

GOAL AREA: HEALTH

STRATEGY NAME: NUTRITION/OBESITY/PHYSICAL ACTIVITY

<p>GOAL:</p> <ul style="list-style-type: none"> • FTF will coordinate and integrate with existing education and information systems to expand families' access to high quality, diverse and relevant information and resources to support their child's optimal development. 			
STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
<p>This strategy include a variety of public health education programs and curricula delivered in diverse settings.</p> <p>Examples provided below describe different options to address childhood obesity including curricula on healthy eating, reducing screen time and increasing physical activity. These do not represent an exhaustive list.</p> <p>Comprehensive programs for child care environments, staff and/or parents to improve nutrition and physical activity</p> <ul style="list-style-type: none"> • <i>Nutrition and Physical Activity in Child Care (NAP SACC)</i> Strategy includes child care center self assessment on nutrition and physical activity practices, goal setting, technical assistance provided by trained child care health consultant, evaluation, revision, repetition. Information provided to parents • <i>I am moving, I am learning (IM/IL) Head Start Obesity Prevention Program</i> Program allows staff to integrate obesity prevention practices into daily practices. A key feature of IM/IL is that it flexible, allows programs to tailor and individualize strategies and activities to meet local program needs. Requires Head Start teachers to attend a 2 ½ 	<p>Effective practice based intervention</p> <p>Research to practice initiative, presently being evaluated, promising practice</p>	<p>If working within child care programs, need to coordinate with other strategies (QF, CCHC etc.) Costs will vary depending upon curriculum and service delivery method.</p> <p>Considerable resources are available on the web. These resources include all staff training power point presentations, implementation manual, parent handouts and online training for those who will implement. All CCHC's funded by First Things First have been trained on this program.</p> <p>Costs unknown due to lack of data outside of Head Start programs.</p>	<p>Impacted by type of professional used to deliver program. If known, curriculum costs are included below</p> <p>\$4,000.00 per center if delivered by a CCHC (cost 120,000 carrying a caseload of 30 centers/homes)</p> <p>Unknown</p>

<p>day training, where they participate in interactive workshops and develop strategies for program implementation.</p> <ul style="list-style-type: none"> • <i>Hip-Hop to Health Jr.</i> Targets three- to five-year-old minority children enrolled in Head Start programs with the aim of reducing the tendency toward overweight and obesity in African American and Latino preschool children. The intervention presents a developmentally, culturally, and linguistically appropriate dietary and physical activity curriculum for preschoolers, and a parent component. • <i>Healthy Start</i> Modification of childcare food service menus and recipes. Outcome: decrease in fat and calories of meals resulting in a reduction in total serum cholesterol. • <i>Color Me Healthy/Color Me Healthy</i> Preschool/childcare center Curriculum that promotes eating fruits and vegetables and being active 	<p>Evidence Based</p>	<p>Evaluated in Head Start settings not in family home settings. Costs unknown due to lack of data outside Head Start Programs</p>	<p>Unknown</p>
<p>Evidence Based</p>	<p>This is an intervention for child care settings with in house food service programs.</p>	<p>Unknown, dependent upon type of professional hired to implement.</p>	<p>\$80 per kit +\$25 for Spanish materials. \$100 for trainers manual. Addition \$ required for professional to provide training to child care staff</p>
<p>Best Practice, reduced screen time linked to reduced BMI</p> <p>Evidence Based</p>	<p>Not tested in family child care homes; difficult to implement in rural areas without preschools and child care centers.</p>	<p>Will vary depending upon professional hired to deliver program.</p>	

<p>Reducing Screen (TV) Time</p> <ul style="list-style-type: none"> • <i>Brocodile the Crocodile – now part of NY state wide Fit 5 Kids curriculum</i> Seven sessions with messages to reduce TV viewing incorporated into creative lessons in language arts, math, movement and song, arts and crafts, health and science <p>Obesity Prevention in the primary care setting</p> <ul style="list-style-type: none"> • <i>High Five for Kids</i> Implemented by nurse practitioners or other professionals trained in Motivational Interviewing with parents with goal to change child's behavior. <p>Increase physical activity</p> <ul style="list-style-type: none"> • <i>Spark PE Early Childhood</i> SPARK EC provided children ages 3-5 with high activity, academically integrated, enjoyable movement opportunities that foster social and motor development and enhance school readiness skills. SPARK EC activities are age-appropriate, engaging, rhythmic, and fun. Curriculum, training, equipment, and support are provided to implement an effective physical activity program. • <i>CATCH Early Childhood</i> Physical education/activities, specifically aimed at increasing moderate-to-vigorous physical activity while at preschool. Lesson plans and activities, combined with music, hand puppets and other stimulating visuals, create an environment where physical activity, health, education, and healthy eating behaviors are valued and taught 	<p>Promising Practice</p> <p>Spark PE for children older than 5 is evidence based</p> <p>CATCH school age is evidence based</p>	<p>This curricula can also be built into home visitation programs such as Parents as Teachers.</p>	<p>\$2700-\$4700 for up to 40 staff- includes training, curriculum and follow up. Equipment is an additional \$1700</p> <p>Kit costs \$375 each, Includes teachers manual, parent tip sheets and lesson plans. Additional costs might be incurred to train staff on implementation.</p>
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FIRST THINGS FIRST

Community Health Education w/Obesity Prevention

Standards of Practice - Final

A great deal of public health research indicates that Arizona's children are not as healthy as they could be. Increased rates of obesity, diabetes, and asthma; paired with poor nutrition, a sedentary lifestyle, and a variety of economic and social factors are all contributing to a poor environment of physical, mental, and oral health for many children. Even more alarming is recent news published in the New England Journal of Medicine that life expectancy for children born today may actually be less than that of their parents. Though we have made significant progress in addressing health issues that affect children through immunization and other public health interventions, many problems remain. The unique geography and population of the state complicate addressing these health concerns.

Health educators work with individuals and communities to provide information and education on how to improve health and health outcomes. They "work to encourage healthy lifestyles and wellness through educating individuals and communities about behaviors that can prevent diseases, injuries, and other health problems" (U.S. Department of Labor, December 2009). There are many health education programs, on a variety of topics, designed to provide individuals and communities with the information they need to improve their health status.

In order to leverage resources and educational efforts, community health education efforts may be integrated into other public health and health programming. For example, community health education can be addressed through other early childhood programs and services, such as home visitation, parenting education or by child care providers.

First Things First Regional Partnership Councils have identified a number of health needs and disparities specific to their individual regions. To address some of these needs, they have chosen to fund community based health education programs in multiple settings. Any grantee implementing community health education on any topic must meet the following requirements:

QUALIFICATIONS FOR A COMMUNITY HEALTH EDUCATOR INCLUDE:

Minimum of a Bachelors Degree in Health Education, or another allied health profession.

Completion of training in the specific curriculum/materials being used.

Excellent communications skills and the ability to adjust to the individual learners' needs.

Have knowledge and skills in:

- Assessing individual and community needs for health education.
- Planning, implementing and administering health education strategies, interventions and programs.

2/16/2010

- Serving as a health education resource person.
- Communicating and advocating for health and health education

PROGRAMS IMPLEMENTING COMMUNITY HEALTH EDUCATION WILL:

Address a documented health need within the target population of children birth through age five.

Choose or develop curriculum based on recognized educational principles.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Build upon, enhance and coordinate with existing community based health education efforts in the region.

To the extent possible, work in partnership with other early childhood initiatives that provide services to the same target population.

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work.

Hire staff with the appropriate qualifications to deliver the specific services in the scope of work.

Assure that staff receive specific training to carry out community based health education activities.

Provide ongoing staff development on diversity issues.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders and the community.

Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families and community members.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Develop a post training evaluation for participant feedback if providing a series of sessions.

Programs implementing best practice models for community health education must adhere to the standards of the model, unless permission to deviate from the model has been obtained from the appropriate source.

Recognize that certain populations have health disparities due to cultural, linguistic, geographic and socioeconomic factors, and tailor interventions/curriculum and programs to address various populations.

Collaborate with existing community resources to reinforce health education messages.

2/16/2010

Maintain confidentiality of all information obtained as part of the community based health education program.

In the United States, Native American Tribes are considered autonomous nations with all of the rights and responsibilities of a nation. Understanding this, Native American Tribes are charged with protecting the health and safety of their people. To this end, Tribes have full ownership over any data collected within their reservation boundaries. This means that Tribes can allow or not allow any program to collect health data on the reservation.

Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive health data. Such data can include but not be limited to:

- Morbidity and mortality among members of their communities
- Information regarding child safety and welfare
- Information regarding children in foster care
- Infectious and chronic disease information among members of their communities
- BMI and healthy weight information

“To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children.”

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> ;

<http://www.naeyc.org/positionstatements/linguistic>

COMMUNITY HEALTH EDUCATORS WILL:

Develop a written program plan that includes:

- Program goals, intended audience
- Measurable objectives
- Appropriate activities to meet objectives, including timelines and responsibilities for implementation
- Description of resources necessary to conduct the program
- Comprehensive evaluation plan to measure the impact of a program, make future improvements and make decision about similar future programs

Communicate the purpose and objectives of the activity to the learner before the activity.

2/16/2010

Identify educational needs/gaps of the learner or target audience.

Select a format and setting for the activity that are appropriate for the target audience and type of program being implemented.

Incorporate principles of adult learning into instruction.

Implement the health education program based on activities and timelines developed in the written program plan.

Utilize a variety of skills in delivering strategies, interventions and programs including effective use of instructional technology.

Incorporate demographically and culturally sensitive techniques when promoting programs.

Assess the effectiveness of the program plan and make appropriate modifications.

Maintain confidentiality of all health information obtained as part of the community based health education program.

ALL PROGRAMS IMPLEMENTING OBESITY PREVENTION STRATEGIES WILL:

Include strategies to address both improving eating habits and increasing physical inactivity.

Align program goals, objectives, and strategies with the goals, objectives, and strategy recommendations identified in the Arizona Nutrition and Physical Activity State Plan. Information on the Arizona Nutrition and Physical Activity State Plan is available on line at:
<http://www.eatsmartgetactive.org/pdf/opp6.pdf>

Understanding the influence that parents and caregivers have on the behaviors of young children, all programs must provide obesity interventions that influence the healthy eating and physical activity behaviors of adults as well as children.

Collaborate with existing community resources/partners to communicate the healthy weight and physical activity message. For example, encourage child care centers and home care providers to participate in the Arizona Department of Health Services' "Empowerment Pack" program. Information on the Arizona Department of Health Services' Empowerment Pack is available on line at
<http://www.theempowerpack.org/>

Programs targeting child care centers and home care providers will actively promote participation in the USDA Child and Adult Care Food Program to potentially eligible centers/providers. Information on the USDA Child and Adult Care Food Program is available online at <http://www.fns.usda.gov/cnd/care/>

Recognizing that certain populations are at greater risk, resulting in disparities in the prevalence of obesity, interventions/curriculum/programs need to be tailored appropriately for various populations and incorporate cultural, linguistic, geographic and socioeconomic factors.

References:

National Commission for Health Education Credentialing (NCHEC), Responsibilities and Competencies of Health Educators. 2008. Available at <http://www.nche.org/credentialing>

California Conference on Local Directors of Health Education (CCLDHE), Standards of Practice for Public Health Education in California Local Health Departments. October, 2008. Available at www.cclde.org

United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2010-2011 edition. December, 2009. Available online at www.bls.gov/oco/ocos063.htm

Nutrition/Obesity/Physical Activity

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Nutrition/Obesity/Physical Activity**, the units of service are:

- Total number of children attending nutrition and recreation training sessions**
- Total number of adults attending nutrition and recreation training sessions**

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Nutrition/Obesity/Physical Activity**, performance measures are:

- Total number of children attending training sessions / proposed service number**
- Total number of adults attending training sessions / proposed service number**
- Total number of training sessions conducted/proposed service number
- Total number of families receiving referrals for health insurance or health coverage enrollment/
target service number
- Total number of information sessions conducted/ proposed service number
- Total number of people reached by information sessions/proposed service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Nutrition/Obesity/Physical Activity**, the data reporting template is: