Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

HEAD START SERVICES FOR CHILDREN WITH ASTHMA

JANET REHNQUIST
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT 15 2002

Debra Robinson

From Director, Regional Operations
Office of Evaluation and Inspections

Subject OIG Memorandum Report: "Head Start Services for Chil&en with Asthma,"
OEI-09-01-00330

To Wade F. Hom, Ph.D.
Assistant Secretary for
Children and Families

Attached is a memorandum report that assesses the type and level of service that Head Start grantees provide to children with asthma. The report is based on a combination of on-site reviews of a random sample of health records of children with asthma, interviews with the staff, teachers, and parents of children with asthma, and a mail survey administered to a random sample of Head Start grantees.

Our inspection indicates that Hekd Start grantees use a multifaceted approach at school to address the needs of children with asthma. Grantees develop asthma management plans and administer medication, when necessary. Grantees also train parents, teachers, and children to help them manage asthma. Although the Head Start Biireau (the Bureau) has taken steps to address asthma, its initiatives could be strengthened. The Bureau's primary initiative has been the publication of training guides for Head Start staff. The Bureau collects data on asthma as well as many other health conditions, but the data are unreliable because grantees are unsure about how to report the health status of children that they serve. Although asthma is the top chronic disease among Head Start children, it is one of many serious health conditions affecting Head Start children and their families.

We identified two opportunities for improvement. The Head Start Bureau could consider:
(1) determining how available resources could better meet the needs of grantees, and
(2) improving data collection by outlining specific reporting requirements for health statistics.

You are welcome to provide comments but are not required to do so, since the report contains no recommendations. If you have any questions about this report or would like a meeting to discuss more detailed information, please have your staff contact Elise Stein, Director, Public Health and Human Services at (202) 619-2686.

Attachment

EXECUTIVE SUMMARY

OBJECTIVE

To assess the type and level of service that Head Start grantees provide to children with asthma.

BACKGROUND

The Head Start program offers comprehensive early childhood education, nutrition, and health and social services to low-income children from birth to age 5. The program serves approximately 900,000 children through approximately 1,545 grantees. In Fiscal Year (FY) 2001, the budget for Head Start totaled nearly $6.2 billion. Within the Department of Health and Human Services, the Head Start Bureau (the Bureau), which is part of the Administration for Children, Youth and Families, oversees the program.

Since the creation of Head Start in 1965, comprehensive health services have been an integral part of the program, which aims to improve children's "social competence" by providing a broad range of both cognitive and social services. Head Start grantees are subject to extensive requirements, or performance standards, in the area of health. The Head Start Bureau reviews compliance once every 3 years.

Asthma is a growing problem for Head Start as well as the nation as a whole. It is the most common chronic disease of childhood and places a disproportionate burden on minority groups and the poor, the populations that Head Start serves.[1]

We determined how Head Start serves children with asthma and their families by reviewing a random sample of children's health records, interviewing Head Start staff and the parents of children with asthma, and conducting a mail survey of a random sample of Head Start grantees. We reviewed 245 records and visited a total of 42 grantees, and we mailed surveys to health coordinators at 300 grantees.

The findings discussed in this report reflect information gathered from record reviews, on-site interviews, and mail surveys. We also analyzed grantees' medication administration policies.

[1]Department of Health and Human Services, Office of Science Policy, "Action Against Asthma: A Strategic Plan for the Department of Health and Human Services," May 2000, page 3.

FINDINGS

Head Start grantees use a multifaceted approach to address the needs of children with asthma. Approximately 50 percent of grantees develop asthma plans for all children with asthma in their program. In addition, 84 percent of grantees provide education and/or training to parents of children with asthma while 55 percent provide education to the children themselves. Some grantees make special efforts to address the needs of children with asthma by developing community partnerships to enhance their program and services.

The Head Start Bureau has taken steps to address asthma, but its initiatives could be strengthened. Although the Bureau has responded to the increased prevalence of asthma by issuing training guides, grantees do not use them. Furthermore, grantees are not always aware of and rarely rely on the resources that the Bureau provides.

National Head Start data concerning the prevalence of asthma among Head Start children are unreliable. The Bureau collects data on a range of health conditions, including asthma, but the data are unreliable because grantees are unsure how to report the health status of children they serve. Although children have been reported as having asthma, we could not find documentation to support reporting for 13 percent of the children.

Asthma is one of many health conditions affecting Head Start children and their families. Most grantees reported that asthma is no more difficult to manage than other health conditions that children have, such as dental problems, obesity, and anemia.

CONCLUSION AND OPPORTUNITIES FOR IMPROVEMENT

Although asthma affects an increasing number of Head Start children, grantees can meet their needs at school by developing management plans, administering medication, and educating children with and without asthma, parents, and staff. According to the grantees that we interviewed, asthma is no more difficult to manage than other health conditions that Head Start children face. The Administration for Children, Youth and Families, which administers Head Start, has tried to address asthma, but it could improve the support it provides to grantees.

The Head Start Bureau could consider:

- determining how available resources could better meet the needs of grantees and
- improving data collection by outlining specific reporting requirements for health statistics.

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INTRODUCTION

OBJECTIVE

To determine the type and level of service that Head Start grantees provide to children with asthma.

BACKGROUND

Head Start Today

The Head Start program offers comprehensive early childhood education, nutrition, and health and social services to low-income children from birth to age 5. In Fiscal Year (FY) 2001, the budget for Head Start totaled nearly $6.2 billion--$6 billion for programs and projects and approximately $200 million for support activities. The program serves approximately 900,000 children, mostly 3- and 4-year olds, through approximately 1,545 grantees. Nearly 80 percent of Head Start families have an annual income of less than $15,000, and the head of household in 53 percent of Head Start families works full-time. The program serves a multiracial population and an estimated 42 percent of eligible children.[2]

Health Services in Head Start

Since the creation of Head Start in 1965, comprehensive health services have been an integral part of the program. The health services component reflects Head Start's approach to improving children's "social competence" (i.e., cognitive, linguistic, social, emotional, and physical development). Head Start programs are required to ensure that each child receives a range of health care services, including medical, dental, mental health, and nutritional. The program increases access to preventive health services and treatment. Head Start children are more likely to receive medical examinations and treatment than non-Head Start children.[3]

[2] Head Start Bureau, *2002 Head Start Fact Sheet*, found at <http://www2.acf.dhhs.gov/programs/hsb/research/02_hsfs.htm> April 25, 2002.

[3] Zigler, E., *Health Services in Head Start*, Annual Rev. Pub. Health 15:511-34 (1994).

Performance Standards for Health Services

In 1975, the Head Start Bureau established performance standards for each component of the program: education, parent involvement, social services, and health. In 1996, the Bureau revised the standards and issued new requirements for six broad health-related areas: determining child health status; developmental, sensory and behavioral screening; extended follow-up and treatment; ongoing care; involving parents; and individualization of the program. Today, a total of 24 performance standards apply to health services for children with asthma. The standards are general and do not refer specifically to asthma or any other health condition. Head Start grantees have the discretion to establish their own programs to meet the standards, and the Head Start Bureau reviews grantees' compliance with all performance standards once every 3 years.

The Growing Problem of Asthma Among Head Start Children and the Head Start Bureau's Response

Asthma is the most common chronic disease of childhood. The rate of asthma in children under the age of 5 has increased more rapidly than the rate for any other age group; in 1999, it was estimated that approximately 1.4 million children under the age of 5 have the disease.[4] Children with asthma under the age of 15 account for approximately 3 million physician visits and nearly 200,000 hospitalizations each year.[5] The estimated annual cost for treating asthma in children under 18 is $3.2 billion.[6] Asthma can affect the quality of life for children and their families and may cause interrupted sleep, limits on activity, disruption of routines, and absences from school.

Early childhood asthma can be successfully managed. Despite the prevalence of pediatric asthma and its potential for adverse impact, the American Academy of Allergy Asthma & Immunology (AAAI) reports that "expected outcomes of care for children with asthma should be high."[7] According to AAAI, "symptoms can be controlled; the disease can be controlled; and activity limitations are not necessary."[8] Schools have a significant role to

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[4]American Academy of Allergy Asthma and Immunology. *"Pediatric Asthma: Promoting Best Practice: Guide for Managing Asthma in Children,"* 1999, page 2.

[5]Id., page 3.

[6]American Lung Association. *"Asthma in Children Fact Sheet,"* found at <http:///www.lungusa.org/asthma/ascpedfac99.html> April 25, 2002.

[7]American Academy of Allergy Asthma and Immunology. *"Pediatric Asthma: Promoting Best Practice: Guide for Managing Asthma in Children,"* 1999, page 3.

[8]Id.

play in asthma management, because they "are a natural community hub for children and families, and thus a good base for asthma education and referral to health care and social services."[9] Schools also may administer medication to children who need it.

According to the Head Start Bureau, asthma has been the top chronic disease among Head Start children for years, and an estimated 4 percent of all children enrolled in the program "receive treatment" for asthma.[10] Asthma places a disproportionate burden on minority groups and the poor, the populations that Head Start serves. The report *Action Against Asthma, A Strategic Plan for the Department of Health and Human Services* notes that "low-income and minority populations experience substantially higher rates of fatalities, hospital admissions, and emergency room visits due to asthma."[11]

The Head Start Bureau has attempted to address asthma by issuing two training guides for staff. The first guide, *Sustaining a Healthy Environment*, discusses environmental factors, such as second hand smoke, that may trigger asthma. The second guide, *Caring for Children with Chronic Conditions*, contains information on the causes of asthma; how to identify and recognize asthma in a preschool setting; sample asthma management plans; and planned classroom activities. In addition to the training guides, a national Head Start Training and Technical Assistance Network is available to assist grantees.

METHODOLOGY

To meet the objectives of our study, we used a multi-method research approach. In order to obtain a complete picture of what services Head Start provides to children with asthma, we conducted (1) an on-site review of a random sample of health records of children with asthma, (2) interviews with the staff, teachers, and parents of children with asthma, and (3) a mail survey administered to a random sample of Head Start grantees.

On-site record review and interviews. We developed on-site record review instruments and interview guides to determine how grantees identify children with asthma and to assess what types of documentation grantees maintain regarding the management of children's asthma at school. We sought information on a number of items including

[9]Marielena Lara, MD, MPH et. al., "Improving Childhood Asthma Outcomes in the United States: A Blueprint for Policy Action," *Pediatrics*, Vol. 109, No. 5, May 2002, page 921.

[10]Head Start Bureau, *Head Start Program Information Report for the 2000-2001 Program Year*, 2002.

[11]Department of Health and Human Services, Office of Science Policy, *"Action Against Asthma, A Strategic Plan for the Department of Health and Human Services,"* May 2000, page 3.

(1) children's health insurance status, (2) children's health history, as reported by parents and/or physicians, (3) asthma management plans, (4) communication between Head Start staff and parents regarding the children's condition, and (5) medication administration.

The purpose of the on-site interviews was to obtain additional information about the grantees' policies and practices related to children with asthma. We interviewed Head Start directors, teachers, health services personnel, and parents of children with asthma. We gathered information on several topics including asthma screening, staff training, asthma management plans, parental involvement, asthma education and training for parents and children, and medication administration.

We pretested the final record review instruments and interview guides with grantees and solicited and received comments from experts and researchers knowledgeable about pediatric asthma.

Sampling methodology for record review. We used stratified cluster sampling to select the children whose records we reviewed. We chose this sampling methodology because we wanted to project our findings to the entire population of children with asthma enrolled in the Head Start program. We grouped all children in the Head Start program into geographic clusters based on the zip code of the program they attended. Each cluster contained approximately 15 children with asthma. We then randomly selected 15 of these clusters in three geographic strata: 3 clusters from the western United States, 5 clusters from the central United States, and 7 clusters from the eastern United States. Within each sample cluster, we reviewed the records of all children with asthma. Our sample consisted of 258 children with asthma. We reviewed records for 245 of these children (95 percent of the total), and we visited a total of 42 grantees. Appendix A contains a more detailed explanation of the child record review sampling methodology.

CLUSTER SAMPLE OF CHILDREN

Strata	Cluster Universe	Number of Clusters Selected
Western U.S.	531	3
Central U.S.	886	5
Eastern U.S.	1257	7

Record reviews allow researchers to view and assess the documentation and other information maintained by respondents. While records provide useful information on practices and performance, the quality of records can be affected by resource constraints.

The usefulness of record reviews may be limited if records do not accurately reflect respondents' procedures.

Mail survey. The mail survey was designed to provide descriptive information on grantees' policies and procedures related to children with asthma. The survey solicited information on the same topics included in the on-site interviews. In addition, we analyzed medication administration policies submitted by grantees. We pretested the mail survey and solicited feedback from Head Start grantees.

Sampling methodology for mail survey. We selected 300 grantees by using a stratified sample. We selected this methodology because we wanted to ensure that we would collect information from grantees that have experience caring for children with asthma. Using the Program Information Report (PIR) data from the 2000-2001 school year, we grouped grantees into three strata based on the number of children with asthma in their program. The first stratum consisted of the 100 grantees with the most children with asthma. The second stratum consisted of the 25 percent of the remaining grantees with the most children with asthma. The third stratum consisted of all remaining grantees. Our response rate for the mail survey was 87 percent (262/300).

MAIL SURVEY SAMPLE

Strata	Grantee Universe	Number of children with asthma per program	Grantees Selected
Stratum I	100	70 or more	100
Stratum II	605	17 to 70	100
Stratum III	1813	fewer than 17	100
TOTAL	2513		300

Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

We used a combination of record reviews, on-site interviews, and mail surveys to determine how Head Start grantees serve children with asthma. We found that grantees meet the needs of children with asthma by developing written action plans, administering medication, and educating and training children, parents, and staff. The Head Start Bureau has attempted to support grantees and collect data on the health status of children, but its efforts could be strengthened and its data are unreliable.

Head Start grantees use a multifaceted approach to address the needs of children with asthma

Grantees consistently conduct initial health assessments during which parents disclose if their child has asthma

According to program performance standards, Head Start grantees are required to request information about the child's overall health condition from the child's parent.[12] Grantees consistently gather this information before school begins and compile a health history for the child (See Appendix B). We found that 94 percent of children's records contained a copy of the child's health history, which includes information about everything from prenatal care to current health conditions. Nearly 80 percent of the records we reviewed showed that the parent had reported the child's asthma to the grantee during the initial assessment.

Performance standards also require grantees to obtain documentation related to the child's current health status from a physician or other health professional.[13] We found evidence of physician[14] diagnosis in only 44 percent of the records we reviewed. However, grantees request information from a physician when a child takes medication at school. Staff interviewed during our on-site record review provided their own explanations for the lack of physician documentation. The most common explanations were: difficulty obtaining information from physicians; lack of parental effort to obtain requested documentation; and misplaced or lost documents from records.

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[12] Program Performance Standards for Operation of Head Start Programs by Grantees and Delegate Agencies, 45 C.F.R. § 1304.22(b)(3).

[13] 45 C.F.R. § 1304.20(a)(1)(ii) (2002).

[14] Throughout this report, the term "parent" may refer to: parent(s); other family members; other caregivers; and/or legal guardians.

Grantees address the needs of children with asthma by developing management plans and administering medication when necessary

Asthma Management Plans. Grantees play a critical role in asthma management because children now spend more time at school. According to national Head Start statistics, the number of Head Start families requiring full-day, full-year child care for their enrolled child has increased significantly. According to one grantee we visited, "Welfare reform has had a significant impact on our families. Ten years ago, before welfare reform, approximately 60 percent of our families were working; now it's approximately 85 percent."

> **"The present asthma program available to our centers has demonstrated a reduction in sick time and days missed. The children's asthma is much improved and the children are learning how to manage their asthma at home and at the center. The program has made a dramatic difference to our children."**
> *Head Start Grantee*

Asthma management plans are one component of grantees' efforts to manage asthma. These plans are documents that may identify the early warning signs of an asthma episode, the medications that a child uses and instructions for administering them, and when to contact the physician or emergency room (see Appendix B for examples of plans used by Head Start grantees). The development of an asthma management plan is part of one of the four key components identified by the National Asthma Education and Prevention Program (NAEPP) of the National Heart Lung and Blood Institute (NHLBI) for long-term control of *persistent* asthma in children.[15] By developing plans, Head Start grantees meet the performance standard which requires that they "develop and implement a follow-up plan for identified conditions."[16]

Approximately 48 percent of grantees indicate that they develop written asthma management plans for *all* children with asthma in their program. Among those grantees that do not develop plans for all children with asthma, many report that they develop plans for children under specific circumstances. For example, grantees may develop plans for children who take medication at school, children with severe asthma, or children with physical and/or dietary restrictions.

One grantee that we visited has developed an asthma protocol to identify the children who need an asthma management plan. After identifying children with active asthma who take medication at school, the grantee works with the child's parent and physician to

[15] National Heart, Lung, and Blood Institute, National Asthma Education and Prevention Program. *Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma.* National Institute of Health pub no 97-4051. Bethesda, MD, 1997.

[16] 45 C.F.R. § 1304.20(a)(1)(iv).

develop an appropriate plan. For children who either have active asthma, but do not take medication at school, or children who do not have active asthma, but who have had a history of the disease, the grantee will note them on a health alert list that is posted in every classroom.

We found asthma management plans in 30 percent of the records that we reviewed. While we did not consistently probe as to the reason the plan might be absent from the child's record, several of the staff members we interviewed offered the following explanations: the grantee does not develop action plans for any of their children; the child had asthma before entering the program, but does not exhibit any symptoms now; parents fail to return information to the program, so the plan cannot be completed; or the grantee only develops plans for children who meet certain criteria, including: children with activity restrictions, children who take medication at school, or children whose asthma is severe.

Medication Administration. Grantees are required to "establish and maintain written medication administration procedures."[17] We found that grantees meet this requirement and are prepared to deliver medication to children who need it. Most grantees (85 percent) that responded to the mail survey report that their staff are authorized to administer medication to children with asthma. We reviewed written policies and found that staff often administer medication after receiving written orders from the child's physician and instructions from the parent (see Appendix B for a sample medication administration policy).

Although grantees are prepared to administer medication, children with asthma often do not need it. One grantee reported, "while we do have a plan for each child with asthma, we rarely need to administer medication at school." We found that at least 53 percent of children with asthma do not receive medication at school. One possible explanation is that parents administer medication at home. When children need medication, the typical drug is albuterol.[18] Of the children we could determine took medication at school, approximately 91 percent took albuterol.

An integral part of Head Start's plan for managing children with asthma is education, training, and parent involvement

Patient Education. Approximately 55 percent of grantees provide some type of education and training to children with asthma. According to NAEPP, "patient education is an essential component of successful asthma management."[19] In order to learn how to manage the disease, every child with asthma should receive the appropriate information about their condition. According to experts, children as young as 2 years old can begin

[17]45 C.F.R. § 1304.22(c) (2002).

[18]Albuterol is a quick relief medication, taken, as needed, to relieve symptoms.

[19]See Supra note 15.

learning about their asthma.[20] While more than half of grantees report they provide some form of training and education to children with asthma, the topics they cover are varied. Of the grantees that educate children with asthma, 53 percent teach children about their symptoms, 44 percent teach children what to do during an asthma emergency, and 33 percent teach children how to administer medication.

Some grantees have developed innovative approaches to educate children with asthma about their disease. One grantee that we visited had developed an asthma prevention program as a pilot project in 1995 after discovering that 37 percent of enrolled children had asthma. According to program materials, most families who began the program completed it. All of the families reported a marked improvement in their child's asthma. This program includes special learning activities at school to teach children about their bodies, respiration, and asthma triggers. In addition, the program distributes an asthma kit to each child. The kit includes a peak flow meter (a device that measures the ability to exhale) and costs $40 initially and $25 a year to maintain.

Education of Children without Asthma. Asthma management also may involve education of children who do not have asthma. Of the 37 percent of grantees that provide education and training to children without asthma, several show children a video developed by the American Lung Association and the Children's Television Workshop. This video, entitled "A is for Asthma," features Sesame Street characters teaching children about the disease and how to help someone who has trouble breathing. The "A is for Asthma" program also includes a companion guide for caregivers as well as suggested classroom activities. Both the video and the guide are available in English and Spanish.

Parent Education and Involvement. Head Start programs are required to involve parents in the care that their children receive at school. One performance standard requires grantees to "establish a system of ongoing communication with parents of children with identified health needs to facilitate the implementation of the follow-up plan."[21] Grantees also "must familiarize parents with use of and rationale for all health and developmental procedures administered through the program or contract."[22] We found that 84 percent of grantees provide education and/or training to parents of children with asthma (See Appendix B for a sample flyer related to parent training). One grantee reported, "parents and staff together receive the same training to ensure that the treatment is administered correctly." Among the grantees that educate and train parents, 74 percent provide information about recognizing symptoms of an asthma attack.

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[20]American Academy of Allergy Asthma and Immunology, *"Pediatric Asthma: Promoting Best Practices: Managing the Child with Asthma,"* Component 4, page 105, found at <http://www.aaai.org/members/resources/initiatives/pediatricasthmaguidelines/default.htm> April 4, 2002.

[21]45 C.F.R. § 1304.20(C)(1) (2002).

[22]45 C.F.R. § 1304.20(e)(2) (2002).

Grantees also provide training on what to do during an asthma emergency and how to administer asthma medications. In addition, parents participate in the development of asthma management plans. Almost two-thirds (65 percent) of grantees report that they involve parents in the development of these plans.

One grantee we visited used a parent education program specifically developed for parents of preschoolers with asthma. The program, known as Wee Wheezers, features a broad curriculum designed to teach parents how to recognize their child's symptoms, administer medication appropriately, and communicate effectively with physicians and other adults who are responsible for the child's care. The program consists of four 2-hour sessions.

In some cases, parents and Head Start staff communicate with each other about children's condition at school. Based on our review of the records of children with asthma, we found that 39 percent of staff have had some type of contact with parents of children with asthma regarding their children's condition. Typically, parents of children with asthma and staff interact when children have asthma-related difficulties at school; children are absent due to their asthma condition; or staff need information about medication administration and/or school emergencies.

Staff Training. Most grantees (90 percent) provide asthma-related training to staff. Head Start staff must have adequate training on how to care for children with asthma.[23] Grantees are required to establish and implement a structured approach to staff training and development.[24] Grantees should develop and integrate asthma-related training to cover topics, such as recognizing the symptoms of asthma, the procedures for handling an asthma emergency and how to administer asthma medications.[25] Approximately 95 percent of grantees that educate their staff provide training on how to recognize the symptoms of asthma and what to do during an asthma emergency, and 85 percent train staff on how to administer medication.

"...when a child has asthma, the parent is the primary educator. Parents will train staff on the specific, individual needs of their child."

[23]National Heart, Lung, and Blood Institute, National Asthma Education and Prevention Program. *"National Asthma Education and Prevention Program Resolution on Asthma Management at School."* found at <http://www.nhlbi.nih.gov/health/public/lung/asthma/resolut.htm> April 3, 2002.

[24]45 C.F.R. § 1304.52(k)(2) (2002).

[25]See Supra note 23.

Some Head Start grantees develop community partnerships to help them address the needs of children with asthma

Some grantees work with universities on asthma-related research projects. One grantee we visited is involved in a 3-year asthma project sponsored by a local university. The first and second years focused on expanded screening. Nursing students administered physical exams at home or school to children with asthma or children using asthma medications. The third year will focus on parent education. Another grantee works with a local university on a project designed to identify children suspected of having asthma and refer them to appropriate medical care when needed. One grantee reported how beneficial it was to work with a local university on a grant on asthma and Head Start children. The grantee stated, "we are fortunate to have the expertise and knowledge from the university to help us in all areas of programming – staff education, parent training, and developing management plans."

A grantee that responded to our mail survey obtained a $65,000 grant from the philanthropic arm of a major pharmaceutical company to fund an outreach project for children with asthma or at risk for asthma, their parents, and staff at 40 Head Start sites. The funding supported multilingual screening and education activities. The program involved over 3,700 Head Start children, 62 parents, and 170 staff members.

The Head Start Bureau has taken steps to address asthma, but its initiatives could be strengthened

The Bureau has issued training guides to support grantees

In the mid-1990's, the Head Start Bureau contracted with a private company to develop health-related training guides for staff. The company wrote a series of eight guides between 1995 and 2000. Two of these guides relate to asthma. The first guide, *Sustaining a Healthy Environment*, discusses ways to promote health at home and at school. The second guide, *Caring for Children with Chronic Conditions*, addresses asthma specifically and contains guidelines for developing health plans for children with the disease. Both guides are available in English only.

Grantees are not always aware of and rarely rely on Head Start Bureau resources to help them address the needs of children with asthma

Only 37 percent of grantees use the Head Start Bureau's training guide, *Caring for Children with Chronic Conditions,* which teaches Head Start staff how to care for children with asthma and other chronic health conditions. A grantee reported, "I do not recall receiving the Head Start Bureau's training guide, nor have I received any technical assistance or training regarding asthma . . . we use the resources that are available to us."

Most grantees do not use the National Head Start Training and Technical Assistance Network for assistance regarding children with asthma. The network consists of regional Quality Improvement Centers staffed by specialists familiar with local cultures and issues. Asthma has not been a priority for the network, although health specialists are available to assist grantees. Almost 85 percent of grantees reported that they do not use the network for assistance regarding asthma.

"We have more children diagnosed with asthma than any other health condition. I would like more information from the Training and Technical Assistance Network"

National Head Start data concerning the prevalence of asthma among Head Start children are unreliable

Head Start prevalence data provide an inaccurate, incomplete picture of the impact of asthma on Head Start programs. The Program Information Report (PIR), the annual survey of grantees, reflects inconsistent reporting on the prevalence of asthma and other health conditions. According to the Head Start Bureau, "the PIR provides comprehensive, national data on the Head Start program . . .the number of children being served and program services and activities.'[26] However, grantees receive little guidance from the Head Start Bureau on how to report the number of children with asthma in their programs. The PIR form only directs grantees to report "the number of children who received treatment for asthma."

"We struggle with whom to count as having asthma. There is no clear definition from ACF and we have to make up our own. Kids who have been diagnosed with asthma, but don't exhibit any symptoms get lost in the group

When asked whom they report as having asthma for purposes of the PIR, grantees responded with a variety of answers. Overall, Head Start grantees identified 10 different criteria for reporting the number of children with asthma on the PIR. In some cases grantees only report those children who were diagnosed by a health care practitioner, while other grantees are more inclusive and report based on a combination of criteria, including those who been diagnosed by a health care practitioner and those who were identified through parent reporting. During our review, we identified some children (13 percent) who had been reported on the PIR as having asthma, but whose records contained no evidence of the condition.

[26]Head Start Bureau, *"Information Memorandum–1997-1998 Program Information Report,"* March 18, 1998.

GRANTEES REPORT ASTHMA CASES DIFFERENTLY

Children identified through parent reporting	*Children diagnosed by a health care practitioner*	*Children receiving medication at school*	*Percent of Grantees**
✔	✔	✔	**34 percent**
	✔		**30 percent**
✔	✔		**19 percent**
	✔	✔	**10 percent**

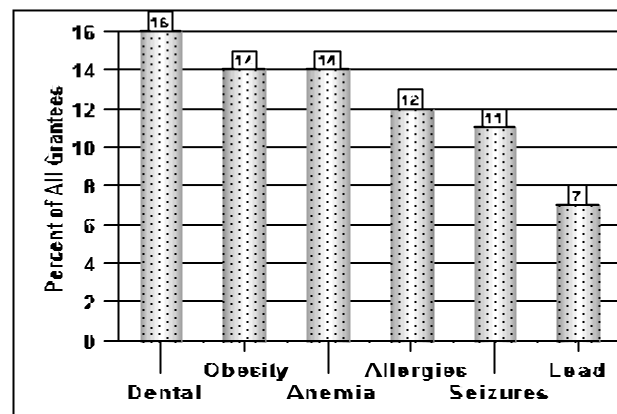
Source: Office of Evaluation and Inspections, 2002

*Note: 7 percent of grantees use other, less common criteria for reporting their asthma cases.

Asthma is one of many health conditions affecting Head Start children and their families

Almost two-thirds (65 percent) of all Head Start grantees reported that there is at least one other health condition they consider to be a health priority in addition to asthma. In all, grantees identified over 50 different health conditions that affect the children in their program. In fact, according to 86 percent of all grantees, asthma is no more difficult to manage than any of the health conditions that children in their program have. After being asked if there were any other health priorities in their program, one grantee responded "All of our health conditions are a priority. . . . they are too numerous to state each one." Some of the more common conditions that Head Start grantees noted include obesity, dental problems, anemia, seizures, and high lead levels.

OTHER HEALTH PRIORITIES IN HEAD START



Source: Office of Evaluation and Inspections, 2002

CONCLUSION AND OPPORTUNITIES FOR IMPROVEMENT

CONCLUSION

Although asthma affects an increasing number of Head Start children, grantees can meet their needs at school by developing management plans, administering medication, and educating children with and without asthma, parents, and staff. According to grantees we interviewed, asthma is no more difficult to manage than other health conditions that Head Start children face. The Administration for Children, Youth and Families, which administers Head Start, has tried to address asthma, but it could improve the support it provides to grantees.

OPPORTUNITIES FOR IMPROVEMENT

Determine how available resources could better meet the needs of grantees

Grantees do not typically use the Training and Technical Assistance Network or the training guide that specifically addresses asthma. Grantees have found other resources to assist children with asthma and their families. These resources include health guides written in English as well as Spanish. Instead of paying for special training guides for the Head Start community, the Bureau could disseminate information that has been developed by a myriad of private and public entities.

Improve data collection by outlining specific reporting criteria for health statistics

Since data on the health status of children drive national policy, the Head Start Bureau could improve the accuracy of this data by outlining criteria for reporting children who have various health conditions. For example, if the Bureau decides that parent reporting is adequate, it could instruct grantees to include in the PIR the number of children whose parents reported that their children have asthma.

Appendix A

Child Record Review Sampling Model

Head Start Cluster Sample

To select the children's records for our review, we used a one-stage cluster sample. Each cluster was generated by grouping children together based on the zip code of the grantee to which they were enrolled. Clusters consisted of children enrolled in the Head Start program during the 2000-2001 school year. We designed these clusters so that they would each contain approximately 15 children who were being treated for asthma.

Since at the time of the sample selection the 2000-2001 PIR was not available, we used the 1999-2000 PIR to create the cluster framework and develop probabilities that children from each Head Start program would be included in a given cluster. Specifically, we developed a computer model that simulated a "clustering" of children with asthma from the PIR. The probability that a specific child at a specific grantee would later be included in a given cluster was determined by dividing the number of that grantee's PIR children with asthma in that cluster by the overall total number of children with asthma in that grantee.

Since some grantees did not have any children being treated for asthma in the 1999-2000 school year, but might during the 2000-2001 school year, we assigned these grantees to the cluster closest to them geographically.

We then randomly selected 15 of these clusters in three geographic strata: 3 from the western U.S., 5 from the central U.S., and 7 from the eastern U.S. We asked the Head Start programs in our sample clusters for the number of children enrolled during the 2000-2001 school year and for a list of the names of the children who had been treated for asthma. Because each grantee's children were divided among 1 or more clusters, we randomly assigned these children to clusters according to the probabilities that we developed using the PIR computer model.

We then conducted site visits to the grantees whose children with asthma appeared in the clusters in our sample.

Example

Grantee X had 200 children enrolled and 10 children being treated for asthma, according to the 1999-2000 PIR. Our computer model clusters 3 of the children with asthma into cluster A and 7 into cluster B. During our cluster selection, we randomly select cluster A. We request from grantee X the total number of children enrolled and a list of the names

of children being treated for asthma during the 2000-2001 program year. Grantee X reports a total enrollment of 100 children and sends us a list of the names of 20 children who were being treated for asthma.

We then randomly assign these 100 children to the two clusters, with probability 3/10 for cluster A and 7/10 for cluster B. Therefore, we would expect approximately 6 children with asthma to be included in cluster A for this grantee. We then review the records of these children with asthma.

Appendix B

Sample Head Start Materials

Head Start Health Interview

Child's Name ____________ Sex ______ DOB ______ Birth wt. ______
Place of Birth ____________ Center ____________ Date of last physical exam ______
Person Interviewed ____________ Relationship to child ____________
Interviewed by ____________ Title ____________ Date ______
Current Health Care Facility ____________ MD ____________ Dentist ______
Family Unit/Members living in household (ages):

Mother	Sister	Grandmother	Aunt	Cousin	Other
		Pat. ______	Pat. ______		
		Mat. ______	Mat. ______		
Father	Brother	Grandfather	Uncle	Friend	
		Pat. ______	Pat. ______		
		Mat. ______	Mat. ______		

Are there any pets in your household? Yes/No If yes, what kind ____________ how many ______

Child's Health History

Allergies ____________ Food or medical restrictions ____________ Medications/Vitamins ____________
Health concerns: asthma febrile seizures ____________ ear tubes ____________ elevated Pb Pb poisoning
FTT overwt G6PD sickle cell disease/trait thalassemia eczema seizures glasses hearing aid
anemia ____________ COM ____________ broken bone ____________
hospitalization ____________ other ____________
additional information ____________

Has your child ever lived outside of the US? Yes/No If yes, where? ____________
Has your child been seen by their health care provider on a regular basis since birth? Yes/No
Child sleeping pattern: morning wake up ______ bedtime ______ nap (time and length) ______

Tell me about your child (personality, activity level, favorite activities, peer interactions, strength)

Does your child have any trouble talking or making sounds? Please explain

Does your child have any problems with walking, running, or moving? Please explain

Does your child have any problems seeing or hearing? Please explain

Does your child have any problems using his or her hands (such as with feeding, puzzles, drawing, small building pieces)? Please explain

Do you have any concerns for your child? (dental, growth and development since birth, speech)

Health problems in family unit/household:

Does anyone in your family or household currently or in the recent past have any problems with:

TB Asthma Lung problems Cancer Heart problems High blood pressure Lead poisoning

Dental Vision Hearing Limited mobility Domestic violence Substance Abuse Overwt

FTT Eating Disorders Others

Additional information

Does anyone in your household smoke? Yes/No If yes, would they be interested in smoking cessation program?

Revised 4/97

HEAD START ASTHMA CARE PLAN

Federal regulations require an Asthma Care Plan to be filed for each child within the first two weeks the child attends

This form needs to be completed by the child's physician.

Child: ______________________ *Date of Birth:* ______________

Parent's Name: ______________________ *Address:* ______________

Head Start Center child attends: ______________________

_____ Yes this child is diagnosed with asthma and I have filled out the Asthma Care Plan.

_____ No, the child does not need treatment for asthma at this time.

_____ I have not treated this child for asthma.

This child's asthma may be triggered by: ______________________

Activities for which this child has needed special attention in the past: ______________

Activity restrictions: ______________________

Any other information you feel would be beneficial: ______________

Medication

1. Medication: ______________
   Dose: ______________
   Time: ______________
   Routine or Emergency: ______________

2. Medication: ______________
   Dose: ______________
   Time: ______________
   Routine or Emergency: ______________

Physician's Name ______________________ Signature ______________
(Please Print)

Address: ______________________ Phone Number: ______________

Date: ___/___/_____

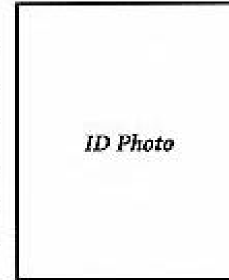
L: FORMS / HEALTH / ASTHMA CARE PLAN updated: 12/01

Asthma and Allergy Foundation of America
1125 15th St., N.W., Suite 502
Washington, DC 20005

STUDENT ASTHMA ACTION CARD

Endorsed by

National Asthma Education Program



Name: ______________________ Grade: ______ Age: ______

Teacher: ______________________ Room: ______________

Parent/Guardian Name: ______________________ Ph: (H) ______________

Address: ______________________ Ph: (W) ______________

Parent/Guardian Name: ______________________ Ph: (H) ______________

Address: ______________________ Ph: (W) ______________

Emergency Phone Contact #1 ______________ ______________ ______________
Name Relationship Phone

Emergency Phone Contact #2 ______________ ______________ ______________
Name Relationship Phone

Physician Student Sees for Asthma: ______________________ Ph: ______________

Other Physician: ______________________ Ph: ______________

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise ☐ Strong odors or fumes ☐ Other ______________
☐ Respiratory infections ☐ Chalk dust ______________
☐ Change in temperature ☐ Carpets in the room
☐ Animals ☐ Pollens
☐ Food ______________ ☐ Molds

Comments ____

- **Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

____

____

____

- **Peak Flow Monitoring**

Personal Best Peak Flow number: ______________________

Monitoring Times: ______________ ______________ ______________

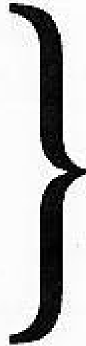
- **Daily Medication Plan**

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Emergency Plan

Emergency action is necessary when the student has symptoms such as ________________, ________________, ________________, ________________ or has a peak flow reading of ________________.

- **Steps to take during an asthma episode:**
  1. Give medications as listed below.
  2. Have student return to classroom if ____
  3. Contact parent if ____
  4. Seek emergency medical care if the student has any of the following:
     - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
     - ✔ Peak flow of ____________
     - ✔ Hard time breathing with:
       - Chest and neck pulled in with breathing
       - Child is hunched over
       - Child is struggling to breathe
     - ✔ Trouble walking or talking
     - ✔ Stops playing and can't start activity again
     - ✔ Lips or fingernails are gray or blue



If This Happens, Get Emergency Help Now!

- **Emergency Asthma Medications**

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Comments / Special Instructions

____

____

____

For Inhaled Medications

☐ I have instructed ____________________ in the proper way to use his/her medications. It is my professional opinion that ____________________ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ____________ should not carry his/her inhaled medication by him/herself.

________________________________ Physician Signature ____________ Date

________________________________ Parent Signature ____________ Date

Handout X: Special Care Plan For A Child With Asthma—

Child's Name: ____________ **Date of Birth:** 6 / 24 / 94

Parent(s) or Guardian(s) Name: ____________

Emergency phone numbers: Mother ____________ Father ____________

(see emergency contact information for alternate contacts if parents are unavailable)

Primary Health Care Provider: ____________ **Emergency Phone #:** ____________

Asthma Specialist's (if any): ____________ **Emergency Phone #:** ____________

Known triggers for this child's asthma (circle all that apply):

colds, tree pollens, grass, weather changes
mold, house dust, excitement, animals
exercise, strong odors, flowers, smoke
foods (specify): ____________ room deodorizers
other (specify): cold air

Activities for which this child has needed special attention in the past (circle all that apply):

outdoors	*indoors*
field trip to see animals	kerosene/wood stove heated rooms
running hard	art projects with chalk, glues, fumes
gardening	sitting on carpets
jumping in leaves	pet care
outdoors on cold or windy days	recent pesticides application in facility
playing in freshly cut grass	painting or renovation in facility

other (specify): ____________

Can this child use a **flowmeter** to monitor need for medication in child care? (NO) YES
personal best reading: ________ reading to give extra dose of medicine: ________
reading to get medical help: ________

How often has this child needed urgent care from a doctor for an attack of asthma:
in the past 12 months? 6 in the past 3 months? 3

Typical signs and symptoms of the child's asthma episodes (circle all that apply):

fatigue, breathing faster, restlessness, agitation
face red, pale or swollen, wheezing, dark circles under eyes
grunting, sucking in chest/neck, complaints of chest pain/tightness
flaring nostrils, mouth open (panting), gray or blue lips or fingernails
difficulty playing, eating, drinking, talking, persistent coughing

Reminders:

1. *Notify parents immediately if emergency medication is required.*
2. ***Get emergency medical help if:***
- the child does not improve 15 minutes after treatment and family cannot be reached
- after receiving treatment for wheezing, the child:

is working hard to breathe or is grunting	is extremely agitated or sleepy	won't play
is breathing fast at rest (> 50/min)	has gray or blue lips or fingernails	cries more softly & briefly
has trouble walking or talking	has nostrils open wider than usual	is hunched over to breathe

has sucking in of skin (chest or neck) with breathing

3. *Child's doctor & child care facility should keep a current copy of this form in child's record.*

For use with Activity 2

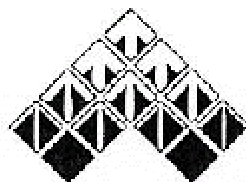
Handout X: Special Care Plan For A Child With Asthma *(continued)*

Medications for routine and emergency treatment for asthma for: ________ (Child's Name)

Date of Birth: 6 / 24 / 94

Name of Medication	Cromolyn	Albuterol		
When to use (e.g., symptoms, time of day, frequency, etc.)	every 4 hours (routine) or emergency	frequent cough, wheezing, rapid breathing, sucking in at neck, ribs routine or (emergency)	routine or emergency	routine or emergency
How to use (e.g., by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting formula, etc.)	inhaler with spacer	inhaler with spacer		
Amount (dose) of medication	2 puffs	2 puffs		
How soon treatment should start to work		within 20 minutes		
Expected benifit for the child	easier breathing	easier breathing		
Possible side effects, if any	cough	cough		
Date instructions were last updated by the child's doctor	Date: __/__/__ Signature: 6 98	Name of Doctor (print):		
Parent's or Guardian's permission to follow this medication plan	Date: __/__/__ Signature: 6 98	Parent's or Guardian's		

For use with Activity 2



COMMUNITY ACTION COUNCIL

CHILD DEVELOPMENT/HEAD START and EARLY HEAD START POLICIES and PROCEDURES

SUBPART: Early Childhood Development and Health Services

SECTION: Child Health and Safety

Procedure Number: B 3.4		**Effective Date:** 8/7/98	Page 1 of 1
Drafted By: ████ **Date:** 7/98	**Policy Council Approval Date:** 8/7/98	**Grantee Approval Date:**	**Requirements:** CFR# 1304.22(c)
Subject: Medication Administration			**Other:**
Objective: To ensure safe administration of required medication, support healthy development, encourage practices that prevent illness, and promote behaviors that enhance well-being.			

NUMBER	TASK	PERSON RESPONSIBLE	DATE TO BE COMPLETED
1.	Written instructions from a physician will be required prior to medication administration. Orders must include name of medication, instructions regarding dosage, and route of administration.	Parent	As needed
2.	Parent/guardian must complete written authorization on form B3.4a, and submit to staff. Medications must be clearly labeled, in the original container, with the child's name, required dosage, and name of the drug clearly labeled.	Parent	As needed
3.	Children may not transport medication to the center. Parents may bring the medication directly to staff, or give to the bus monitor to deliver to the center.	Parent, Bus monitor	As needed
4.	Medication will be stored in a locked file cabinet, or if refrigeration is required, in the refrigerator in a locked box.	SM, T, AT	As needed
5.	Document medication administration on form B3.4b; children will be monitored for any adverse reaction, which will be documented and reported to parents.	SM, T, AT	Daily
6.	Staff are trained in proper techniques for handling and dispensing medication.	TC, H/NC, ADH/N	Annually, or as needed

B3.4a

PERMISSION TO ADMINISTER MEDICATION

____________________ ____________
Child's Name Date

I hereby grant permission to ____________________________

To give my child ____________________________ medication on

Date____________

Reason________________	Reason________________
Name of medicine__________	Name of medicine__________
Dosage________________	Dosage________________
At____________o'clock	At ____________o'clock
Specific Instructions:________	Specific Instructions:________
____________________	____________________

Signature of Parent/Guardian____________________________

Physician's Name and Phone Number________________________

B3.4b

Medication Log

Center Name ______________________ Child's Name ______________________

Classroom Teacher ______________________ Date of Birth ______________________

Medication to be administered: ____

* Use a different sheet for each medication administered.

Date	Time	Dose	Given By	Comments

Asthma

Transition from Preschool to School

September 21,1999

5:00 p.m. – 6:30 p.m.

SPEAKER:
John R. Meurer, MD, MM
Assistant Professor of Pediatrics
Center for the Advancement of Urban Children.
Medical College of Wisconsin

A **FREE** COMMUNITY EVENT
Light refreshments served and free childcare provided.

For More Information, call
Fight Asthma Milwaukee at 286-5113.

A FREE Community Forum Presented by Fight Asthma Milwaukee. Specials thank you to the for hosting this event.

Appendix C

Confidence Intervals for Selected Statistics

The following tables show the point estimates and 95 percent confidence intervals for selected statistics in the order that they appear in the report.

Statistic	Point Estimate	95 Percent Confidence Interval
Percent of records that contained a "health history" form	94%	89%-100%
Percent of records that contained documentation of parent-reported asthma	80%	73%-87%
Percent of records that contained documentation of asthma diagnosed by health care practitioner	44%	34%-54%
Percent of grantees that develop written management plans for all children with asthma in their program	48%	40%-56%
Percent of grantees that develop plans for children with asthma who take medication at school	17%	11%-23%
Percent of grantees that develop plans for children with asthma who have "active" and/or "severe" asthma	8%	3%-12%
Percent of grantees that develop plans for children with asthma who have physical and/or dietary restrictions	3%	1%-6%
Percent of records that contained a copy of an asthma management plan	30%	15%-44%
Percent of grantees that have authorized staff to deliver medication to children with asthma while they are at school	85%	79%-90%
Percent of children with asthma who do not receive medication while they are at school	53%	37%-68%
Of children with asthma who take medication while they are at school, percent who take albuterol	91%	75%-100%
Percent of grantees that provide education or training on asthma to children with asthma	55%	46%-63%
Of the grantees that provide training and education on asthma to children with asthma, percent who teach them about recognizing symptoms of an asthma attack	53%	41%-65%

Of the grantees that provide training and education on asthma to children with asthma, percent who teach them about what to do during an asthma emergency	44%	32%-55%
Of the grantees that provide training and education on asthma to children with asthma, percent who teach them about administering asthma medication	33%	22%-44%
Percent of grantees that provide education or training on asthma to children without asthma	37%	28%-46%
Percent of grantees that provide education or training on asthma to parents of children with asthma	84%	77%-89%
Of the grantees that provide education or training on asthma to parents of children with asthma, percent who teach them about recognizing symptoms of an asthma attack	74%	66%-82%
Percent of grantees that involve parent in the development of asthma management plans	65%	57%-73%
Percent of records that have documentation of contact between parents of children with asthma and the program about the child's condition	39%	26%-52%
Percent of grantees that provide education or training on asthma to Head Start staff	90%	86%-95%
Of the grantees that provide education or training on asthma to Head Start staff, percent that teach them about recognizing symptoms of an asthma attack	96%	93%-100%
Of the grantees that provide education or training on asthma to Head Start staff, percent that teach them about what to do during an asthma emergency	95%	91%-99%
Of the grantees that provide education or training on asthma to Head Start staff, percent that teach them about how to administer asthma medication	85%	79%-91%
Percent of grantees that use the Head Start Bureau's training guide, "Caring for Children with Chronic Conditions," Module 3	37%	29%-44%
Percent of grantees that have not received assistance on asthma from the Head Start Training and Technical Assistance Network	84%	79%-89%
Percent of children who were identified as having asthma, but whose records contain no mention of the condition	13%	8%-17%

Percent of grantees that use a combination of parent reporting, physician diagnosis, and receiving asthma medication at school as the criteria for reporting children with asthma on the Program Information Report	34%	26%-41%
Percent of grantees that use physician diagnosis as the only criterion for reporting children with asthma on the Program Information Report	30%	23%-37%
Percent of grantees that use a combination of parent reporting and physician diagnosis as the criteria for reporting children with asthma on the Program Information Report	19%	13%-26%
Percent of grantees that use a combination of physician diagnosis and receiving asthma medication at school as the criteria for reporting children with asthma on the Program Information Report	10%	6%-15%
Percent of grantees that reported there is at least one other health condition they consider to be a health priority in addition to asthma	65%	57%-72%
Percent of grantees that reported that asthma is no more difficult to manage than any of the health conditions that children in their program have	86%	81%-91%
Percent of grantees that report that dental health is another health priority for their program	16%	10%-21%
Percent of grantees that report that obesity is another health priority for their program	14%	9%-19%
Percent of grantees that report that anemia is another health priority for their program	14%	8%-19%
Percent of grantees that report that allergies are another health priority for their program	12%	7%-17%
Percent of grantees that report that seizures are another health priority for their program	11%	7%-16%
Percent of grantees that report that lead levels are another priority for their program	7%	3%-10%

Note: In the tables above, point estimates and confidence intervals are rounded to the nearest percentage point.

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Gottlober, Regional Inspector General for Evaluation and Inspections in the San Francisco Regional Office. Other principal Office of Evaluation and Inspections staff who contributed include:

Cindy Lemesh, *Project Leader*
Christopher Tarbell, *Program Analyst*
Barbie Robinson, *Program Analyst*
Camille Harper, *Program Analyst*
Robert Gibbons, *Program Analyst*
Steven Zerebecki, *Program Analyst*
Steve Milas, *Program Analyst*
Alan Levine, *Program Specialist*

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