Early Head Start National Resource Center

Technical Assistance Paper No. 7

A Holistic Approach to Health and Safety

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

EARLY HEAD START NATIONAL RESOURCE CENTER

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The contents of this paper are not intended to be an interpretation of policy.

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Introduction

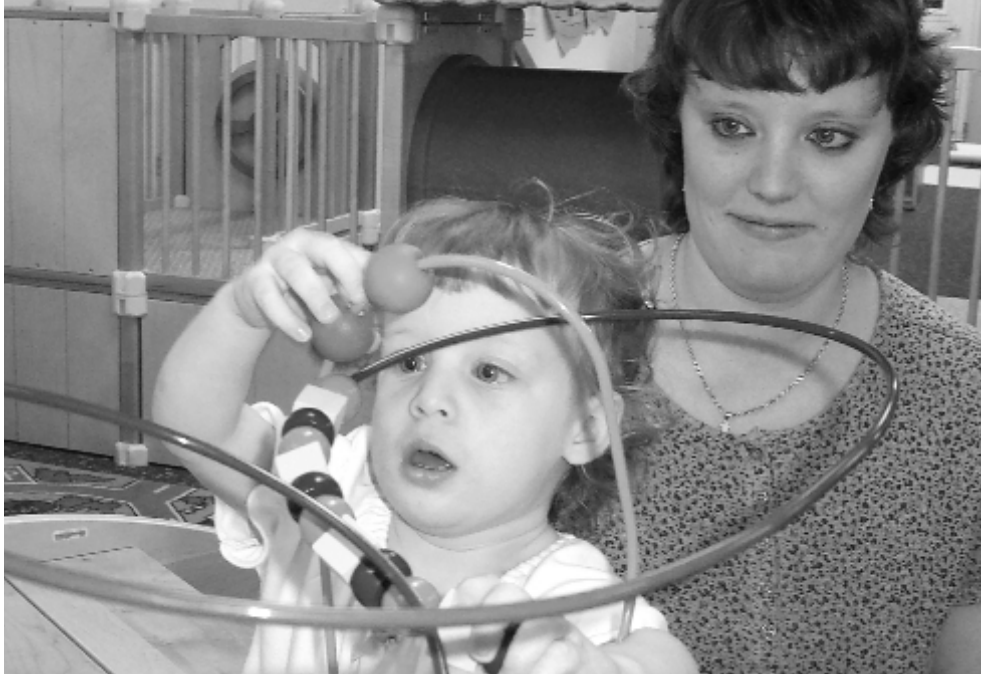
Health is the primary prerequisite to school readiness and social competence because it provides the foundation from which children can grow, develop, and learn. A child who is sick, tired, hungry, under emotional stress, or in an unsafe environment is at a serious disadvantage. His or her energy for thinking, playing, learning, and relating to others is sapped, leaving him or her at risk for additional problems. The more that we can do to prevent health problems, intervene early, and provide an ongoing model of health and safety, the more likely it is that the children in our care will enter school ready to learn and succeed in all areas of development.

Too often, we think about health only in relation to illness. A broader perspective on health and well-being recognizes that the environment and all areas of development—physical, emotional, social, cognitive—interact to support or impede good health. When one of these areas is impaired, it affects every other. In fact, the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] We need to pay attention to all aspects of individual development and to the environment to promote health and well-being.

Following are some examples of the outcomes in the various dimensions of health that we want for infants, toddlers, and their families:

- Physical—*Absence of illness or injury; regularly scheduled and administered immunizations and well-baby care, including oral health; well-maintained nutrition and hygiene; and opportunities for exercise and physical fitness*
- Emotional—*The ability to cope with stress, the experience of and ability to express a range of emotions, and the ability to engage in meaningful play or work*
- Social—*A sense of belonging or community, the ability to have an effect on the world in work or play, and the ability to sustain intimate relationships*
- Cognitive—*The ability to concentrate, to remember, and to solve problems*
- Environmental—*The experience of living, working, and playing in areas that are clean, safe, and pleasant*

[1] *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (WHO,* Official Records of the World Health Organization, *Vol. 2, p. 100, Washington, D.C.: Author) and entered into force on 7 April 1948.*



Head Start programs that provide services to pregnant women and to families with infants and toddlers have the opportunity to prevent health problems before they occur through health screening, parent education, and access to a variety of resources. Ideally, programs can instill healthy habits and provide a model for good health practices that will continue long after the children leave Head Start.

In this paper, we will consider how Early Head Start and Migrant and Seasonal Head Start programs can have a positive and lasting effect on the healthy growth and development of infants, toddlers, and their families. First, we will examine how health contributes to the everyday practices and to the roles of staff and families. Next, we will focus on systems that support health practices. Then we will turn to special topics, including health services for pregnant women, dental care for infants and toddlers, health screenings, and health care in rural communities.

Health in Everyday Practices

The promotion of good health and prevention of poor health occurs in the daily experiences of staff members, children, and families. *The Head Start Program Performance Standards* emphasize the importance of prevention and early intervention by requiring health assessments that are conducted in a timely manner and systems that track the providing of health-care services **(45 CFR 1304.20).**

Health Is Everybody's Business

Health in Head Start is a shared venture. The health coordinator or the Health Services Advisory Committee members are not the only ones to be concerned about, committed to, and involved in health services. Front-line staff members such as classroom caregivers and home visitors have a profound influence on many of the dimensions of health that are listed above. A holistic approach to health ensures that all aspects of a child's well-being is taken into consideration when planning and delivering services for infants, toddlers, and their families. The earlier in a child's life that we can prevent health problems from occurring and the sooner that we can intervene when problems exist, the more likely it is that children will grow and develop in ways that lead to later success.

Health Promotion, Prevention, and Treatment

A useful approach is to think of health services along a continuum of activities and services that promote healthy habits, prevent health problems, and provide treatment when necessary. Health promotion occurs on a daily basis in all of the ways that are mentioned above. In addition, staff members provide an important model for children and families. How they pay attention to their own health, carry out health policies and procedures, and talk to families about health issues makes a strong impression. Both formal and informal efforts to educate families on health topics can promote healthy habits.

Obviously, a healthy environment should be clean and safe. A dirty classroom or home will harbor conditions that will lead to illness and safety hazards that will lead to injury. Less obvious aspects of the environment that contribute to good health include the following:

- How the classroom or home is arranged. Even simple things like the placement of furniture make a difference in how children and adults move around the room, find and use play materials, and interact with one another. A cluttered environment can lead to disorganization and can increase stress.
- How the children are supervised and disciplined. Close supervision ensures that children are using materials safely and helps prevent accidents. Discipline should be used to guide children's behavior and teach social skills in a positive rather than a punitive manner.
- How the curriculum promotes meaningful learning. The choice of materials, activities, and experiences should engage children and build on their emerging skills in all areas of development.
- How the staff members communicate with one another, the children, and the families. Tone of voice, the choice of words, and body language should communicate respect for self and others. An emotionally healthy environment includes open lines of communication, appropriate boundaries, and constructive problem solving.

In center-based settings, the prevention of health problems occurs when staff members provide nutritious meals, ensure opportunities for rest and for active play, encourage exercise and fresh air, and are diligent about safety guidelines. For example, staff members store medications and cleaning supplies out of reach, check playground equipment regularly for hazards, and follow the *Head Start Program Performance Standards* requirements for group size and child:staff ratios.

Home visitors play an equally important role and can have a powerful influence on health and safety in the home. When staff members provide services in the home, they are able to readily identify health and safety issues that need to be addressed. For example, home visitors might educate parents on the dangers of baby walkers or the importance of keeping accurate health records, or they might provide practical support such as helping parents find a safe crib for the baby, calling an exterminator if there is a rodent or pest infestation, or getting emergency heat turned on in the winter. They can also support families by discussing neighborhood crime issues and ways to make the community safer through efforts such as Neighborhood Watch. Additional important preventative functions that all programs participate in as required by the *Head Start Program Performance Standards* include providing screening and assessment, ensuring that children have a continuous source of coordinated care and are up-to-date on immunizations, and involving parents in health services.

The treatment of health problems is a priority and should be addressed quickly in collaboration with parents and health-care partners. *Head Start Program Performance Standards* require a system for tracking health services to ensure that services are provided in a timely manner and meet child and family needs. Staff members may need to assist families in following up on appointments or referrals to specialists.

First Things First: A Healthy Staff

Staff members will have a hard time creating a healthy environment for families if they do not experience a healthy work environment for themselves. Some of the important ways that program administrators support staff health include

- health insurance so staff members have access to health care;
- adequate sick leave so staff members can take time off for doctor appointments and to recover from illness;
- daily work schedules that are manageable and allow for a physical or mental break from the demands of the job;
- a work environment that is clean, safe, and pleasant;
- work responsibilities that build on strengths and that are appropriately challenging;
- practical and emotional support in the form of regular supervision, open lines of communication, and policies and procedures through which to address grievances;
- individualized training and staff development;
- posted emergency evacuation plans; and
- safety guidelines for home visitors.

Taking care of young children is physically demanding, and staff members should have access to resources to help alleviate potential problems. For example, train staff members on proper techniques for bending and lifting to prevent back injuries.

Of course, staff members need to be thoroughly trained on health and safety guidelines and need to know how to put them into effect. A helpful strategy is to post reminders such as proper diaper changing and hand washing techniques in the classroom. Make sure that supplies—soap, tissues, paper towels—are well stocked

and easily accessible. Policies and procedures for illness, accidents, and emergencies should be clear and should be known to both staff members and families.

Every program should have a protocol to deal with safety issues, and the safety of home visitors is the first priority in a home-based program. For example, home visitors might travel with a cell phone and a telephone number where a supervisor or other support person is readily available. In some communities, home visitors might work in pairs to avoid being alone in unsafe neighborhoods. Families can also help by identifying the safest time of day to visit or streets that should be avoided. The local police department may also provide additional protection if they are aware that home visitors are in the community. The police may also provide self-defense training. Home visitors should be trained to anticipate when they are in danger and to create a plan to protect themselves should the need arise. A crisis protocol is also important for the safety of children and families. For example, Head Start staff members are required by *Head Start Program Performance Standards* to report suspected child abuse or neglect **[45 CFR 1304.22(a)(5)].**

Building Healthy Families

Parents have the primary responsibility for their children's health, and Early Head Start programs support parents in this role by involving parents in all aspects of health services and by offering health education programs. An important point to remember is that health topics can be very personal by nature; thus, staff members must take into account personal attitudes, family and cultural norms and differences, religious beliefs, and educational levels.

One of the first and most important ways that staff members collaborate with parents for their child's health is to ensure that each child has a "medical home"—a continuous source of accessible, coordinated medical care **[45 CFR 1304.20(a)(i)].** If families do not have a continuous source of health care, a helpful strategy is to explore with parents their attitudes and beliefs about preventative health care and the barriers they may face in accessing health care. They may be experiencing language or cultural barriers, financial issues, lack of transportation, or trouble locating providers. Families may need assistance

PROGRAM VOICES

Our agency has an incentive program to promote physical fitness. Staff members who complete and track their exercise and health activities (e.g., having a cholesterol screening) can enter weekly drawings for a prize.

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PROGRAM VOICES

We work with families from diverse cultural backgrounds. Our goal as an organization is to provide services in a culturally respectful manner. The first step is to establish a trusting relationship between the Home Visitor and the family. By educating respectfully and modeling differences, parents are willing to consider different ideas and try new things.

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applying for Medicaid or the State Children's Health Insurance Program (SCHIP). An additionally helpful strategy is to identify pressing health needs of parents and provide referrals if necessary. Parents with their own health concerns may need additional support to create a healthy environment for their children. The family partnership agreement process [2] can be an excellent way to identify and address health concerns and to track progress in meeting health-related goals.

The physical, emotional, and spiritual dimensions of health care are strongly influenced by cultural values and expectations. Culturally based differences may lead to misunderstanding or conflict among families, health-care providers, and programs. If tension occurs between the program and the family, program staff members should carefully examine how they are addressing those issues so parents remain engaged and committed to the program. For example, are there language barriers that need to be addressed? Do parents fully understand their child's diagnosis and treatment options? What are the family's attitudes and beliefs about health and healing? Does the family have a strong spiritual or religious belief that influences their approach to health care? Programs that attempt to understand these cultural differences are doing much to support the healthy development of young children.

PROGRAM VOICES

We help parents to be their child's advocate for health care by giving them tools to use to communicate with their primary health provider. For example, some families benefit when we model how to call for an appointment, or how to check on the status of their child's immunization. We educate parents about their responsibilities as health-care consumers and they see the rewards of developing a relationship with a health-care provider.

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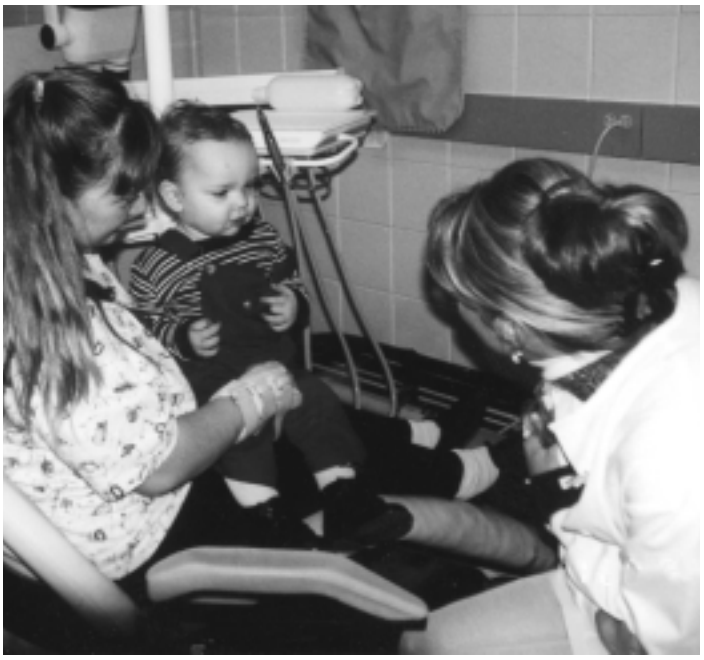
[2] *The family partnership agreement process refers to the* Head Start Program Performance Standards *requirement* **[45 CFR 1304.40(a)]** *to offer families the opportunity to set individualized goals.*



PROGRAM VOICES

Some of the families in our program lead such stressful lives that health care is not a priority. Home visitors work individually with families to remove the barriers that are preventing them from recognizing the importance of good health. We have to find a way to make health important and meaningful to them, to make it matter, before we can have an impact.

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WORKING WITH PARENTS

- Talk to parents about their child's health history to determine whether they have a "medical home" where their child receives ongoing health supervision. The source of health care should be easily accessible and available after the child transitions out of the program.
- Help parents locate a medical home by seeking recommendations from the Health Services Advisory Committee on health professionals and sources of funding; help families learn about and access health-care assistance programs, if eligible; and, if necessary, provide practical assistance such as help with scheduling appointments and arranging transportation.
- Help parents prepare for health-care visits by assembling a medical history with documentation and any relevant records.
- Prepare parents for what to expect during routine health-care visits, offer them information about patient rights and responsibilities, and provide support as they follow up on health recommendations.
- Accompany families to health-care appointments if necessary. Some parents or children may have anxiety over particular health issues or procedures and might benefit from additional support.
- Reduce some of the barriers parents may have to accessing health care, for example, finding child care for siblings, accessing transportation, or (for non-English-speaking families) arranging interpretation services.
- Create a program of education for parents on the importance of health care (including dental health) that takes into account differences in education, culture, attitudes, and fears. Use a variety of mechanisms—workshops, home visits, field trips, newsletters—to present positive, consistent messages about the importance of health care.
- Encourage parents to model good health-care habits and create healthy routines for the whole family.
- Seek parent involvement in the Health Services Advisory Committee.

Systems That Support Health Services

Management systems for quality health services include planning, communication, record-keeping and reporting, self-assessment, human resource management, and fiscal management. Below we will consider how a thorough community assessment, community partnerships, and a strong Health Services Advisory Committee contribute to cohesive management systems.

Community Assessment and Partnership

The *Head Start Program Performance Standards* requirement for a community assessment **[45 CFR 1305.3(b)]** provides an opportunity to identify the health needs of children and families in the community and how well those needs are being met. This process helps programs determine whether they should provide health services through the program, broker with community partners for those services, or do some combination of both. It also identifies gaps related to health services—for example, low immunization rates, inadequate prenatal care, or a lack of dental services—so programs know where to focus their efforts.

Community partnerships for health services should be built and formalized with health-care providers, mental health organizations, nutritional services, and organizations such as local health departments, child welfare agencies, managed care organizations, medical or dental schools, and professional associations. Ideally, services for families should connect those families with the community so they can continue to find and use needed services after they leave the Early Head Start program.

Health Services Advisory Committee

The *Head Start Program Performance Standards* require that every Head Start and Early Head Start program form a Health Services Advisory Committee (HSAC) to guide in the planning, operation, and evaluation of health services **[CFR 45 1304.41.(b)].** This group is composed of volunteers from the community who are involved in health-related professional roles—nurses, pediatricians, dentists, early intervention providers, or mental health professionals. Representatives from social service agencies such as the nutrition program for Women, Infants, and Children (WIC) as well as Early Head Start staff members and parents also participate in the committee.

The HSAC is an advisory group and can be a valuable resource for the Policy Council. Members can help identify pressing health needs in the community and can help programs design services that effectively meet those needs. Members of the committee might share their expertise either by offering their own services or by training staff members or parents. They can also be instrumental in providing access to community resources.

Each program's HSAC will be set up and will operate differently depending on local program and community

differences. Head Start programs that have a combined Head Start and Early Head Start HSAC must ensure that representation of expertise on health issues for pregnant women and infants and toddlers is adequate. No specified number of times per year is required for the committee to meet; that number is determined by program and family needs, local health conditions, and other variables. The size and composition of the committee is similarly based on local needs. However, despite this diversity among HSACs, five elements of a successful HSAC are [3]:

1. A clearly articulated mission;
2. Membership that represents the health needs of the program and community;
3. A responsive recruitment and orientation process for members;
4. An effective working environment, policies and procedures for members; and
5. Continuous evaluation of how the committee is functioning.

Clearly, administrative support must exist for the HSAC to be developed and maintained. Health services managers need adequate time for planning and for supporting the committee; staff members need time to participate; parents may need transportation or child care. Program leaders can ensure the success of the HSAC by nurturing community collaborations, creating an open and inviting atmosphere, attending meetings, and supporting health staff members to follow through on committee recommendations.

PROGRAM VOICES

We collaborate with a pediatric clinic that will donate well-child exams to families who do not have a means to pay for health care. One of the pediatricians at this clinic is a member of our HSAC and was able to facilitate this partnership after learning about the number of children who were not receiving health care due to lack of health insurance.

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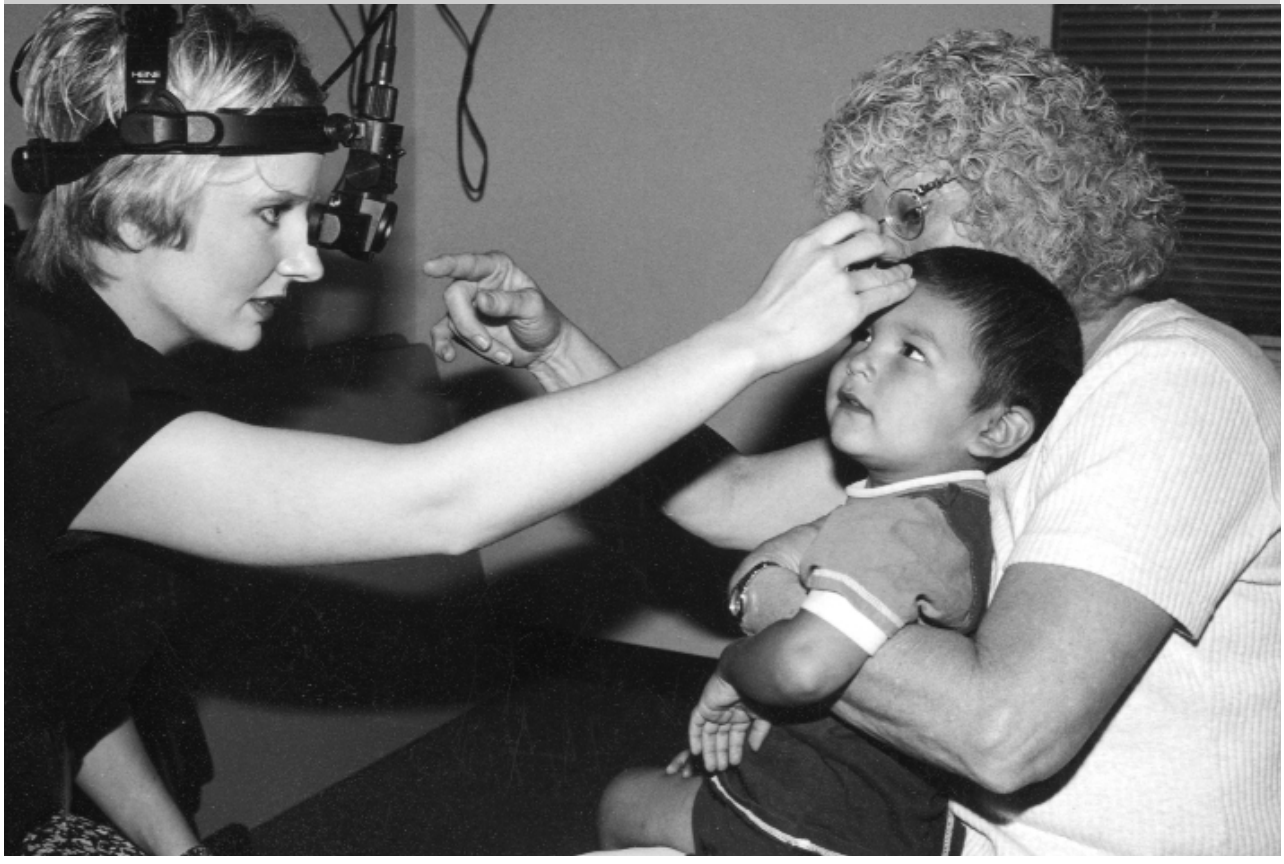
[3] *Head Start Bureau. (2003).* Weaving connections: The Health Services Advisory Committee *(p. 4). Washington, DC: Author.*

WORKING WITH COMMUNITY PARTNERS

- Know your state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines and the schedule and procedures for preventative health care. You can obtain these guidelines from your State Medicaid office. The Health Services Advisory Committee may make additional recommendations based on prevalent community health problems **[45 CFR 1304.20(a)(1)(ii)].**
- Work with health-care providers to create a schedule to bring children up-to-date on age-appropriate preventative care.
- Collaborate with your state's early intervention system for infants and toddlers with disabilities.
- Develop systems of communication and tracking with your health-care partners to ensure that children are examined and treated as necessary and that families are fully involved in their children's health care. See appendix A for sample record-keeping forms.
- Enlist the help of health-care professionals to develop educational programs for families. Emphasize the importance of anticipatory guidance, early detection of health-care problems, and the importance of follow-up care.
- Involve health-care providers in your program. In addition to participating on the Health Services Advisory Committee, create less formal opportunities for collaboration, for example, a visit from a health-care provider to your program to hear from parents about their health concerns and questions. Explore ways that your EHS program can contribute to the health-care provider's practice, for example, by providing parent education handouts for the clinic or by giving a presentation to clinic staff members on the particular health-care issues and needs of the children and families with whom you work.



Early Head Start National Evaluation

The Early Head Start Research and Evaluation Project [4] examined health status and access to health care as part of the national evaluation of Early Head Start. This study involved more than 3,000 families and 17 programs around the country. Families in EHS were compared with a randomly assigned control group. Some of the highlights of the report include the following:

- A higher percentage of children in EHS received immunizations or visited a doctor for treatment of illness and were less likely to be hospitalized for accident or injury than were children in the control group. Overall, the majority of children in EHS were in very good health. The youngest children were more likely to have health problems.
- Many children suffered from asthma and other respiratory problems. The incidence of household smoking was also high and is a likely contributor to the high rate of asthma and ear infections found in Early Head Start children.

- The use of car seats declined as children grew. Almost all parents used car seats with their infants, but approximately 30% of parents did not use car seats with their 3-year-olds.
- Children in EHS programs were more likely to have health insurance than were children from low-income families not participating in the program. Children not covered by insurance were more likely to be from Hispanic families and to have mothers who had not completed high school. Children in center-based programs were more likely to have health insurance than those in home-based programs.
- Hispanic families were at an increased risk for health problems because they tended to lack either health insurance or a regular health-care provider. This finding may reflect not only cultural or language barriers but also concerns about legal immigration status.
- Teenage mothers carried out fewer safety practices and were less likely to have a regular source of health care for their children. They more often used hospital emergency rooms as their source of health care and were less likely to report that their child received a well-child exam.

The implications of this study for Head Start programs include the need to monitor health insurance coverage and the need to increase enrollment in appropriate programs. Programs should also educate parents on the recommendations for car-seat safety and partner with local resources to ensure that parents have car seats for their toddlers and preschool-age children. Health education efforts are also needed on the relationship between household smoke and children's health problems to reduce children's exposure and prevent respiratory problems.

[4] *Mathematica Policy Research, Inc. (2002)*. Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. *Washington, DC: U.S. Department of Health and Human Services. Early Head Start evaluation reports are available on-line at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html*

Special Issues

The following section of this paper explores a number of health-care issues that are of particular concern to Head Start programs that provide services for pregnant women and families with infants and toddlers.

Health Services for Pregnant Women

Inadequate prenatal care is associated with low birth weight, premature delivery, birth defects, and increased risk for learning and behavioral problems. Thus, a focus on maternal health is paramount for programs that provide services to expectant families.

Pregnant women and their families are not enrolled in Head Start Program Options **(45 CFR 1306)** because the Program Options describe the delivery of services to children. Program staff members and families have the flexibility to determine how services will be provided to pregnant women and their families through the individualized family partnership agreement process. For example, although many services to expectant families may be delivered through home visits, the frequency and duration of home visits are determined by the needs, resources, and goals of the family. [5]

Early Head Start grantees must assist pregnant women, through referrals, to access comprehensive prenatal and postpartum care immediately after enrollment in the program **[45 CFR 1304.40].** Some of these services include:

- risk assessments,
- nutrition counseling,
- medical examinations,
- dental care, and
- mental health services.

A pregnant woman should be connected to a regular, ongoing source of medical care (a medical "home") to have her health monitored during pregnancy and after delivery. Oral health is also important for pregnant women. The increase in hormones during pregnancy can cause gums to swell and bleed more frequently, which can lead to discomfort and additional oral health problems. Early Head Start funds may be used for professional medical and dental services when no other source of funding is available **[45 CFR 1304.20(c)(5)].**

[5] *Head Start Bureau. (2002).* Services to pregnant women participating in Early Head Start *(Information Memorandum, ACYF-IM-HS-02-04). Washington, DC: Author.*

In addition to the above, Early Head Start programs must provide pregnant women with prenatal education on:

- fetal development,
- the risks of smoking and alcohol,
- labor and delivery,
- postpartum recovery,
- maternal depression, and
- breastfeeding.

Community collaboration is essential for ensuring access to this comprehensive array of services. Early Head Start programs might collaborate with health clinics, birthing centers, mental health programs, food banks, transportation services, or translation services for non-English-speaking families. The Health Services Advisory Committee plays a vital role in locating community resources and establishing linkages for services to pregnant women.

Early Head Start staff members can help expectant families prepare for the arrival of the baby by creating a plan for getting to prenatal appointments; preparing for the delivery, including packing an overnight bag for the hospital or birth center; organizing transportation to the hospital; and ensuring that the family has a car seat to transport the baby home from the hospital. This preparation period is also a good time to identify environmental hazards such as secondhand smoke and to take the necessary steps to eliminate these problems before the baby arrives. Another task to accomplish before the birth of the baby is finding a pediatrician or clinic where the baby will go for regular medical care after delivery. Ideally, expectant parents can familiarize themselves with the medical practice where they will take their child and share important prenatal history. Establishing a "medical home" for the baby right from birth is the best way to ensure ongoing, comprehensive health care throughout infancy and childhood.

The Head Start Program Performance Standards require that programs "must arrange for health staff to visit each newborn within 2 weeks after the infant's birth to ensure the well-being of both the mother and child." **[45 CFR 1304.40(i)(6)].** Ideally, the staff member who conducts this visit has had a relationship with the family during the mother's pregnancy. This individual may be a staff member of EHS who has the appropriate medical background or may be with a public health or other collaborating community agency. In some cases, it may be helpful for health staff members to conduct this visit jointly with another service provider such as a home visitor to minimize disruptions in family life. The first postnatal visit is an important time to assess the baby's feeding, sleeping, and growing; the parents' physical health and emotional adjustment; and family's needs and resources.

Oral Health for Infants and Toddlers

Oral health is an important component of overall health and development. Poor oral health can lead to tooth decay, infections, and disease. These problems are largely preventable by providing parents and caregivers with the skills to properly clean and care for young children's teeth. Oral health services begin from birth and include guiding families to oral health service providers, building families' capacity and interest in caring for the oral health of the family, educating families about the role of oral health professionals, and teaching children good oral hygiene and healthy eating habits.

Most infants receive their oral health care during regular well-baby exams from the health professionals who provide their well-child care. Health-care practitioners such as doctors, nurses, or physician assistants can screen for dental problems, conduct risk assessments, educate parents on oral health and development, and refer children to a dental professional if needed.

State Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines provide recommendations for a child's first dental exam. In some communities, pediatric dental professionals encourage preventive dental visits beginning at the age of 1 year or even as early as the eruption of the first tooth. In other

PROGRAM VOICES

I try to visit the family during the time they already have scheduled with their Family Educator, in order to disrupt their already hectic lives as little as possible. I take the infant scale and weigh the baby (especially if I've heard any concern at all about the baby's feeding) and the OAE to do a hearing test on the visit. I use a form (see appendix A.2) to guide the discussion. I ask every question on the front of the form. New moms usually enjoy telling their birth stories, and then I use the checklist on the back according to the needs of the family.

I ALWAYS check carefully how feeding is going. Especially important questions to ask a breastfeeding mom are how frequently and how long the baby is nursing and how many wet and poopy diapers the baby is producing. It is also important to ask a mom who is bottle-feeding, how much she is feeding and how she is preparing the formula. I think it's also important to ask about circumcision and how it is healing, and if the baby was not circumcised, to be sure the parents know proper care and cleaning. These are all issues that MANY parents are not informed about before they leave the hospital.

I also always discuss baby blues and postpartum depression, and leave a short pamphlet on the topic. I have breastfeeding and formula preparation handouts as well as baby safety handouts, a pamphlet on how dads can help with the baby, etc., and leave the information that will best meet each family's needs.

A parent on the Health Services Advisory Committee recommended making a follow-up phone call to each family 2–4 weeks after the newborn visit, an excellent suggestion. So now I make an informal call just to ask how things are going and if they have any questions. The moms really seem to appreciate this.

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communities, dental professionals treat patients under the age of 3 years only if a dental problem is evident. Because this preventive care varies by community, the Health Services Advisory Committee should take an active role in determining how the oral health needs of infants and toddlers can adequately be met given the particular circumstances of the community. Especially important in communities that do not have pediatric dentists is to increase the capacity of other health-care professionals to provide prevention-based oral health care for infants and toddlers. For example, pediatricians can include oral health screenings as a part of routine well-baby care, dental hygienists can conduct screenings and preventative services, and partnerships with dental schools may lead to opportunities for students to provide services and gain experience.

Early Head Start programs can educate parents and caregivers on oral hygiene for babies and toddlers as well as provide guidance on the use of bottles and cups, injury prevention, and dietary habits. A serious but preventable condition called "baby bottle tooth decay" is linked to propping bottles in a baby's mouth or letting him or her fall asleep with a bottle. Health professionals also recommend weaning a baby from a bottle to a cup at approximately the age of 12 months. In addition to formal parent education efforts, both center- and home-based staff members can use naturally occurring routines such as meal and nap time to discuss and demonstrate healthy practices.

A number of valuable resources are available to support programs in their oral health services. Most states have a government office for oral health that partners with other state organizations and recommends oral health policy. In addition, various national and state organizations for dentists, dental hygienists, dieticians, and physicians focus on oral health issues. The National Oral Health Resource Center (http://www.mchoralhealth.org), funded by the Maternal and Child Health Bureau in the Health Resources and Services Administration of the Department of Health and Human Services, develops and disseminates valuable information about emerging public oral health issues. The center supports health professionals, program administrators, educators, policymakers, and others with the goal of improving oral health services for infants, children, adolescents, and their families. Resources include listservs, bibliographies, and fact sheets, as well as practice and policy guidelines.

Health Screenings for Developmental, Sensory, and Behavioral Concerns

The *Head Start Program Performance Standards* require that, within 45 days of entry into the program, EHS programs must perform or obtain screening procedures for developmental, sensory, or behavioral concerns **[45 CFR 1304.20(b)(1)].** These screenings must be done in collaboration with parents and must be linguistically appropriate, culturally sensitive, and age-appropriate. Each of the three types of health screenings are described further here

Developmental screening measures a child's progress in reaching age-appropriate developmental milestones in gross and fine motor skills, language and speech development, or thinking and problem solving. Screening instruments and procedures vary. Some screening instruments might consist of a checklist of items that the

PROGRAM VOICES

There are few pediatric dental providers in our rural community. Before children begin dental exams at the age of 2, we educate parents on proper dental care for infants and toddlers. We model good oral hygiene and encourage, support and expect parents to brush children's teeth after all meals and snacks served at our socializations. We are participating in an oral health grant where we hope to increase the dental care available by increasing the number of dental providers in the area. We are working with the Kids In Need of Dentistry (KIND) organization to bring their mobile dental clinic to the area to provide services for the children in our programs.

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screener observes or elicits from the child; others might consist of parent-completed questionnaires. The *Head Start Program Performance Standards* do not specify a particular strategy to be used but encourage an approach that is comprehensive and systematic, includes multiple sources of information, and conforms to sound early childhood practice.

Sensory screening refers to evaluations of vision and hearing. Vision and hearing screenings should be conducted by trained health professionals. Frequently, Early Head Start programs can obtain preexisting information such as the results of a recent vision or hearing test that was performed at the child's last well-child health visit. If it is impossible to obtain a record of a prior screening, then efforts should be made to have the appropriate screenings performed at the next scheduled well-child visit. The frequency of vision and hearing screenings is determined by each state's Medicaid agency as specified in the EPSDT program. The EPSDT guidelines represent a program of the state Medicaid agency for preventative and primary well-child care. Each state Medicaid agency sets its own guidelines. To determine a child's health status, Early Head Start programs should follow those guidelines in conjunction with (a) the latest immunization recommendations issued by the Centers for Disease Control and (b) the recommendations of the Health Services Advisory Committee that reflect specific community needs.

Behavioral screening refers to social and emotional functioning. Few screening instruments exist for infants and toddlers in this area; thus, the screening process should consist of observation of the child's behavior; interactions with family, peers, and staff members; health and developmental status; and consultation with family, caregivers, and health or mental health professionals.

An important point to remember is that screening for developmental, sensory, and behavioral concerns determines only whether further evaluation is necessary. It does not lead to a decision about whether a child has a developmental, sensory, or behavioral problem. If the results of the screening indicate a potential concern, then a referral for an in-depth evaluation is warranted. For more in-depth information on screening and assessment, please see the resources in appendix B.

Health Care in Rural Communities

Rural communities face a number of unique challenges in accessing health care. Doctors and other health-care professionals may be scarce, and families may have to travel long distances to obtain care. Finding pediatric professionals who are skilled in working with infants and toddlers may be especially challenging. Under these circumstances, families will have difficulty visiting health professionals for preventative care, so parents might seek help only after a health problem occurs. In addition,

families might not have the means to travel great distances. Public transportation may be nonexistent or too costly, and securing time off from work creates additional barriers. In addition, for immigrant populations that often live in rural areas, language and cultural differences further complicate access to health care.

EHS can help offset these challenges by focusing efforts on preventive health services and by developing community partnerships that help minimize some of these barriers. Effective strategies are described in the following sections.

Educate parents on preventive health care. Many health problems can be prevented if parents are armed with information and have supportive guidance. For example, much can be done in the daily environment to decrease the incidence of tooth decay, or dental caries, in infants and toddlers. Teach parents procedures for properly cleaning an infant's or toddler's teeth, and warn them about the hazards of propping a bottle in a baby's mouth. Toothbrushing activities can be a part of each home visit or part of the daily routine in center-based programs.

Use the home environment to teach parents basic health and safety techniques, for example, storing medications and cleaning solutions out of children's reach. Demonstrate how to "child proof" a home so safety is a priority.

Teach parents the warning signs of potential health problems; for example, an infant who becomes increasingly fussy and frequently tugs on his ear may be developing an ear infection. Make sure parents know basic first aid as well as signs and symptoms that warrant a call to a doctor. Conduct hands-on workshops for parents to "make and take" their own first aid kits. The community fire and police stations may offer speakers or materials on relevant topics.

Provide information and training to health-care providers. Help health-care providers understand the needs of the children and families in your program and how to meet them. For example, inform health-care providers of cultural issues such as strong religious beliefs that may influence the family's approach to health care. Provide language translation for non-English-speaking families. Effective systems of communication among your program, families, and health-care providers will minimize potential misunderstandings.

Help health-care providers understand how the developmental needs of infants and toddlers have an effect on health care. For example, an 8-month-old in the throes of stranger anxiety can be expected to strongly resist being taken out of her parent's arms and placed on an examining table by a stranger. The doctor can minimize the child's (and parent's) distress by allowing a parent to hold the baby on his or her lap during the examination.

Develop collaborative relationships with health-care assistance programs. Many low-income families do not know how to find resources such as Medicaid or the SCHIP to help defray the costs of health care. Identify local, state, and federal sources of health-care funding, and develop collaborative processes that help parents navigate a potentially confusing system. Parents may need help compiling information, completing applications, or locating participating health-care providers.

Provide specialized training to EHS staff members. Help staff members gain health-related skills such as training to be a doula [6] or a lactation consultant or the skills necessary to conduct health-related screenings. The investment of time and money is well worth the benefit to the EHS program and the community.

Migrant and Seasonal Head Start Programs

Migrant and Seasonal Head Start programs face unique challenges in providing health services to families. Migrant families live in a number of different locations throughout the year as they move from crop to crop for seasonal farm work. The vast majority of migrant workers do not speak English as their native language. Some of the challenges for these Head Start programs include the following [7]:

- High mobility. Children and families have inconsistent access to medical care and usually do not have a primary health provider. Thus, it is challenging for service providers to obtain a medical history, and it is difficult for parents to track and follow up on services.
- Exposure to pesticides. Environmental toxins can be especially damaging to a developing fetus. Pesticides not only are a danger to the workers in the field but also can be found in food and can be transmitted to infants in breast milk. Children may be more susceptible than adults to the toxic effects of pesticides because of their lower weight and higher metabolism.
- Long, labor-intensive work hours. Farm work is physically demanding. Parents are often in the field for many hours each day, in all weather conditions. The work demands standing, bending, and lifting heavy loads. Bathroom facilities are usually inadequate, posing additional health concerns.
- Substandard living conditions. Migrant workers live in extreme poverty. Housing may be overcrowded and unsanitary, and diseases are easily transmitted from one person to the next. These stressful living conditions, combined with poor nutrition and limited access to health care, leave families particularly vulnerable to health problems.
- Immigration status. Families may fear using public health services if it will put them at risk for deportation or compromise their ability to attain citizenship.

Health screenings are particularly valuable given that many parents of migrant children do not have their children's medical records. The screenings provide an opportunity to examine how children are currently functioning and to make referrals as needed. It is also of great benefit when programs use their record-keeping and tracking systems to ensure that parents are able to follow up on appointments and treatment plans. Parents may need assistance in locating providers, making appointments, accessing translation services, and coordinating transportation.

Emerging concerns with respect to the health of migrant families include social and behavioral issues such as substance abuse, family violence, and children's behavioral problems. Head Start programs, providing a comprehensive and individualized program of services, can mitigate these issues by reducing the social isolation that often accompanies a migrant lifestyle, mobilizing the community to offer culturally sensitive supports and services for all family members, and working in partnership with families to identify and meet their needs.

Infant and Child Mental Health

The *Head Start Program Performance Standards* require a comprehensive array of services related to mental health, including prevention, assessment, and early identification of mental health needs; professional mental health consultation; and the delivery of mental health services. Infant mental health refers to social and emotional development in very young children. Although the term mental health often conjures negative images of mental

[6] *A doula provides professional labor support and childbirth education.*

[7] *U.S. Department of Health and Human Services. (1999).* Descriptive study of children and families served by Migrant Head Start programs. *Washington, DC: Author.*

illness or dysfunction, infant mental health is a term that encompasses a continuum of experience. Infants and toddlers can experience the full range of mental health functioning—from secure, nurturing relationships and the ability to feel the spectrum of human emotion to dysfunction and disorders of early childhood.

Infant mental health is firmly tied to every other area of growth and development: physical growth and health, communication and language development, and cognitive skills and the ability to learn. In fact, the most recent research on early brain development suggests that early nurturing relationships are different from later relationships because they provide a foundation from which "all meaningful development unfolds." [8] Thus, when considering infant mental health, it is important to look at the child's unique social and emotional attributes as well as at all aspects of the child's development and environment such as significant relationships in the child's life, the status of the child's physical development and health, and whether the environment supports the child's capacities and challenges him or her appropriately.

Some of the common mental health challenges that Early Head Start programs confront include the following:

- Depression
- Substance abuse
- Parental stress from a variety of issues such as economic concerns, violence in their communities, immigration issues, relationship stressors, low-self esteem, and a lack of understanding about child development
- History of unresolved grief or loss
- Attachment issues between children and families
- Parents with developmental delays
- Domestic violence
- Child behavior problems

Early Head Start programs deliver services to families in both center-based and home-based program options or in a combination of the two. Staff members may have backgrounds in early childhood development, social work, health care, or other human service fields. Thus, the manner in which infant mental health is integrated in the program can vary a great deal. Some of the strategies that Early Head Start programs use include the following:

- Hiring mental health professionals on staff
- Using mental health consultants to provide training, consultation, or crisis intervention
- Focusing on prevention and early identification of mental health problems
- Developing partnerships with university training programs that provide services through trainees in the fields of counseling, psychology, or psychiatry
- Collaborating with local mental health agencies

In addition to working closely with community mental health programs, Early Head Start is able to provide ongoing, intensive mental health support to children and families through the close, trusting relationships that grow out of the parent involvement and family partnership opportunities available to all participants in Early Head Start.

[8] *National Research Council & Institute of Medicine. (2000).* From neurons to neighborhoods: The science of early childhood development. *(p. 27). Washington, DC: National Academy Press.*

Children With Special Health-Care Needs

Early Head Start must make 10% of their funded enrollment available to children with disabilities **[45 CFR 1305.6 (c)].** Children may come to EHS with an already identified disability or chronic health issue, or the problem may be discovered as a result of the screening and assessment process required by EHS programs. All EHS programs are expected to partner with local agencies that provide early intervention services to infants and toddlers with special needs.

Some of the challenges for programs include the following:

- Training for staff members. Staff members should be adequately trained to create an environment that is welcoming and individualized for each child; they may need training on specific skills, for example, the proper use and care of devices such as heart monitors, oxygen dispensers, or feeding tubes; those who have not had experience with children with special needs may need extra support to examine any fears or concerns they have.
- Support for parents. Parents need support as they go through the process of evaluating and identifying potential problems; they may experience a wide range of normal reactions, including denial, anger, and grief. Program staff members should be sensitive to the challenges and needs of the parents and of the child.
- Gap between those who are eligible and those who are served. There is a gap between the number of children who are identified as eligible for Part C early intervention services and those who actually receive services.[9] Families in particular groups—such as teen parents, Hispanic parents, and families with many risk factors—were particularly unlikely to use the services. Although the reason for the gap is unknown, programs should identify any obstacles that might interfere with a family following through on a referral for early intervention, for example, language or cultural barriers, a lack of transportation, inconvenient times or places that services are available, or financial concerns.

Program staff members can support families by accompanying families to medical or related appointments, by sharing important information with early intervention or medical staff members about children's strengths and challenges, and by allowing early intervention services to be provided in the EHS classroom or during home visits. The respectful, supportive relationships that staff members build with families will allow all partners in this effort to negotiate the challenges that arise and to foster the successful inclusion of children with special needs.

Poverty and Obesity

Concern has been growing in the scientific community about the relationship between poverty and obesity [10]. Obesity and related diseases such as diabetes and hypertension are on the rise in those who are economically disadvantaged. Of special concern is the rising rate of obesity and related health problems in children. At the same time, children in poverty face hunger and food insecurity because of a lack of food or an uncertain or limited supply of food. The apparent paradox that children are both hungry and growing overweight has much to do with the high cost of healthy eating. The least expensive food choices are processed items and convenience foods that are high in fats, sugars, and calories. Healthier foods such as lean meat, fish, and fresh vegetables and fruits cost more. Thus, families with limited financial resources may deliberately choose the less expensive—and unhealthy—food choices to save money and ward off hunger.

In addition to the diseases associated with obesity mentioned above, children who are overweight can also suffer nutrient deficiencies that lead to developmental concerns such as limited growth and brain development as well as reduced immune functioning. Obesity also has negative social and emotional consequences, affecting behavior and self-esteem.

[9] *Mathematica Policy Research, Inc. (2002)*. Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. *Washington, DC: U.S. Department of Health and Human Services*.

[10] *Food Research and Action Center. (2003)*. The paradox of hunger and obesity in America. *Washington, DC: Author.*

Head Start programs can address hunger and lack of adequate food by helping families access food programs such as (a) WIC, the special supplemental nutrition program for women, infants, and children; (b) the Child and Adult Care Food Program, which provides food to children in child-care programs; and (c) the Food Stamp Program for families in poverty. In addition, Head Start programs may be able to locate other community resources such as food banks that are run by churches or nonprofit associations. Parent education efforts should focus on helping families learn how to make low-cost but nutritious meals. Another helpful effort would be to explore how families can access stores and restaurants that sell healthier food choices. Low-income neighborhoods may have only fast-food restaurants or small grocery stores with a limited selection of fresh food, presenting additional barriers for families.

Of particular concern is the nutritional status of pregnant women because their nutrition has such a direct effect on the health of their developing babies. And pregnant women who have other children may be at increased risk; research has shown that mothers first sacrifice their own nutrition by restricting their food intake to protect their children from hunger.[11] In addition, breastfeeding mothers have extra nutritional needs for their own health and for the health of their baby.

A physically active lifestyle is also related to health. The National Association for Sports and Physical Education released the first ever physical activity guidelines for infants and toddlers,[12] linking sedentary habits with the rising rate of childhood obesity. These guidelines warn that confining babies to infant seats, strollers, and playpens for extended periods not only encourages sedentary practices but also may lead to delayed motor and cognitive skills. Caregivers and parents should promote and foster the enjoyment of movement and competence in motor skills by interacting with infants in daily activities that encourage them to explore their environment. Furthermore, toddlers and preschoolers need daily structured physical activity to practice movement skills in a variety of activities and settings.

Children acquire habits for eating and exercise early in life. Parent involvement plays a significant role in children developing motor competence, enjoying physical activity, and cultivating healthy eating habits. The sooner we can teach and model a healthy lifestyle for children, the more we enhance their health now and provide a strong foundation for the future.

Conclusion

Clearly, effective health services in Early Head Start require the commitment of every staff member to do his or her part in creating and sustaining a healthy environment for infants, toddlers, and their families. The depth and breadth of the health services that are required by the *Head Start Program Performance Standards* ensure that participating families experience a comprehensive and coordinated approach to health and well-being that encompasses all aspects of infant and family development during a child's earliest years. Attaining the ultimate goal of getting each and every child ready to reach his or her fullest potential begins here.

[11] *Radimer, K. L., Olson, C. M., Greene, J. C., Campbell, C. C., & Habicht, J. (1992). Understanding hunger and developing indicators to assess it in women and children.* Journal of Nutrition Education, *24, 36–45.*

[12] *National Association for Sports and Physical Education. (2002).* Active start: A statement of physical activity guidelines for children birth to five years. *Washington, DC: Author.*

Early Head Start

PRENATAL WORKSHEET **Program Year** _____

Mom's Name / Baby's Name	Start Date	EDC Date	Nutrition Assesment	Prenatal Care, Physical exam	Prenatal Care, Dental exam	Mental Health Substance Abuse prevention and treatment	Prenatal Health Education			Newborn Visitation visit by health staff
							Smoking Alcolhol, Drugs, caffeine	Breast Feeding, SIDS	Labor & Delivery, Post-Partum depression	

Appendix A-2

Newborn Health Visit
Bear River Early Head Start

Date:

Name: _____ DOB: _____ Gender: _____

Parent's Name: _____

Baby's HCP: _____ Mother's HCP: _____

BIRTH WEIGHT	LENGTH @ BIRTH	BABY	MOTHER
		☐ active, good color	☐ Good
		☐ sleeping, good color	☐ OK
		☐ jaundiced, lethargic	☐ Fair
		☐ other	☐ Poor

Interval History:

Gest. Age at delivery: _____

APGAR score: 1 min. _____ 5 min. _____

Medications:

_____

_____

Injury or illness:

_____

_____

Special health care needs:

_____

_____

Visits to health care providers or facilities:

_____

_____

Change/stressors in family or home:

_____

_____

Notes:

_____

_____

Questions for Parent:

- How are you feeling? _____

_____

- How did the delivery go? _____

_____

Delivery location:

☐ Hospital ☐ BC ☐ Home ☐ Other

Type of Delivery:

☐ Vaginal ☐ Cesarean Section

Length of baby's hospital stay:

☐ Routine ☐ Non-routine (< one week)

☐ one week to one month

☐ over one month

Reason for non-routine hospital stay:

_____

_____

- What do your other children think about the new baby?

_____

_____

- What are your questions about feeding the baby?

_____

_____

- What questions or concerns would you like to discuss today?

_____

_____

Anticipatory Guidance

Healthy Habits

☐ Car seat
☐ Crib safety
☐ Sleep on back
☐ Water temperature <120∞
☐ Keep hand on baby
☐ Smoke-free environment
☐ Hot liquids, cigarettes
☐ Signs of illness
☐ Emergency procedures

Nutrition

☐ Successful breastfeeding practices (positioning, latching on, feeding on cue)
☐ 6-8 wet diapers per day
☐ Maternal care (rest, nipple care, eating properly, follow-up support
☐ Formula (preparation, equipment, semi-sitting position)
☐ No bottle in bed or microwave

Infant Care

☐ Cord
☐ Intact penis or circumcision care
☐ Vaginal discharge, bleeding
☐ Skin, nails
☐ Crying
☐ Sneezing, hiccups
☐ Burping, spitting up
☐ Thumbsucking, pacifiers
☐ Sleep patterns, arrangements
☐ Meconium to transitional stools
☐ Thermometer use
☐ Layers of clothing

Parent/infant interaction

☐ Baby's temperament
☐ Console baby
☐ Hold, cuddle, rock
☐ Talk, sing

Family Relationships

☐ Partner involvement
☐ Rest, fatigue, depression
☐ Support from family/friends
☐ Siblings' reactions _____

_____

_____

_____

Other Needs

- Offer materials for review at home on child safety, childproofing home, breastfeeding.
- Suggest resources to help with breastfeeding.
- Provide information about parenting classes or support groups.
- Suggest community resources.
- Discuss how to access health care.

Referrals

☐ Health insurance/Medicaid
☐ SSI
☐ Part C
☐ WIC
☐ Food Stamps
☐ Social Services
☐ Housing
☐ Other: _____

_____

_____

_____

_____

Mother's Signature _____

Father's Signature _____

EHS Health Staff Signature _____

Appendix A-3

Nursing Control Form-
Otero Junior College Early Head Start

Home Visitor

Pregnant	Name of Child	Start Date	Date of Birth	P C P	Dentist	Medicaid / Wic	Health History	Health Screenings once / year: Lead Screen	Height and Weight Head Circumference	Blood Pressure > 15 mo	Vision Screen	Hearing Screen / Tymp	Hgb / Hct > 9 mo	Dental Screen	Well Child Exams: 2wks, 2mo	4mo, 6mo	9mo, 12mo	15mo, 18mo	2yrs, 3 yrs	Vaccination: IZ Complete at 2 & 4 mo	IZ Complete at 6 & 15 mo

Appendix A-4

OJC/CDS Early Head Start
Health Screening and Immunization Record

Child's Last Name	First	Middle	DOB	Sex

IMMUNIZATIONS (due at 2, 4, 6, and 15 months)

VACCINE	Enter date each immunization was given. Copy dates from child's record and update with any IZ given.				
DTaP					
IPV					
Hib (*One dose must be after 1st birthday)*					
Measles					
Mumps					
Rubella					
HB (Hepatitis B)					
Varicella *(Or parents report of disease)*					
PCV					
Hepatitis A					

Screening Results and/or Date Done

B.D.	2 wks	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	2 yrs.	3 yrs.
Well Child Evaluation, Physical Exam									
Head Circum.									
Height/ Weight									
Hgb *(Once a year)*									
Blood Pressure *(Once a year)*									
Eye-Vision Screen *(Once a year)*									
Hearing Screen *(Once a year)*									
Denver II									
Ages & Stages									
Dental Screen *(Once a year)*									
Lead Screen *(Once a year)*									

Appendix B

Additional Resources

Head Start Training Guides

The Head Start Bureau Training Guides are available on the website of the Head Start Information and Publications Center.
http://www.headstartinfo.org>publications>Training Guides

Caring for Children With Chronic Conditions (1998)
Enhancing Health in the Head Start Workplace (1996)
Laying a Foundation in Health and Wellness (2000)
Preventing and Managing Communicable Diseases (1996)
Promoting Mental Health (1998)
Safety First: Preventing and Managing Childhood Injuries (2000)
Sustaining a Healthy Environment (1997)
Well Child Health Care (1998)

Additional Publications

Early Head Start National Resource Center. (1999).
Giving children the earliest head start: Developing an individualized approach to high-quality services for pregnant women (EHS NRC Technical Assistance Paper No. 3). Washington, DC: Head Start Bureau.

Early Head Start National Resource Center. (2000).
Developmental screening, assessment, and evaluation: Key elements for individualizing curricula in Early Head Start programs (EHS NRC Technical Assistance Paper No. 4). Washington, DC: Head Start Bureau.

Early Head Start National Resource Center. (2003).
Early Head Start program strategies: Responding to the mental health needs of infants, toddlers, and families. Washington, DC: U. S. Department of Health and Human Services, Head Start Bureau.

Early Head Start National Resource Center. (2004).
Pathways to prevention: A comprehensive guide for supporting infant and toddler mental health. Washington, DC: U.S. Department of Health and Human Services, Head Start Bureau.

Harden, B. J. (1997).
You cannot do it alone: Home visitation with psychologically vulnerable families and children.
Zero to Three, 17(4), 10–16.

Head Start Bureau. (2003).
Adult health. *Head Start Bulletin, 75*.

Head Start Bureau. (2003).
Weaving connections: The Health Services Advisory Committee. Washington, DC: Author.

Head Start Information and Publications Center.
Health tool kit. Available on-line: http://www.headstartinfo.org/infocenter/health_tkit.htm.

Mann, T. (1998). *Promoting the mental health of infants and toddlers in Early Head Start: Responsibilities, partnerships, and supports*. Zero to Three, 18(2), 37–40.

National Center for Cultural Competence. (2002). *Rationale for cultural competence in primary health care (policy brief)*. Washington, DC: Author.

National Center for Cultural Competence. (2003). *A guide to choosing and adapting culturally and linguistically competent health promotion materials*. Washington, DC: Author.

Taylor, L., and Willes-Jacaobo, L. (2003) *The culturally competent pediatrician: Respecting ethnicity in your practice*. Contemporary Pediatrics, 20(6), 83-105.

Tonniges, T. F. (1997). *Promoting optimal health in child-care settings*. Healthy Child Care America, 1(3), 1–5.

U.S. Department of Health and Human Services. (2002).
Bright futures: Guidelines for health supervision of infants, children, and adolescents (2nd ed., rev.). Washington, DC: Maternal and Child Health Bureau. *Available on-line: http://www.brightfutures.org*

National Organizations

The American Academy of Pediatrics

141 Northwest Point Boulevard
Elk Grove Village, IL 60007
Phone: 847-434-4000
Web: *www.aap.org*

KidsHealth (Created by the Nemour's Foundation)

Web: *www.kidshealth.org*

La Leche International

P.O. Box 4079
Schaumburg, IL 60168
Phone: 847-519-7730
Web: *www.lalecheleague.org*

National Immunization Program

Centers for Disease Control and Prevention
1600 Clifton Road, NE
Mailstop E-52
Atlanta, GA 30333
National Immunization
Information Hotline: 1-800-232-2522 (English);
1-800-232-0233 (Spanish)

National Maternal and Child Oral Health Resource Center

Georgetown University
Box 571272
Washington, DC 20057
Phone: 202-784-9771

National SIDS and Infant Death Program

1314 Bedford Avenue, Suite 205B
Baltimore, MD 21208
Phone: 410-415-5093 or 1-800-638-7437

NICHD/Back to Sleep

Building 31, Room 2A32, MSC 2425
31 Center Drive
Bethesda, MD 20892-2425
Phone: 1-800-370-2943
Web: *www.nichd.nih.gov*

Early Head Start National Resource Center