access to and information about healthy foods for low-income families. CFN is also building community capacity by coordinating private and public nutrition resources, assisting low-income communities in identifying potential sponsors of child nutrition programs and initiating the programs, and developing innovative State and local strategies to meet the nutrition needs of low-income populations.

More about the African American anti-obesity initiative can be found at www.hhs.gov/news/press/2005pres/20050407.html. For information about CFN, including grant eligibility, visit www.acf.hhs.gov/programs/fbci/progs/fbci_cfn.html.

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Child Care Bureau

A Healthier Outlook for Our Children

by Shannon Christian, Associate Commissioner of the Child Care Bureau

Just as learning the ABCs is essential to a child's intellectual growth, learning to make healthy choices is crucial to a youngster's success in school and in life. With obesity, chronic asthma, poor nutrition, and other serious conditions putting children's health in jeopardy, prevention and outreach are more important than ever before for promoting sound development. At the Child Care Bureau, we are eager to support the important role the child care field can play in ensuring that more children grow up healthy and successful.

In this issue, we highlight programs in several States that take a creative approach to supporting children's health and nutrition, and call for those in the medical field to join child care providers and parents in efforts to ensure the well-being of our youngest. We suggest steps agencies and providers can take to improve access to health care coverage for children, and show why adequate food is fundamental to proper health and nutrition.

In addition to offering useful tips for managing asthma and infectious diseases in child care settings, we present recommendations for babies' sleep position and new dietary guidelines that can be put into practice right away. We also review ways the child care field, including policymakers, providers, and parents, can enhance health and nutrition through effective outreach, collaboration, and prevention strategies.

Hopefully, this issue will not only assist you in identifying some of the major threats to children's healthy development, but also give you ideas about how you can help. I encourage all of us to embrace and extend the roles we can play in ensuring all children have a bright and successful future.

A New Approach
Healthy Child Care America and Early Childhood Comprehensive Systems

Healthy Child Care America (HCCA) is the product of a shared vision between the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) and the Administration for Children and Families' Child Care Bureau. This shared vision of strong linkages between health and child care professionals supports the health and safety of children in child care settings. The blueprint for this campaign provided communities with five goals and ten action steps. As communities adopted campaign goals and initiated the action steps they thought were most needed, MCHB supported health and child care linkages and funded State grants. Focus areas included implementation of new standards or enhancement of existing standards; development of health consultation systems and use of consultants; and increased access for children and families to health insurance and a medical home. Read more about the campaign's history, strategies, and outcomes at *www.healthychildcare.org/hcca_info.cfm*.

After more than eight years of ongoing support, Federal funding for State HCCA projects ended in January 2005. The MCHB is supporting a new effort to include the HCCA objectives within State Early Childhood Comprehensive Systems (SECCS) planning and implementation. By including these objectives, the SECCS initiative encourages Maternal and Child Health agencies to collaborate with other groups to plan and implement activities that will strengthen each State's system for providing early childhood support services. The five focus areas for SECCS grants are access to medical homes, mental health and social-emotional development, early care and education, parent education, and family support.

MCHB provides funding through the National Healthy Child Care America Cooperative Agreement Program for the continuation of the National Resource Center for Health and Safety in Child Care and Early Education, the National Training Institute for Child Care Health Consultants, and (in collaboration with the Child Care Bureau) the Health and Child Care Partnership program (coordinated with the American Academy of Pediatrics). These efforts aim to strengthen the integration of HCCA objectives into State SECCS initiatives and to ensure that children enter school healthy and ready to learn. MCHB recently announced its support for a new Healthy Child Care Consultant Network Support Center that will strive to strengthen Statewide child care health consultant networks through development of State profiles and a national registry.

MCHB continues to encourage State HCCA programs to identify new partners and sources of funding to ensure sustainability. Learn more about State Early Childhood Comprehensive Systems by visiting the Health Resources and Services Administration Web site at *www.hrsa.gov/default.htm* or by calling 301-443-3376, or e-mailing comments@hrsa.gov.

For more information about Healthy Child Care America support efforts, call 888-227-5409 or visit the Web at http://www.healthychildcare.org.

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MyPyramid for Kids
Gives Dietary Guidelines a New Shape

Children and adults alike will benefit from the new interactive food guidance system introduced by the U.S. Department of Agriculture (USDA). MyPyramid, Steps to a Healthier You, supports President Bush's HealthierUS initiative and incorporates recommendations from the 2005 Dietary Guidelines for Americans, released by the USDA and the U.S. Department of Health and Human Services earlier this year and is available at *www.health.gov/dietaryguidelines/dga2005/document*.

In addition to the MyPyramid for adults, available at *www.mypyramid.gov*, the USDA recently released MyPyramid for Kids to help educate children about exercise and nutrition. MyPyramid for Kids includes the same guidelines provided for adults, using simplified language and descriptions. It features a color-coded image that corresponds to the type and amount of food children should eat, and stair steps to emphasize the importance of exercise to children's well-being.

The MyPyramid for Kids Web site also includes an online interactive game for children, a tip sheet to help families eat well and exercise, and materials that teachers can use in the classroom. Child care providers can use lesson plans and additional materials.

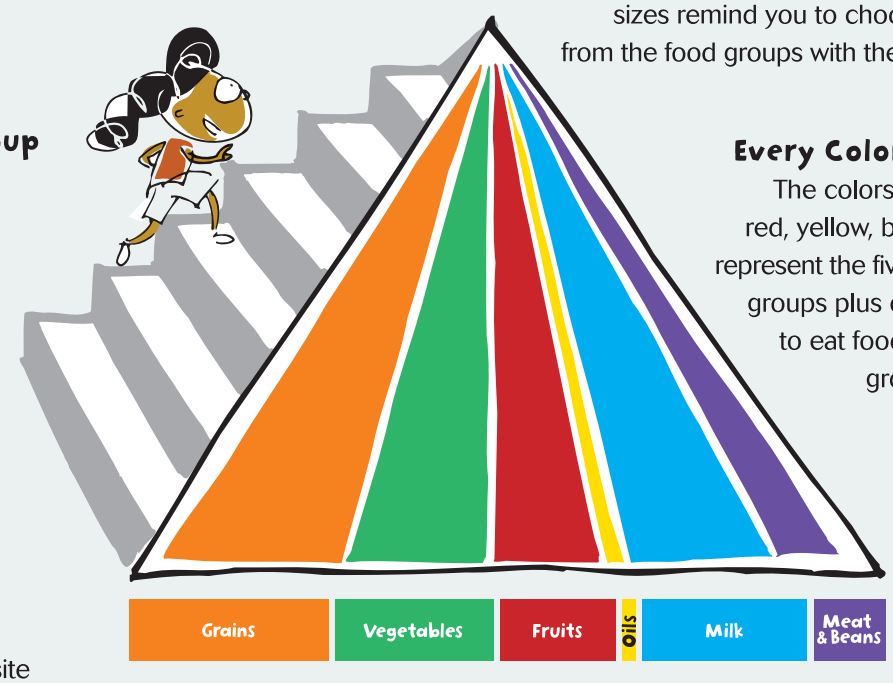
MyPyramid for Kids is on the Web at www.mypyramid.gov/kids/index.html. Lesson plans and additional information are available at http://teamnutrition.usda.gov/resources.html.

A Close Look at MyPyramid For Kids

Be Physically Active Every Day
The person climbing the stairs reminds you to do something active every day, like running, walking the dog, playing, swimming, biking, or climbing lots of stairs.

Eat More From Some Food Groups Than Others
Did you notice that some of the color stripes are wider than others? The different sizes remind you to choose more foods from the food groups with the widest stripes.

Choose Healthier Foods From Each Group
Why are the colored stripes wider at the bottom of the pyramid? Every food group has foods that you should eat more often than others; these foods are at the bottom of the pyramid.



Every Color Every Day
The colors orange, green, red, yellow, blue, and purple represent the five different food groups plus oils. Remember to eat foods from all food groups every day.

Make Choices That Are Right for You
MyPyramid.gov is a Web site that will give everyone in the family personal ideas on how to eat better and exercise more.

Take One Step at a Time
You do not need to change overnight what you eat and how you exercise. Just start with one new, good thing, and add a new one every day.

Caregivers and Teachers Can Help Prevent Infectious Diseases

Recognizing the vital role caregivers and teachers play in promoting healthy behaviors and preventing the spread of infectious diseases, the American Academy of Pediatrics has published *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide,* edited by Dr. Susan S. Aronson and Dr. Timothy R. Shope.

The guide is filled with fact sheets, charts, and sample forms that provide practical information about infectious diseases in group settings. The guide includes the following:

- Fact sheets on more than 40 diseases commonly found in group settings.
- Strategies for limiting the spread of infection.
- A chart describing common symptoms, and whether they necessitate exclusion.
- Information on deciding when not to exclude a child.
- Guidance about situations that require immediate attention by a health professional.
- Sample letters and forms for health professionals, caregivers, and teachers.

For more information or to order the guide, visit www.healthychildcare.org or e-mail hcca@aap.org.

State Licensing Regulations on Health and Nutrition for Child Care Centers

State child care licensing regulations provide a baseline of protection of the health and safety of children in out-of-home care. Licensing rules seek to prevent various forms of harm to children and represent the required level of quality in each State.

The following table shows the number of States with regulations for child care centers on a variety of health and nutrition issues. Included is information from the 50 States and the District of Columbia.

State Licensing Regulation	# of States
Immunizations required for children	50
Administration of medication allowed	50
Requirements for nutritional content of meals/snacks	49
First aid training required for staff	46
Hand washing required for adults	44
Hand washing required for children	41
Smoking not allowed in center	31
Physical exam required for children	28
Infants placed on their backs to sleep	24
Health consultant required	18

Source: *This information is based on NCCIC's review of State child care licensing regulations, which are available on the National Resource Center for Health and Safety in Child Care and Early Education Web site at http://nrc.uchsc.edu/STATES/states.htm.*

Take a Deep Breath

Managing Childhood Asthma in Early Care and Education

According to the Centers for Disease Control and Prevention, asthma is the most prevalent chronic childhood illness in the United States, affecting 6.3 million children under the age of 17. More information is in *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2003*, available at *www.cdc.gov/nchs/data/series/sr_10/sr10_223.pdf*.

Although more common in school-age children, asthma rates among preschool children (birth through age 5) have jumped in recent years. Asthma also has a more dramatic impact on certain populations, with African American children twice as likely to be hospitalized for asthma and two to four times more likely to die from an asthma episode than their Caucasian peers.

There are several simple strategies caregivers and teachers can follow to help children in their care breathe easier.

Control Exposure

Controlling children's exposure to asthma and allergy triggers is a critical first step in managing asthma. Pollen, mold, temperature changes, dust, foods, or chemicals can prompt allergic reactions or lead to an asthma episode.

The U.S. Environmental Protection Agency offers a free Indoor Air Quality Tools for Schools kit, which can help evaluate the presence of allergy and asthma triggers. Order the kit at *www.epa.gov/iaq/schools/tools4s2.html*.

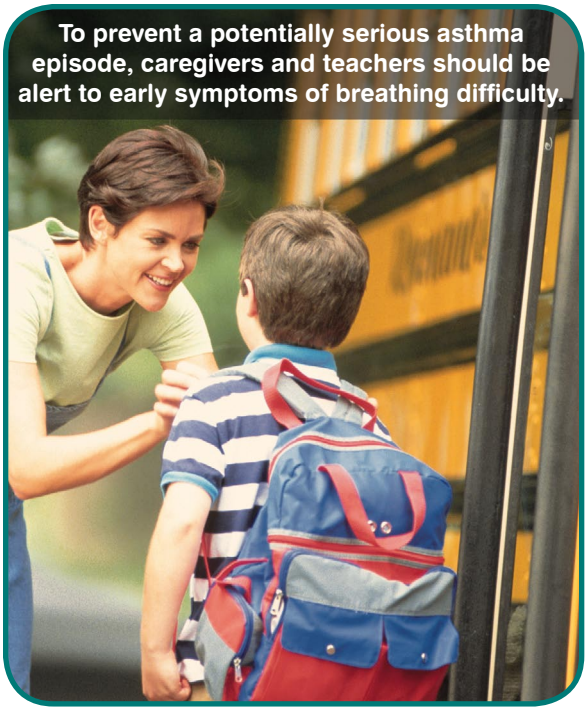
Establish a Team

Strong coordination among the school, family, and medical providers offers the greatest potential for successfully managing asthma in children. The asthma management team might include the child, family members, doctors, teachers, administrators, transportation providers, after-school staff, custodial staff, volunteers, and others who have a role in the child's care.

Know the Warning Signs

Warning signs can include the following:

- Persistent cough
- Shortness of breath
- Increased breathing rate
- Sneezing
- Dark circles under the eyes
- Fever
- Sore or itchy throat
- Clipped speech
- Change in face color
- Chest tightness or pain
- Drop in peak flow reading (a peak flow meter is used to measure lung capacity).



To prevent a potentially serious asthma episode, caregivers and teachers should be alert to early symptoms of breathing difficulty.

Keep Emergency Medications Handy

When children with asthma are at the center or school, their emergency asthma medications should always be nearby. One strategy is to transport inhalers, which deliver medicine to the lungs, and EpiPens, injectors that deliver epinephrine, in a portable fanny pack. The age at which a child should assume responsibility for carrying medications depends on the child and on center or school policy; however, an adult should always closely monitor the location of the medication.

Develop an Asthma Action Plan

Formulate a written, step-by-step approach that outlines symptoms to look for, actions to take if symptoms appear, and medications and equipment for treatment. The asthma action plan should be prepared by the family and the child's physician and shared with caregivers and teachers.

See a sample asthma action plan at the Asthma and Allergy Foundation of America Web site at *www.getasthmahelp.org/studentAAFA.pdf*.

Information for this article was adapted from "Managing Asthma in Early Care and Education Settings" by Yvette Q. Getch and Stacey Neuharth-Pritchett, which appeared in the March 2004 issue of Young Children, *published by the National Association for the Education of Young Children.*

Obesity Threatens the Health of America's Children

By Jordan Richland, former Executive Director, American College of Preventive Medicine

Children growing up in the United States today are more likely to suffer lifetime harm from the way they eat than from tobacco, drugs, and alcohol combined. Although the number of adults who are overweight or obese has risen dramatically in recent years, the rate of obese and overweight children has increased at twice the rate among adults.* More than one in seven children and adolescents aged 6 to 19 are now overweight or obese.[1]

More than one in seven children and adolescents aged 6 to 19 are now overweight or obese.

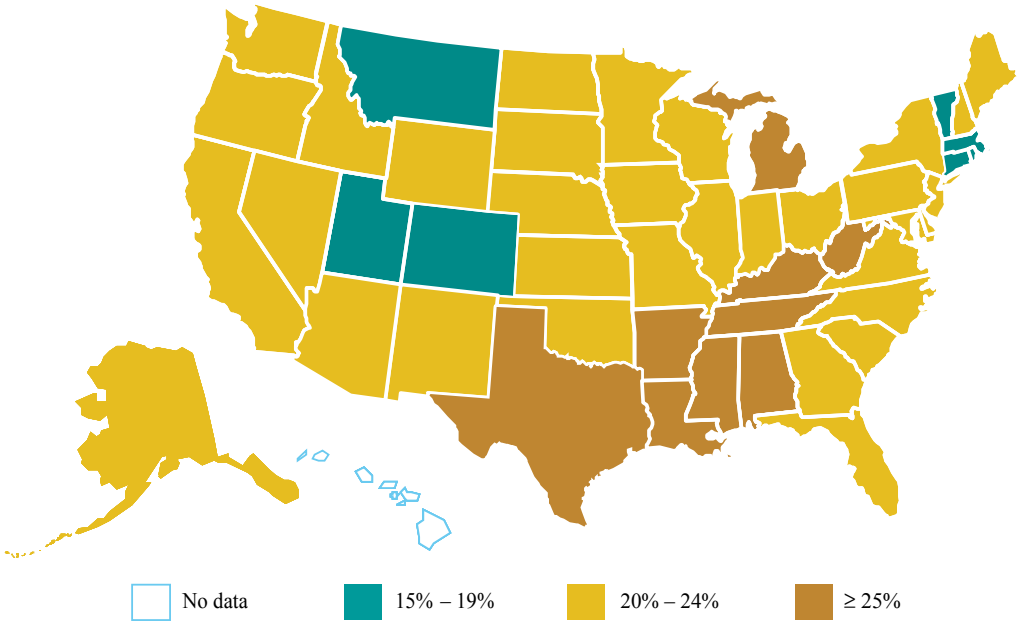
Not only are children who are overweight at risk for health problems as adults, they also potentially face serious short-term health consequences. The increase in childhood overweight and obesity is related to a surge in Type II diabetes. Formerly called adult onset diabetes, Type II diabetes no longer can be considered age-specific. The National Institutes of Health concluded that diabetes is such a big risk factor for vascular disease that heart disease may be assumed when diabetes is present. Given current obesity trends among young people, heart disease could become an increasingly common pediatric disease. Medical experts also anticipate a rise in obesity-related stroke, certain types of cancer (colon, breast, prostate, and endometrial), and osteoarthritis. In addition, serious psychological problems such as depression, eating disorders, and low self-esteem have been associated with obesity.[2,3]

A Complex Issue

Overweight and obesity result from an energy imbalance when people eat more calories than they use, so weight management must come through changes either in diet or physical activity, or both. However, this simple formula can mask complex causes of obesity, including behavior, the environment, and genetics, which are complicated further by the way we live, work, and spend our leisure time.

Personal behavior determines the types and amounts of food an individual eats. Food choices are affected by taste, convenience, cost, and nutritional value. They also are influenced by our physical and social environments,

2004 Obesity Trends among U.S. Adults
(BMI ≥ 30, or about 30 lbs overweight for 5'4" person)



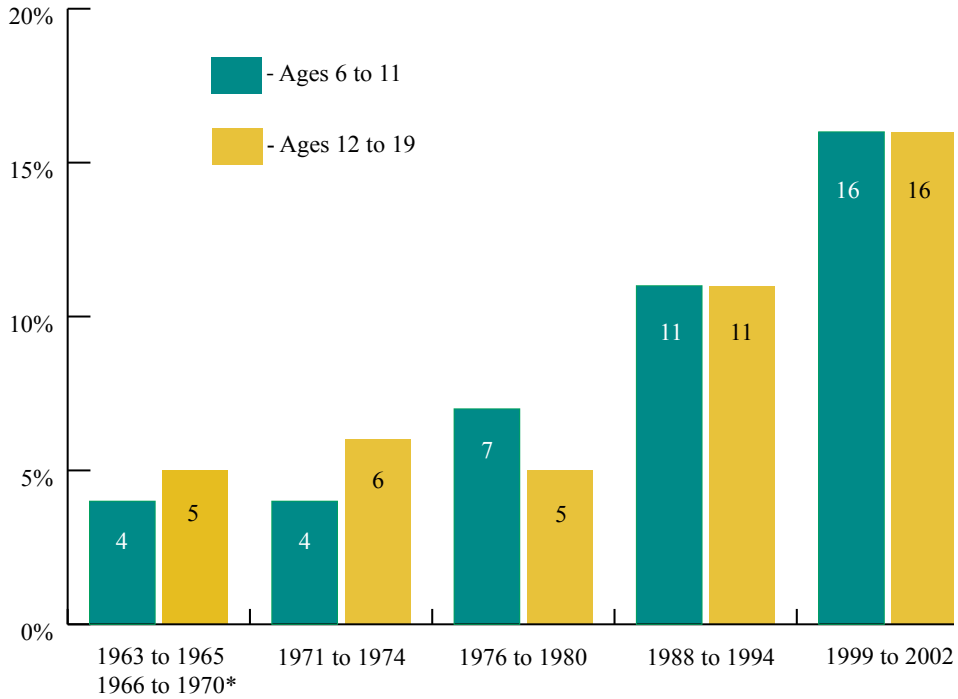
Source: *Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.*

* Overweight refers to adults with a Body Mass Index (BMI) ranging from 25.0–29.9, while obesity refers to a BMI greater than or equal to 30. (BMI is a measure for assessing weight status in adults by relating weight to height.) Obesity and overweight are defined differently for children and are based on age/gender growth charts. Yet, the phrase "obesity epidemic" has gained popular usage and often refers not just to those who are obese, but also to those who are overweight.

which often make healthy choices difficult. In many schools, high-calorie foods and soda are easy to get and inexpensive. Makers of prepackaged foods often include ingredients high in fat, sugar, and calories because people report they taste better.

Rates of overweight and obesity are especially high in low-income communities. Studies have shown that many U.S. inner cities have fewer supermarkets than suburban communities, making it more difficult for residents to obtain fresh and nutritious foods. More fast food restaurants are located in low-income areas, and healthy and nutritious foods often are more expensive than processed foods high in fat, sugar, and sodium.[4]

Percent of Overweight Children in the United States, 1963 to 2002



*Data for 1963-65 are for children 6-11 years of age; data for 1966-70 are for adolescents 12-17 years of age, not 12-19 years.

Source: *National Center for Health Statistics, Centers for Disease Control and Prevention.*

Current societal trends also discourage healthy eating among children. The number of households in which both parents work has grown, decreasing parents' time for preparing nutritious meals. More families are now eating more meals outside the home, including in fast food restaurants where high-calorie foods are served.

Today's physical environment also is less conducive to activity and exercise than in the past, and the Centers for Disease Control and Prevention reveals that 40 percent of adults report no leisure time physical activity. A decrease in the number of neighborhood schools throughout the country means fewer children walk to school, and suburban sprawl precludes walking to stores for daily errands.[5]

A Chance to Make a Difference

Caregivers have an opportunity to help reduce childhood obesity by teaching children to make healthy choices, implementing health and nutrition and physical activity programs in child care centers and after-school programs, and encouraging parents to be more health conscious. Policy-makers can lead by creating awareness campaigns and allocating funding to childhood obesity prevention programs.

1 Guo, S. S., Wu, W., Chumlea, W. C., & Roche, A. F. (2002). Predicting overweight and obesity in adulthood from Body Mass Index values in childhood and adolescents. *American Journal of Clinical Nutrition, 76*(3), 653–658.

2 Fagot-Campagna, A., Saaddine, J. B., & Engelgau, M. M. (2000). Is testing children for type 2 diabetes a lost battle? *Diabetes Care, 23*(9), 1442–1443.

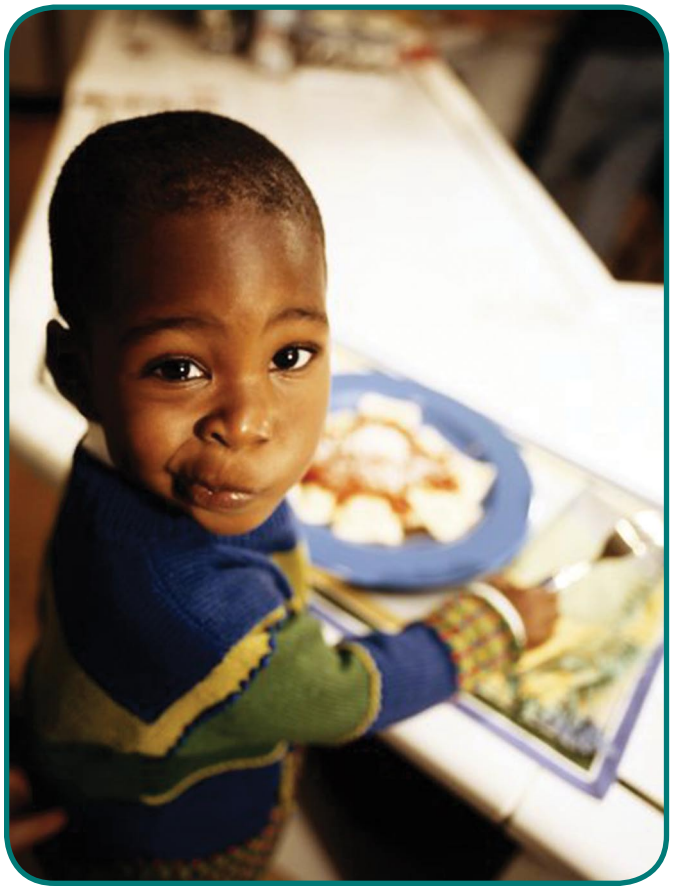
3 National Heart, Lung, and Blood Institute, National Institutes of Health. (2002, September). *Third report of the expert panel on detection, evaluation, and treatment of high blood cholesterol in adults (adult treatment panel III).* Bethesda, MD. (NIH Publication No. 02-5215).

4 Cassady, D. L. (2001, October 25). *Mapping the availability of healthy food: Does neighborhood income make a difference?* Paper presented at the 129th Annual Meeting of the American Public Health Association. Abstract retrieved October 2005, from *http://apha.confex.com/apha/129am/techprogram/paper_27241.htm*

5 U.S. Department of Health and Human Services. (2000). *Healthy people 2010* (conference ed. in 2 vols.). Washington, DC: Author.

Food for Thought…and Other Child Outcomes

By Lori Kowaleski-Jones, Assistant Professor, Department of Family and Consumer Studies, University of Utah



The U.S. Department of Agriculture reports that, based on a national U.S. Census Bureau Survey, 11 percent of all U.S. households in 2002 were food insecure, which means they lacked access to enough food to meet basic needs at all times, due to inadequate financial resources. Food insecurity, which is strongly associated with poverty, varies greatly across the nation, with southern and western States showing the highest rates.[1]

Fortunately, several Federally funded programs help low-income families reduce food insecurity among children and alleviate its effects. These programs can also lead to other positive child outcomes, and child care providers can share information about them to parents they serve.

WIC…

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) focuses on reducing neonatal mortality, low birth weight, slow development, and anemia among young children. WIC is available to pregnant women and children from birth to age 5 who live in households with an income less than 185 percent of the poverty line and who are at nutritional risk. In 1998, almost half of all infants, 25 percent of all children ages 1 through 5, and 25 percent of all pregnant women gained WIC benefits. In 1999, the average monthly WIC benefit was $32.52 per person.[2,3]

…and Its Impact

Past research suggested that WIC can improve birth weight and children's diets, but many studies failed to account for important differences between mothers who used WIC and those who did not. Furthermore, few studies focused on whether WIC has an effect on other child outcomes.

More recent research addressed some of these issues by studying a national sample of children and their siblings and examining the relationship between program participation and infant temperament and social development. Comparisons of siblings whose mothers received WIC benefits during pregnancy with one sibling but not the other show that children of mothers who receive WIC have higher birth weight. The research also indicates that WIC participation can have a positive effect on infant temperament.[4,5]

For information about how to contact a WIC agency in your State, WIC eligibility requirements, and other program information, visit www.fns.usda.gov/wic.

National School Lunch Program…

The National School Lunch Program (NSLP) serves approximately 26 million children a day, with estimated expenditures of $5.8 billion in 1998. Eligibility for free NSLP lunches is limited to families whose incomes are at or below 135 percent of the poverty line. Reduced

price lunches are available to families whose incomes are between 135 percent and 185 percent of the poverty line. Approximately 47 percent of all school lunches are served to children whose family incomes are less than 185 percent of the poverty level. NSLP also subsidizes full-priced lunches in most schools, so nearly all school children may benefit. NSLP lunches provide at least one-third of the recommended daily allowance of the nutrients children need.[6]

…and Its Impact

Research that has investigated the effects of NSLP on children did not find that the program plays a role in the relationship between food insecurity and child outcomes; however, the studies suggest that eating lunch is associated with improvements in boys' reading test scores. Future research on NSLP is called for to explore how it affects boys and girls differently, and to compare similar children who receive NSLP with those who do not to determine the program's effect on child development.[7,8]

For more information about income eligibility for NSLP, applications for free or reduced-price lunches, and information about the NSLP Afterschool Snack Program, visit www.fns.usda.gov/cnd/Lunch/default.htm.

Policy Implications

Although research has shown that food assistance programs remain important supports for children, more research with more stringent methodology will increase understanding of the benefits of current programs and pinpoint how they can be improved to further promote children's healthy development. Carefully planned research and timely results will give policy-makers the information they need to allocate funds and implement programs that most effectively reach children in need.

1 Nord, M., Andrews, M., & Carlson, S. (2004). Household food security in the United States, 2003. *Food Assistance and Nutrition Research Report, 42.*

2 Besharov, D. J., & Germanis, P. (1999). Is WIC as good as they say? (Special supplemental nutrition program for women, infants and children). *The Public Interest, 134*, 21–36.

3 U.S. Department of Agriculture. (2000). *WIC program: Average monthly food costs per person* [Online]. *www.fns.usda.gov/pd/wifyavgfd$.htm*

4 Kowaleski-Jones, L., & Duncan, G. J. (2000). *Effects of participation in the WIC food assistance program on children's health and development: Evidence from NLSY children.* Institute for Research on Poverty, University of Wisconsin.

5 Kowaleski-Jones, L., & Duncan, G. J. (2002). Effects of participation in the WIC food assistance program on children's health and development: Evidence from NLSY children. *American Journal of Public Health, 92*(5), 799–804.

6 Oliveira, V. (1999). Food-assistance expenditures fall for second year. *Food Review, 22*(1), 38–44.

7 Dunifon, R., & Kowaleski-Jones, L. (2003). The influence of participation in the National School Lunch Program and food insecurity on child well-being. *Social Service Review, 76*(4), 72–92.

8 Kowaleski-Jones, L., & Dunifon, R. (2005). *Gender differences in the influence of the National School Lunch Program on children.* Unpublished manuscript.

States Set Health and Nutrition Programs and Children in Motion

To put children on the move toward healthy development, several States have introduced initiatives that focus on nutrition and physical activity. The Centers for Disease Control and Prevention's State-Based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases awarded funds to 28 States, including North Carolina, Pennsylvania, and Washington, to build capacity and implement strategies to promote childhood health and nutrition. Take a look at what four States have achieved with CDC and other funding.

North Carolina

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) project is an environmental intervention aimed at improving nutrition and physical activity policies and practices in preschool settings to address the increased prevalence of childhood obesity.

The cornerstone of NAP SACC is an environmental assessment instrument, which was designed to allow child care centers and family child care homes to self-evaluate their nutrition and physical activity environments, without repercussions from regulatory or licensing groups.

Child Care Health Consultants (CCHCs), who are community health professionals, team with child care centers or family child care homes to implement the NAP SACC environmental intervention in several phases:

- Initial assessment—Child care facilities complete the NAP SACC self-assessment instrument.
- Action plan—CCHCs work with facility staff to develop an action plan to improve at least three areas of concern identified from the NAP SACC instrument.
- Workshops—CCHCs deliver NAP SACC continuing education workshops on childhood overweight, healthy eating for young children, physical activity for young children, and personal health.
- Technical assistance—CCHCs provide ongoing targeted technical assistance (site visits and telephone calls) to support policy and practice changes.
- Follow-up assessment—Child care facilities complete a follow-up NAP SACC self-assessment instrument to evaluate changes made during the intervention period.

The NAP SACC pilot intervention was implemented in two child care centers across eight North Carolina counties in 2003. NAP SACC staff visited centers four months post-intervention to interview staff and document environmental improvements. Broader project implementation began this past April and will reach 102 child care centers across the State.

Learn more at www.napsacc.org or e-mail napsacc@unc.edu.

Ohio

Two years ago, with funding from the Maternal and Child Health Services Block Grant, the Child Care and Development Fund, and Individuals with Disabilities Education Act, Part C, Healthy Child Care Ohio (HCCO) launched the HCCO Child Care Health Consultant network.

Registered nurses from nine different agencies consult with child care providers on topics such as hand washing, diapering, communicable diseases, accommodating children with special needs, and other health and safety issues.

CCHCs offer technical assistance and consultation by phone or visits to any child care provider in the State at no cost. CCHCs are certified vision screeners and offer free, on-site screenings for preschool children at their child care programs. CCHCs also help families apply for

health insurance and link families and providers to other resources such as immunization clinics, early intervention services, mental health consultants, and child abuse prevention programs. CCHCs also offer providers training on health and safety topics, with a special focus on asthma and allergy essentials for providers, medication administration for out-of-home child care, and reducing the risk of Sudden Infant Death Syndrome in child care.

HCCO added registered or licensed dietitians as Child Care Nutrition Consultants, who provide free training and technical assistance on food safety, classroom nutrition activities, managing food allergies, and special dietary needs. HCCO is also collaborating with the Ohio State University's Extension Office to pilot a new nutrition curriculum, Steps to Success: Literacy, Fitness, and Food Activities for Young Children, which shows how nutrition can involve a fun and active learning process so children establish healthy habits.

Learn more at www.occrra.org.

Pennsylvania

In 2003, the Pennsylvania departments of Education and Public Welfare, the Head Start Collaborative, the American Cancer Society, the Pennsylvania Nutrition Education Network, and other organizations convened by the Pennsylvania Department of Health reviewed model nutrition and physical activity programs from other States for implementation in Pennsylvania. The consortium selected Color Me Healthy—a North Carolina program that teaches children ages 4 and 5 that healthy eating and physical activity can be fun.

A Color Me Healthy pilot project was launched in more than 300 child care, Head Start, and Family Literacy Centers across Pennsylvania in early 2004. Three child care provider workshops were held in each pilot county using resources from the organizing partners.

After the pilot project, providers reported positive changes in children's fruit and vegetable recognition and eating habits, and that children were excited about and enjoyed physical activity. Color Me Healthy was expanded to an additional 12 Pennsylvania counties that fall and is scheduled to reach more child care providers through 2006.

Learn more at www.dsf.health.state.pa.us/health/site/default.asp or contact the Pennsylvania Department of Health at 877-PA-HEALTH.

Washington

The Washington State Nutrition and Physical Activity Plan was developed in 2003 to encourage policy-makers to promote environments that make choosing healthy food and being physically active easier. The plan intends to accomplish the following:

- Increase the number of physical activity environments available to children.
- Improve access to health-promoting foods.
- Enlarge the proportion of mothers who breastfeed their infants and toddlers.
- Ensure all child care settings follow national recommendations for structured and unstructured active play time and television viewing.

- Help child care settings support breastfeeding mothers.
- Encourage child care providers to establish environments that foster development of healthy eating habits.

The City of Moses Lake is working with the Washington State Department of Health to implement portions of the plan and evaluate ways to reach communities. Moses Lake has worked to establish policies that support breastfeeding in the local hospital, at worksites, and in child care, and the local breastfeeding coalition has supplied child care providers with resources to help them create baby-friendly breastfeeding policies of their own.

Because evidence indicates that children who watch excessive amounts of television are at risk of overweight and other nutrition-related problems, a ClicKit about TV reduction for early childhood education programs is being piloted this year. Also this year, CCHCs are receiving training in physical activity, television reduction, and healthy food environments and will subsequently train child care providers in these areas.

Learn more at www.doh.wa.gov/cfh/NutritionPA/wa_nutrition_pa_plan.htm.

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FIT SOURCE

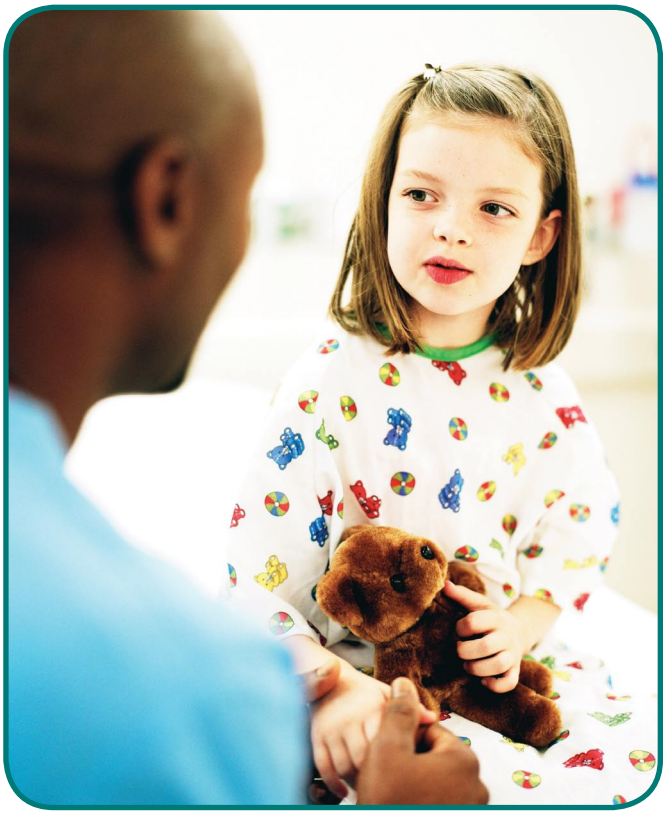
A New Web Directory for Providers

The Child Care Bureau recently announced Fit Source, a new Web directory of fitness and nutrition resources for child care and after-school providers. The directory features activities, lesson plans, healthy recipes, information for parents, and other tools for incorporating fitness and nutrition into child care and after-school programs. Resources on finance strategies, research, and community mobilization techniques related to childhood fitness and nutrition are also included. Look for this useful directory on the National Child Care Information Center Web site at *http://nccic.acf.hhs.gov/fitsource*.

Increasing Children's Health Coverage

Another Way Child Care Professionals Can Promote Children's Health

Detecting medical problems in a child's early years can be crucial to preventing major health concerns later in life; however, obtaining medical services, especially preventive care, can be difficult for families without health insurance. Working parents who earn low wages, and do not have health coverage through their jobs, often rely on early childhood professionals they know and trust for advice and help in finding health care for their children.



Early childhood program staff, in partnership with community-based organizations and State and local children's health insurance agencies, can alert families to available health coverage and help children become enrolled. Staff at Head Start, child care centers, family child care homes, preschools, after-school programs, and child care resource and referral agencies can inform parents about free or low-cost health coverage through Medicaid or a State Children's Health Insurance Program (SCHIP). SCHIPs make coverage available to nearly all the nation's 5.7 million low-income, uninsured children.

Early childhood programs can follow several simple but effective approaches to increase children's enrollment in health coverage.

Communicate from Classes and Clinics

Post information about free or low-cost health coverage on classroom bulletin boards, distribute it at parent meetings, or send it home with children's art projects, lunch menus, or notices about upcoming activities. Because most States require children in out-of-home care to be immunized, children without a regular health care provider might attend an immunization drive for shots, making these events great opportunities to inform families about coverage and offer application assistance.

Use the Child and Adult Care Food Program Application

Children eligible for free or reduced-price child care meals are also likely to qualify for Medicaid or SCHIP. Child care programs that serve meals under the Child and Adult Care Food Program (CACFP) can attach a flyer to the program application to inform families about children's health coverage and explain how they can receive application assistance.

Under Federal law, with parents' consent, child care programs can share information from a CACFP application with Medicaid and SCHIP to start the process to determine if children are eligible to receive free or low-cost health coverage.

Ohio Streamlines Applications

In Ohio, families can apply for Medicaid and SCHIP at the same time they apply for subsidized child care. Since the application for subsidized child care gathers most of the information needed to determine eligibility for Medicaid and SCHIP, the State created a one-page health insurance supplement that can be attached to its subsidized child care application.

For more information about Ohio's SCHIP program, contact Healthy Start & Healthy Families at 800-324-8680; for information about Ohio's Medicaid program, contact the Office of Ohio Health Plans at 614-644-0140.

Rules for sharing data and details about using the school lunch application to increase children's enrollment in health coverage can be found in *Enrolling Children in Health Coverage: It Can Start with School Lunch* at *www.cbpp.org/1-1-01health.pdf*.

Coordinate with Child Care Agencies

State and county agencies that determine eligibility for subsidized child care can run a computer match to learn whether children in the child care program also are enrolled in health coverage. If not, the agency can send families information about children's health insurance programs and help them apply.

Child care agencies can allow parents to apply for health coverage and subsidized child care at the same time, either by helping them complete the application or by conducting a presumptive eligibility* determination. If State or local children's health insurance program eligibility staff are available, they can speed enrollment in Medicaid or SCHIP by presumptively enrolling children, if the State permits.

Child care agencies also can make it easier for children to keep health coverage by providing family income and other information for Medicaid and SCHIP renewal, so families do not have to produce documents they already have supplied to the child care agency.

Help Child Care Providers Enroll Their Own Children

Child care providers, who frequently earn low wages and receive few employee benefits, may have children of their own who are eligible for Medicaid or SCHIP. Providers who experience easy, successful enrollment for their own children will be more likely to discuss children's health coverage programs with the families of children in their care.

This article includes excerpts from Enrolling Children in Health Coverage Before They Start School: Activities for Early Childhood Programs *(2001), prepared for Covering Kids by Donna Cohen Ross and Meg Booth, which is available at www.cbpp.org/10-1-01health.pdf.*

* Presumptive eligibility is a Federal option under which States allow certain agencies, including Head Start and those responsible for determining subsidized child care, to enroll children who appear to qualify for Medicaid or SCHIP for a temporary period, pending a final eligibility decision by the agencies that administer these programs. Children receive health coverage immediately, without having to wait for their applications to be fully processed by the children's health insurance agency, and health providers are paid for care they deliver during the temporary period, regardless of the final eligibility decision. In States that allow presumptive eligibility but do not yet allow the full range of "qualified entities," child care programs can create partnerships with agencies or organizations authorized to presumptively enroll children and arrange for them to assist the families of children in the child care programs.

As of July 2005, six States (CA, IL, MA, MD, NJ, and NM) have adopted presumptive eligibility in their children's Medicaid programs or both children's Medicaid and SCHIP. (MI, NH, and NY have presumptive eligibility in their separate SCHIP programs only.)

California's 100% Campaign

With support from the California Endowment, Children Now, the Children's Defense Fund, and the Children's Partnership have spearheaded the 100% Campaign: Health Insurance for Every California Child. This campaign is implementing a pilot program in Fresno County. This program is supporting a partnership between the Central Valley Children's Services Network, a child care resource and referral agency, and the Fresno Health Consumer Center (FHCC), an advocacy group and health insurance enrollment organization, to increase children's enrollment in low-cost health care programs. This pilot project provides outreach to families in three ways:

- Encouraging child care providers to distribute flyers about health insurance to parents;
- Informing parents seeking child care about how FHCC can help them enroll in health coverage (i.e., providing FHCC contact information to parents, and conducting a follow-up call to interested families to offer enrollment assistance); and
- Including FHCC contact information with every child care application mailed, and reminding parents who are on the waiting list for subsidized child care about how FHCC can help them apply for health insurance.

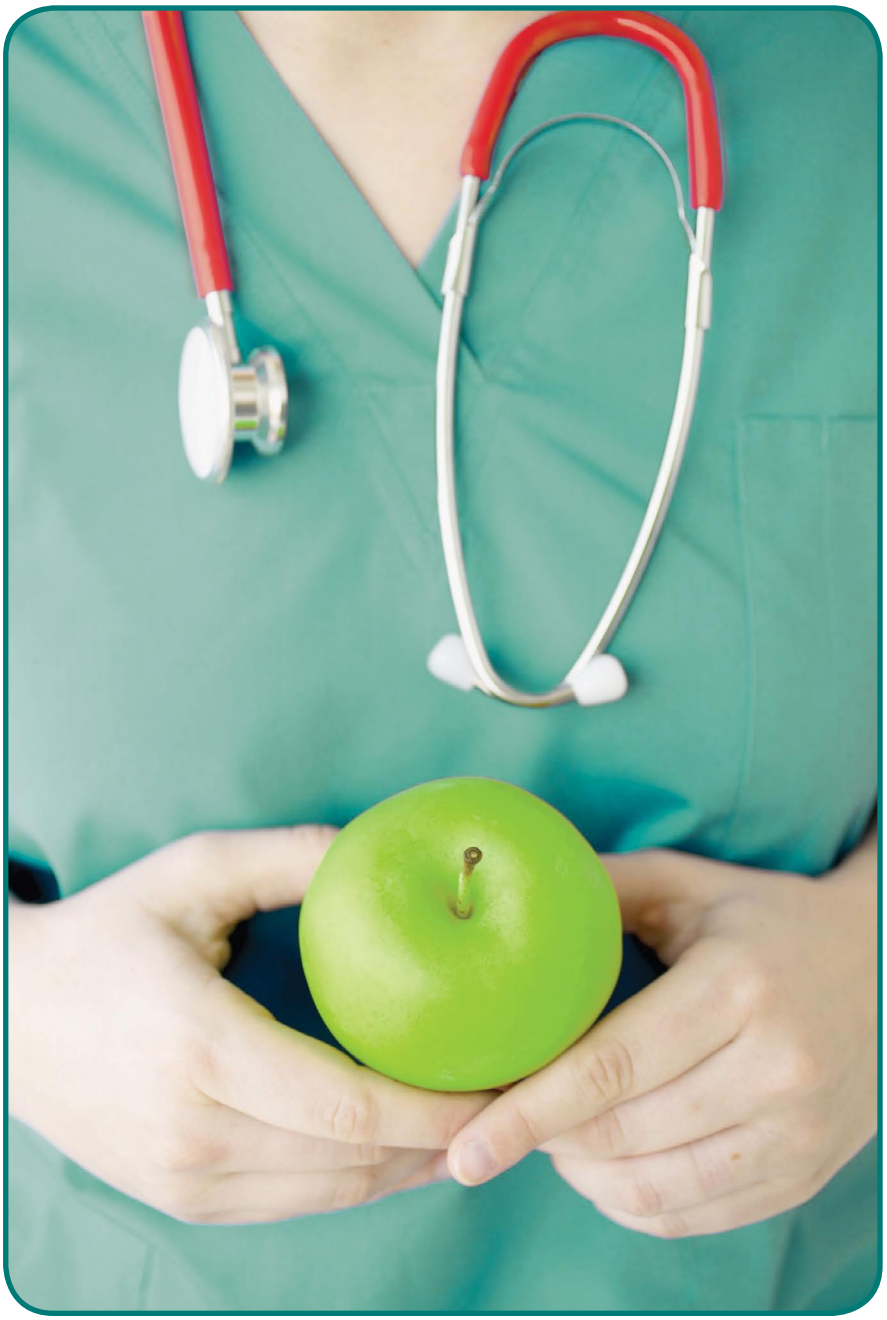
For more information about the Fresno pilot project or the 100% Campaign, visit www.100percentcampaign.org.

Beyond the Stethoscope

Pediatricians, Child Care, and Children's Health

by Liz Jarvis, Division Assistant, Child Care Initiatives, American Academy of Pediatrics

Quality child care and early education can have a profound positive impact on children's health, development, and ability to learn. The striking correlation between children's experience in quality child care and later success demonstrates the importance of continually improving child care environments. The American Academy of Pediatrics (AAP) understands its members can make a significant contribution to making quality child care available throughout the country.



AAP encourages pediatricians to help parents promote healthy early learning environments for their children's development and act as advocates for improved child care in their communities. Stimulating communication and collaboration between health care professionals and child care providers also generates quality. As AAP volunteer and child care advocate Susan Aronson, M.D., explains, "The gulf between these two disciplines can be bridged by education of each about the potential value of working together and the most significant issues that should be addressed. When the bridge is built, quality improves in both the health and education of children."

In addition to partnering with child care providers, pediatricians have tremendous opportunities to work with patients and their communities to enrich children's child care experiences. The AAP policy statement, *Quality Early Education and Child Care from Birth to Kindergarten*, was prepared by the AAP Committee on Early Childhood, Adoption, and Dependent Care and makes several recommendations for pediatrician action:

- Ask families about their arrangements for infant and young children's care.
- Provide a medical home for patients by creating a three-way partnership with parents and child care providers. A 2002 AAP policy statement defines a medical home as "high quality care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."
- Learn to recognize and share the essential components of quality early education and child care programs.

- Provide families with information and resources to help them choose and afford quality programs.
- Educate policy-makers about the correlation between child care and later outcomes, emphasizing the key factors in quality programs—parent involvement, strong developmental elements, and a safe, healthy environment. Each AAP chapter has a legislative group, and most chapters have AAP Chapter Child Care Contacts who are wonderful resources for advocacy efforts.
- Work to improve national and State funding by mobilizing action through AAP's national organization and its chapters.

In collaboration with child care providers and early childhood advocates, pediatricians can make a substantial difference in the healthy development of children in child care. And by enhancing the quality of early education and child care programs, pediatricians and their partners can help all children reach their potential.

For more information about child health and safety or to access Quality Early Education and Child Care from Birth to Kindergarten, *visit www.healthychildcare.org or e-mail hcca@aap.org.*

How Pediatricians are Involved...

"Pediatricians are already involved in the promotion of quality early education and child care in a variety of ways. Many already counsel families about finding quality situations for their children and have reliable resources to share with these families. Pediatricians are also working with their State policy-makers to shape access to quality through Federally supported efforts like the State Early Childhood Comprehensive Systems initiatives or through community-based coalitions or programs. Most States have AAP Chapter Child Care Contacts who are involved at all these levels and encourage other pediatricians to do more."—Dr. Danette Glassy, Chairperson, American Academy of Pediatrics Early Education and Child Care Special Interest Group

To find out how pediatricians are involved in promoting quality child care in your local area, or to find a pediatrician, visit www.healthychildcare.org or e-mail hcca@aap.org. For information about State AAP chapter activities, visit www.aap.org/member/chapters/chapters.htm.

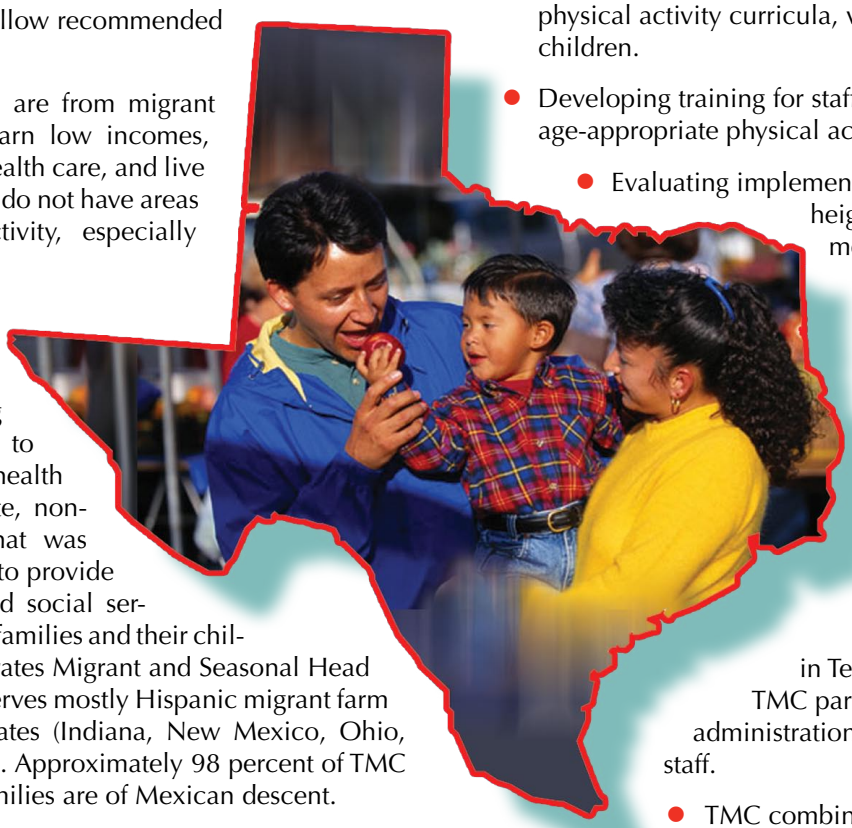
Helping Hispanic Migrant Families Become Healthier

by Sonia Cotto-Moreno, Child Care Food Program Director, Texas Migrant Council

Data collected by the Texas Department of Health have generated concern about the health of the State's children:

- Approximately 22 percent of Texas children are obese.
- Approximately 6 percent are at risk for diabetes.
- About 29 percent are inactive.
- Physical activity levels of 46 percent are insufficient.
- Only 25 percent follow recommended levels of activity.

Many at-risk children are from migrant families who often earn low incomes, have poor access to health care, and live in neighborhoods that do not have areas for safe physical activity, especially when they migrate.[1-6]



Several organizations, including the Texas Migrant Council (TMC), are working with migrant families to reduce children's health risks. TMC is a private, nonprofit organization that was incorporated in 1971 to provide health, education, and social services to Texas migrant families and their children. The agency operates Migrant and Seasonal Head Start (MSHS), which serves mostly Hispanic migrant farm workers in several States (Indiana, New Mexico, Ohio, Texas, and Wisconsin). Approximately 98 percent of TMC staff, children, and families are of Mexican descent.

TMC centers are in a great position to help prevent childhood obesity and diabetes as well as promote general health and nutrition because TMC staff interact frequently with children and families. During the summer, TMC migrant children might be at MSHS centers an average of six to ten hours, six days a week.

To help migrant families become healthier, TMC staff are following several key strategies:

- Emphasizing the need for health guidelines.
- Using culturally relevant health and nutrition lesson plans.
- Using developmentally appropriate health and nutrition resources in the classroom.
- Building consensus with administrative and operational staff and governing bodies to focus on related issues.
- Developing policies that promote and model healthy lifestyle behaviors.
- Budgeting for materials and supplies, instructional physical activity curricula, videos, and equipment for children.
- Developing training for staff to effectively implement age-appropriate physical activity in classrooms.
- Evaluating implementation by tracking height and weight data and monitoring classroom lesson plans.

TMC staff have introduced a variety of innovative activities to implement these strategies, several of which are outlined below:

- Information about the obesity epidemic and increased childhood diabetes in Texas was shared with TMC parents, governing bodies, administration, and regional and center staff.
- TMC combined several different curricula and resources that incorporated scenarios familiar to Hispanic migrant farm workers, children, and families; included culturally relevant music (salsa, ranchera, Mexican, meringue, or folk); and used traditional games and songs from their culture. Newsletters on nutrition and handouts also were translated for parents.
- TMC developed the Sweet Foods Policy, which limits the amount of foods with high sugar content allowed during center activities (in the classroom and for parent contributions to class activities).

- A module that included a PowerPoint presentation, hands-on activities, and ways to document these activities for health and nutrition lesson plans was developed to train center staff.
- Healthy lifestyle promotions are embedded in science, literacy, and math activities throughout the week. These activities are documented in TMC MSHS lesson plans to facilitate ongoing evaluation of children's learning and the current curriculum.

TMC MSHS will continue to analyze annual health data of children from infancy through preschool to assess the impact of the nutrition and physical activity curriculum on migrant families and their community.

For more information about TMC or MSHS, visit http://tmccentral.org/english.htm. For information about child nutrition policies in Texas, visit the Texas Department of Agriculture's Square Meals: Nourishing Children's Bodies and Minds Web site at www.squaremeals.org.

[1] Texas Department of Health. (2000). *Texas Behavioral Risk Factor Surveillance Survey 2000.* Unpublished data.

[2] Texas Department of Health. (2001). *Texas Youth Risk Behavior Survey 2001.* Unpublished data.

[3] Sinha, R., Fisch, G., Teague, B., Tamborlane, W. V., Banyas, B., & Allen, K. (2002). Prevalence of impaired glucose tolerance among children and adolescents with marked obesity. *New England Journal of Medicine, 346*(11), 802–810.

[4] Hoelscher, D. M., Day, R. S., Lee, E. S., et al. (n.d.) *Measuring the prevalence of overweight in Texas school children.* Under review.

[5] Wong, W. W., Hollier, D. R., Myres, D., Fraley, J. K., Smith, E. O. B, & Klish, W. J. (2001). Childhood obesity in Texas: Evidence of rapidly developing epidemic. *Pediatric Research, 49*(4), 101A.

[6] Roman-Shriver, C. R., Atkinson, J. M., & Shriver, B. J. (2001). High prevalence of overweight children in a rural Texas school based clinic. *Texas Journal of Rural Health, 19*(2), 16–21.

Back to Sleep Reduces SIDS Risk

Deaths from Sudden Infant Death Syndrome (SIDS) have fallen nearly 40 percent since the launch of the Back to Sleep campaign, based on the American Academy of Pediatrics (AAP) recommendation to place healthy babies on their backs to sleep.

SIDS is the sudden death of an infant under 1 year of age that remains unexplained after a death scene investigation, autopsy, and review of the baby's medical history. Sometimes called crib death, SIDS is the leading cause of death in infants between 1 month and 1 year of age, most often occurring when a baby is between 2 and 4 months old. Although SIDS cannot be predicted or prevented, studies have shown that placing babies on their backs to sleep reduces the risk of SIDS.

In addition to placing babies on their backs to sleep, parents and caregivers can take other precautions:

- Place the baby to sleep in a safety-approved crib with a firm mattress.
- Keep the crib free of fluffy bedding, stuffed animals, and toys.
- Make sure the baby's sleep environment is smoke free.
- Avoid overheating the baby with too much clothing, bedding, or excess heat in the room.

Parents and caregivers should remember to incorporate awake and supervised tummy time for babies for building strong muscles that aid in proper development and for preventing the occurrence of a flat head.

More information about SIDS and the Back to Sleep campaign, which is sponsored by the National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, AAP, the Sudden Infant Death Syndrome Alliance, and the Association of SIDS and Infant Mortality Programs, can be found at *www.nichd.nih.gov/sids/*.

Visit *www.healthychildcare.org/section_SIDS.cfm* for information about the Healthy Child Care America Back to Sleep campaign, specifically geared toward child care providers, which suggests parents discuss babies' sleep position with providers and family members.

Health and Nutrition Resources

Administration for Children and Families (ACF)

Community Food and Nutrition Program (CFN)
800-281-9519
www.acf.hhs.gov/programs/fbci/progs/fbci_cfn.html

Fit Source
http://nccic.acf.hhs.gov/fitsource

Centers for Medicare and Medicaid Services (CMS)

Medicaid
877-267-2323
www.cms.hhs.gov/medicaid

State Children's Health Insurance Program (SCHIP)
877-267-2323
www.cms.hhs.gov/schip

Food and Nutrition Service (FNS)

Child and Adult Care Food Program (CACFP)
www.fns.usda.gov/cnd/Care/CACFP/cacfphome.htm

National School Lunch Program (NSLP)
www.fns.usda.gov/cnd/Lunch/default.htm

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
www.fns.usda.gov/wic

Health Resources and Services Administration (HRSA)

Maternal and Child Health Bureau (MCHB)
http://mchb.hrsa.gov

National SIDS/Infant Death Resource Center (NSIDRC)
866-866-7437
www.sidscenter.org

National Agricultural Library (NAL)

Child Care Nutrition Resource System
www.nal.usda.gov/childcare/index.html

Food and Nutrition Information Center (FNIC)
www.nal.usda.gov/fnic

National Institutes of Health (NIH)

Medline Plus
U.S. National Library of Medicine
http://medlineplus.gov

National Institute of Child Health and Human Development (NICHD)
800-370-2943
www.nichd.nih.gov/default.htm

Additional Federal Resources

Centers for Disease Control and Prevention (CDC)
800-311-3435
www.cdc.gov

MyPyramid.gov
Center for Nutrition Policy and Promotion
www.mypyramid.gov

The President's Council on Physical Fitness and Sports
Department of Health and Human Services
www.fitness.gov

The Steps to a HealthierUS
Office of Disease Prevention and Health Promotion
Office of Public Health and Science
www.healthierus.gov/steps/index.html

Links to national health and nutrition organizations and publications can be found in *Childhood Obesity Prevention* and *Early Childhood Nutrition Resources* on the NCCIC Web site at *http://nccic.org/poptopics/childobesity.html* and *http://nccic.org/poptopics/infant-nutrition.html*, respectively.

2005
The Year of the Healthy Child

Remember…the U.S. Surgeon General has designated 2005 The Year of the Healthy Child. Do your part to ensure a healthier population for the next generation.

For more information, visit the Web at *www.hhs.gov/surgeongeneral/healthychild*.

Child Care Bulletin
Fall 2005

Please circulate or photocopy the Child Care Bulletin for maximum distribution

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