September 18, 2015

Office of Head Start
Administration for Children and Families
U.S. Department of Health and Human Services
Attention: Director of Policy and Planning
1250 Maryland Avenue SW
Washington, DC 20024

SUBMITTED ELECTRONICALLY

Re: ACF-2015-0008: Head Start Performance Standards

To Whom It May Concern:

Trust for America's Health (TFAH) is thankful for the opportunity to comment on the Administration for Children and Families (ACF) proposed rulemaking concerning Head Start Performance Standards. TFAH is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. Head Start, with its programs to "support the comprehensive development of children from birth to age 5,"[1] operates in accordance with this goal. Indeed, the link between education,[2] especially early childhood education,[3] and health is well established in both its positivity and strength.[4] Accordingly, the Head Start Performance Standards proposed rule, with its focus on early childhood education and development is of great importance to public health.

Given our report, *The State of Obesity: Better Policies for a Healthier America*, which we release annually with the Robert Wood Johnson Foundation, we are particularly concerned with the impact that childhood obesity is having on our nation's health.[5] Today, more than 3 in 10 (31.8 percent) of our children are either obese or overweight.[6] About ten percent of infants to two year olds and 23 percent of children from ages two to five are overweight or obese.[7] TFAH

[1] Office of Head Start. (2015, June 22). About the Office of Head Start. Available from: http://www.acf.hhs.gov/programs/ohs/about
[2] Ross, C.E., Wu, C. (1995) The Links Between Education and Health. *American Sociological Review*. 60(5): 719-745
[3] Campbell, F., Conti, G., Heckman, J. J., Moon, S. H., Pinto, R., Pungello, E., & Pan, Y. (2014). Early childhood investments substantially boost adult health. *Science*, *343*(6178), 1478-1485.
[4] Montez, J. K., & Friedman, E. M. (2015). Educational attainment and adult health: Under what conditions is the association causal?. *Social Science & Medicine*, (127), 1-7.
[5] Trust for America's Health. The State of Obesity 2014: Better Policies for a Healthier America. www.stateofobesity.org
[6] Id.
[7] Ogden CL, Carroll MD, Curtin LR, et al. 2014. "Prevalence of High Body Mass Index in US Children and Adolescents, 2011-2012." *Journal of the American Medical Association* 311(8), 806-814. http://dx.doi.org/10.1001/jama.2014.732

recognizes the importance of Head Start settings in providing numerous opportunities to promote healthy eating and physical activity behaviors in young children to help prevent obesity and other related comorbidities. We support the enhanced emphasis on nutrition as part of healthy development, and we offer specific suggestions on how to strengthen language around healthy eating.

We at TFAH are pleased that ACF has made updating this rule a priority. Our specific comments regarding the contents of the proposal are outlined below:

TFAH encourages incorporating hospital Community Health Needs Assessments (CHNAs) into Head Start's community assessments.

We recommend incorporating information from hospital Community Health Needs Assessments, where available, in Head Start community assessments to ensure programs are designed to meet the broadest scope of community needs possible (page 35528, first column, § 1302.11(b)). Under the Affordable Care Act, nonprofit hospitals are subject to updated standards for reviewing the health needs of the communities they serve.[8] The contents of these "community health needs assessments," or CHNAs, vary from hospital to hospital, but must draw on "input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health." As such, they represent an invaluable resource for other stakeholders in the community, including Head Start, to develop their own programs to serve community needs. The importance of health factors is also reflected in the proposed requirements that Head Start community assessments include estimates of many health-related measurements including pregnancies, status of disabilities among children, and health and nutrition needs for children and their families. Consequently, hospital CHNAs are a particularly relevant tool for broader community assessments like those Head Start must undertake. With this in mind, we believe that Head Start programs should be required to consider the contents of CHNAs from 501(c)(3) hospitals within their communities and use these assessments to inform the design of their programs.

We support the proposed inclusion of "nutrition" as a component of the community assessment provision and we recommend the final rule include the term "physical activity" be added after the word "nutrition" in the description of the community assessment required on pg. 35528, first column, §1302.11 (b) (vii), so that the section would state, "The education, health, nutrition, *physical activity,* and social service needs of eligible children and their families; and …" We also respectfully note that the YMCA's Early Childhood Program Assessment tool the Community Healthy Living Index (CHLE) may provide some guidance on assessing the physical activity environment.[9]

[8] Internal Revenue Service. New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act. http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act. Updated June 9, 2015.

[9] YMCA's CHLE: http://www.ymca.net/sites/default/files/communityhealthylivingindex/chli-assess-early-childhood.pdf

TFAH supports new regulations for tracking attendance and addressing absenteeism.

We strongly support increased efforts to promote regular Head Start attendance of each child (page 35531, first column, § 1302.16). In order for children to receive the developmental and educational instruction they need to thrive, it is imperative that they are present to receive instruction. Children can develop problematic patterns of attendance early in their academic careers and, in carrying these patterns throughout their schooling, are more likely to drop out of school than their peers with more regular attendance.[10] It is inappropriate and reductive to attribute absenteeism to "truancy" when children often miss school for "excused" health reasons including asthma, dental problems, and mental health issues.[11] When taken in context with research that suggests that education and health are positively associated, absenteeism is potentially both a cause and an effect of poor health.

We favor many of the methods the proposed rule employs to address this problem. The proposed rule requires tracking attendance for each child instead of counting the total number of students in the program each day. The latter method of attendance tracking may mask patterns of problematic absenteeism among individual children, which represents a missed opportunity to identify children in need of services. The rule also requires program staff to conduct home visits for children who miss 4 consecutive days in a row or who are "frequently absent." We approve of conducting home visits for students exhibiting patterns of absenteeism and recommend the rule include more clarity about the definition of "frequently absent" as we are concerned the current text is open to interpretation. This ambiguity may allow some students who would benefit from home visits to fall through the cracks. Finally, we welcome the new requirements to manage systematic program attendance. The proposed rule requires programs to conduct analyses and, if necessary, address public health related issues that may be contributing to absentee rates when its attendance rate falls below 85 percent. We enthusiastically support such a requirement and its potential to impact population health.

TFAH supports increasing Head Start dosage for program participants.

In a similar vein, we support increasing both the minimum required hours in Head Start programs from 3.5 to 6 hours per day and the minimum number of required service days from 128 to 180 per year (page 35532, third column, § 1302.21(c)). As we have previously noted, education and health are positively correlated. It follows that maximizing instruction time, whether through minimizing absenteeism or through increasing the availability of programming, is important to help ensure positive health, development, and educational outcomes for children. As ACF notes in its proposed rule, the current minimums for Head Start programs, both in service days per year and number of hours of instruction per day, are too low to produce strong childhood outcomes. This places the higher risk children Head Start often serves at a great disadvantage once they reach kindergarten, as they are far behind their lower risk peers with a nearly insurmountable task of catching up.[12] In order to give these children a chance to develop,

[10] Attendance Works. Mapping the Early Attendance Gap: Charting a Course for School Success. 2015. Available at: http://www.attendanceworks.org/research/mapping-the-gap/

[11] Id.

[12] Bernstein, S., West, J., Newsham, R., & Reid, M. (2014). *Kindergartners' Skills at School Entry: An Analysis of the ECLS*. Mathematica Policy Research.

learn, and be healthier like their lower-risk counterparts, we believe it is appropriate to increase instruction time in the manner proposed.

TFAH supports the updated requirements for programs to determine if children have appropriate sources of healthcare.

We support reducing the timeline to determine if an enrolled child has an appropriate source of healthcare (page 35537, second column, § 1302.42) to 30 days. Ensuring this assessment occurs within 30 days of the child's enrollment enables programs to identify such children who lack access appropriate healthcare more quickly. When coupled with the important proposed requirement that programs must "assist families in accessing a source of care and health insurance…as quickly as possible" when assessments reveal children do not have access to appropriate sources of healthcare, the proposed rule creates a system for establishing linkages between children and healthcare. Creating connections between patients and healthcare providers is a fundamental component of public health promotion, and we believe this regulatory update enhances Head Start's ability to create these linkages.

Additionally, we support the updated definition of appropriate sources of healthcare to include facilities that are "not primarily…source[s] of emergency or urgent care." Such facilities are sub-optimal for the Head Start population for a number of reasons: receiving primary care in these facilities costs more,[13] these facilities may be unequipped to meet pediatric needs,[14] and treating non-urgent conditions in emergency or urgent care settings funnels resources away from patients with more urgent needs.[15] We are pleased that ACF has recognized that it is insufficient for Head Start enrollees to use emergency and urgent care facilities for "ongoing sources of continuous, accessible health care" and has updated the definition of appropriate care accordingly.

We also applaud the proposed addition of the child's nutritional health needs assessment to this section as an important component of understanding whether a child is experiencing or is at-risk for poor nutrition or physical inactivity. We recommend strengthening language to better assess the food and beverage intake and activity status of children as follows:

- On page 35537, third column, (b)(4), after "body mass index" add "physical activity status," and after "nutrition-related assessment data," add "healthy eating, including eliminating sugar sweetened beverages, and encouraging the consumption of fruits, vegetables, whole grains and water…"
- On page 35537, third column, at the ending of § 1302.42(a)(4), we recommend adding: "If concerns continue to persist on these issues, then the family should be referred to the physician or primary care provider for further assessment."

[13] Wang, C., Villar, M. E., Mulligan, D. A., & Hansen, T. (2005). Cost and utilization analysis of a pediatric emergency department diversion project. *Pediatrics*, *116*(5), 1075-1079.

[14] Wier, L. M., Yu, H., Owens, P. L., & Washington, R. (2013). Overview of children in the emergency department, 2010.

[15] Berry, A., Brousseau, D., Brotanek, J. M., Tomany-Korman, S., & Flores, G. (2008). Why do parents bring children to the emergency department for nonurgent conditions? A qualitative study. *Ambulatory Pediatrics*, *8*(6), 360-367.

TFAH supports the updated requirements for programs to determine if pregnant women have appropriate sources of healthcare.

We also favor ACF's expansion of services for pregnant women enrolled in Head Start (page 35542, second column, § 1302.80). Many of the services mirror those Head Start already offers, or has proposed to offer, to its child enrollees. As discussed earlier, we support the 30 day requirement for programs to determine if pregnant women have "an ongoing source[s] of continuous, accessible health care." If pregnant women do not have access to appropriate sources of healthcare, we again support requiring programs to help them establish linkages between healthcare providers and insurers. As noted above, we also support the updated definition of appropriate sources of healthcare to include facilities that are "not primarily…source[s] of emergency or urgent care." Together these requirements will help secure the health of pregnant women and, in turn, their children.

TFAH supports oral health requirements to ensure tooth brushing every day.

We support the redesignation of oral health requirements in the proposed rule to ensure enrolled children are brushing their teeth every day (page 35538, first column, § 1302.43). Tooth decay is the most common chronic disease among children and is disproportionately burdensome for the disadvantaged and underserved populations Head Start targets.[16] Poor dental health can also prevent children from attending school which this proposed rule specifically takes steps to address in § 1302.16. We are pleased ACF has updated this rule to accurately reflect the expectations that children should brush their teeth every day. Moreover, we support removing the concept that oral hygiene should be promoted in conjunction with meals as it increases program flexibility to promote oral hygiene more generally. It is also consistent with research that suggests that one should not brush his or her teeth immediately after consuming food or beverages that can soften dentin.[17]

TFAH supports developing requirements for immunization.

We recommend the proposed rule expand on immunization requirements for children in Head Start programs by requiring all enrollees to receive vaccination when medically appropriate, regardless of state requirements (page 35531, first column, § 1302.15(e)). In February of this year, Representative Anna Eshoo of California introduced the Head Start on Vaccinations Act to the House of Representatives. The act establishes immunization requirements for all children in Head Start (with exemptions for those for whom vaccines are medically contraindicated).[18] We support this bill, and believe that ACF should strongly consider using a regulatory pathway to achieving greater access and immunization rates in Head Start programs through this proposed rule - both for children, and for Head Start staff.. Vaccination is one of the most effective tools to

[16] HHS Oral Health Initiative 2010. Available at: http://www.hrsa.gov/publichealth/clinical/oralhealth/hhsinitiative.pdf
[17] Attin, T., Siegel, S., Buchalla, W., Lennon, A. M., Hannig, C., & Becker, K. (2004). Brushing abrasion of softened and remineralised dentin: an in situ study. *Caries research*, *38*(1), 62-66.
[18] Head Start on Vaccinations Act, H.R.933, 114 Cong. (2015).

combat infectious disease available to healthcare providers.[19] However, evidence suggests the current trend of vaccine underutilization can lead to outbreaks.[20] Non-medical vaccine refusal is particularly dangerous for children because it puts them at greater risk for diseases like measles and pertussis while simultaneously threatening the health of those who are too young to be vaccinated.[21] Due to the importance of immunization for children, we believe ACF should not wait for Congress to pass the Head Start on Vaccinations Act, but instead use this opportunity to develop new regulatory guidelines for immunization in Head Start programs.

TFAH supports language aligning Head Start meals and snack nutrition standards to related USDA nutrition standards.

TFAH supports the proposed language (page 35538, first column, § 1302.44(a)(2)(iii)) to help ensure that Head Start programs serve meals and snacks that conform to U.S. Department of Agriculture (USDA) requirements in 7 CFR parts 210 (National School Lunch Program), 220 (School Breakfast Program), and 226 (Child and Adult Care Food Program). However, we recommend that the agency remove the additional language in that section that programs ensure meals are "high in nutrients and low in fat, sugar, and salt." We believe that in light of recently updated nutrition standards under these respective parts that this language is effectively redundant and potentially confusing.

We further recommend that the language for infants and toddlers § 1302.44(a)(2)(iv) be strengthened to ensure that programs are required to adhere to nutrition standards and meal patterns outlined in 7 CFR parts 210, 220, and 226. Specifically, we recommend that (2)(iv) read as follows:

> (iv) Feed infants and toddlers meals and snacks that conform to USDA requirement *in 7 CFR parts 210, 220, and 226, and* according to their individual developmental readiness and feeding skills as recommended in USDA requirements outlined in 7 CFR parts 210, 220, and 226, *and* ensure that infants and young toddlers are fed on demand to the extent possible;

TFAH supports language that supports breastfeeding.

We support the proposed rule's emphasis on breastfeeding (page 35538, first column, § 1302.44(a)(2)(viii)), including the requirement that programs properly store and handle breast milk, and make accommodations, as necessary, for mothers who wish to breastfeed during program hours.

[19] Omer, S. B., Salmon, D. A., Orenstein, W. A., deHart, M. P., & Halsey, N. (2009). Vaccine refusal, mandatory immunization, and the risks of vaccine-preventable diseases. *New England Journal of Medicine*, *360*(19), 1981-1988.
[20] Id.
[21] Id.

TFAH supports program collaboration with parents around health and wellbeing.

TFAH supports the proposed language (page 35538, second column, § 1302.46) to ensure that programs collaborate with parents to promote health and wellbeing by providing medical, oral, nutrition, and mental health education support services. Subsection (b)(ii) in particular will help programs work with parents to understand the importance of child's nutrition and physical activity status in promoting healthy development.

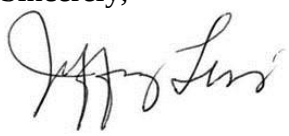
TFAH supports not withholding physical activity as a disciplinary action.

TFAH supports the addition of subsection (J) (page 35543, first column, § 1309.90(c)) to ensure that staff members do not take away a child's physical activity and/or outdoor time as punishment. As described throughout our comments, we believe strongly that fostering participation in regular physical activity is essential to child health and development.

Conclusion

Thank you for your consideration of these comments. We look forward to the release of the final rule, which we believe has considerable potential to improve the nation's health. If you have any questions, please feel free to contact Jack Rayburn, TFAH's Senior Government Relations Manager, at (202) 223- 9870 x 28 or jrayburn@tfah.org.

Sincerely,



Jeffrey Levi, PhD
Executive Director