



September 17, 2015

Ms. Colleen Rathgeb
 Policy and Planning Director
 Office of Head Start
 1250 Maryland Avenue SW
 Washington, DC 20024

RE: Head Start Performance Standards (Docket No. ACF-2015-0008)

Dear Ms. Rathgeb:

On behalf of the undersigned organizations and individuals, we thank you for the opportunity to provide comments in response to the notice of proposed rulemaking (RIN 0970-AC63) regarding the Head Start Performance Standards. We are submitting these comments to urge that the final Performance Standards include a requirement to address parental/guardian smoking and child exposure to secondhand smoke in order to remove a significant barrier to attendance and school readiness.

For the last 11 years local Head Start Programs integrated tobacco use screening and education for Head Start parents. This effort was on a voluntary basis since adults in low income families smoke at disproportionately high rates and they and their children disproportionately suffer the serious, adverse health consequences that inevitably follow. To date, Truth Initiative has worked with sixteen states and two territories with requests from programs in other states. Once Head Start Directors understand the profound impact secondhand smoke has on the children in their programs, they immediately agree they must address the issue.

The draft Head Start Performance Standards emphasize the importance of regular attendance in the program and properly recognize that the biggest barrier to regular attendance is child illness.¹ Given the well-established causal connection between exposure to secondhand smoke and health consequences including asthma and other respiratory illnesses that lead to absenteeism, our proposal will have a critical and sustainable positive effect on the school readiness and health of children served by Head Start.

Specifically, we request that a Performance Standard be added to the Family and Community Partnership Program Services; Subpart E. Under the structure of the new rule, we request that §1302.50(b) include the following requirement:

Promote shared responsibility with parents for identifying and addressing tobacco use in the home as a barrier to child wellness and regular child attendance including identifying parents or guardians who are smokers and providing those that smoke with educational resources regarding health and developmental consequences of secondhand smoke exposure and tobacco use and resources for quitting (e.g. 1-800-QUIT-NOW or the resources at www.smokefree.gov).

Recognizing the Office of Head Start's intent to streamline the regulatory structure, if a decision is made that a formal Performance Standard would not be appropriate, we urge the adoption of the following non-regulatory solutions:

- Program Instruction. Issuing a tobacco control-related program instruction will strengthen Head Start's goal to increase child attendance by reducing children's exposure to secondhand smoke. Such an action will increase the status of secondhand smoke exposure and tobacco use a significant issue that must be addressed by programs.
- Program Information Report. Adding data collection requirements focused on tracking whether tobacco products are permitted in the house, general tobacco use amongst adults in the household, and referrals to cessation services ensures this critical issue is seen as a priority that supports child attendance and adherence to the Program Instruction.

- Integration into the Training and Technical Assistance Centers. Requiring that the National Center on Parent, Family, and Community Engagement and/or the National Center on Health promote a tobacco control programmatic framework and the necessary training and technical assistance to support it, programs will then have the knowledge and skill to address secondhand smoke exposure and tobacco use.

The Health Consequences Of Secondhand Smoke Exposure Are A Major Barrier To Child Health And Therefore Program Attendance.

The high prevalence of smoking in low-income families has a devastating impact on the health of their children through exposure to secondhand smoke. Children exposed to secondhand smoke are at an increased risk of sudden infant death syndrome (SIDS), lower respiratory illnesses, middle ear disease, asthma and more severe forms of asthma, slowed lung growth, and at increased risk for respiratory symptoms including cough, phlegm, wheeze, and breathlessness.²

Asthma is a leading chronic health problem among children.³ It is also one of the most common causes of children's absence from school.³ An estimated 8.3% of children suffer from this chronic respiratory condition.⁴ 10.9% of Americans living below 100% of the federal poverty level have asthma, compared to 7.0% of those living at between 100% and 250% of the federal poverty level.⁴ Nearly one in two children with asthma miss at least one day of school each year because of the disease.⁵ In 2008, asthma caused 10.5 million missed days of school.⁵

While our focus here is, of course, on the children, it is important to keep in mind that the high cost of tobacco products, and the soaring costs of health care associated with smoking-related illness and disease, also have substantial economic impact on families struggling to make ends meet.⁶ Smokers have an increased risk of work absenteeism,⁷⁻⁹ which may impact the financial stability of the family.

Head Start/Early Head Start Eligible Families Have High Rates Of Tobacco Use And Second Hand Smoke Exposure.

While great strides have been made over the past four decades in reducing the prevalence of tobacco use, 17.8% of adults in the United States, about 42.1 million persons, still smoke.¹⁰ Importantly, these smokers are not evenly spread across the population. Rather, the lower one's income and education level, the more likely they are to smoke. Head Start parents are among the adults most likely to smoke. In 2012-2013, 29.8% of adults in the United States with an annual household income of less than \$20,000 reported every day or some day use of tobacco products. 25.6% of adults with an annual household income between \$20,000 and \$49,999 smoke.¹¹ The median annual household income for HS/EHS families was \$22,714 in the fall of 2009 – putting these families squarely among the most likely smokers. Not only are Head Start parents most likely to smoke, their families are also most likely to be exposed to secondhand smoke since 43.2% of nonsmokers in the U.S. who live below the poverty level are exposed to secondhand smoke.¹²

The Proposed Tobacco Control Performance Standard Is Consistent With Other Head Start/Early Head Start Mandates In The Notice Of Proposed Rulemaking.

The proposed tobacco control performance standard is consistent with other Head Start mandates described in the notice of proposed rulemaking including tooth brushing (Section 1302.43) which requires ensuring children brush their teeth during program hours; nutrition (Section 1302.44) which, in part, requires that each child receive meals and snacks that provide at least one-third (for part-day) and one-half to two-thirds (for full-day) of the child’s daily nutritional needs; mental health (Section 1302.45) which requires mental health consultants must be engaged in supporting teachers for effective classroom management, formulating and implementing strategies for supporting children with challenging behaviors, and facilitating community partnerships in mental health; and family support services for health, nutrition, and mental health (Section 1302.46) which requires programs to collaborate with parents to promote children’s health and well-being by providing medical, oral, nutrition, and mental health education support services that are understandable to individuals with low health literacy. Section 1302.81 requires programs to provide enrolled pregnant women, fathers, and partners the prenatal and postpartum services that address the risk of smoking, in part.

This Program Standard Will Align Head Start And Early Head Start With The Broader HHS Goal Of Reducing Tobacco Use And Its Devastating Public Health Impact.

Adopting the proposed performance standard would align Head Start with the overarching HHS goals to reduce tobacco use and its health impacts. For example, the “HHS Action Plan to Reduce Racial and Ethnic Health Disparities” includes three strategic actions where a Head Start tobacco performance standard would naturally fit. The first, in which Administration for Children and Families is listed as a participating agency, is to reduce tobacco-related disparities through targeted evidence-based interventions in locations serving racial and ethnic minority populations. The second, in which ACF is listed as a lead agency, is to increase education programs, social, support, and home-visiting programs to improve prenatal, early childhood, and maternal health. The third is to implement targeted activities to reduce asthma.¹³

In the 2010 report, “Ending the Tobacco Epidemic: A Tobacco Control Strategic Plan for the U.S. Department of Health and Human Services”, HHS suggests reducing tobacco-related disparities through targeted interventions in locations serving high-risk populations.¹⁴ Head Start meets all of these criteria and arguably would be one of the best programs in which to accomplish these objectives.

On The Ground Experience With Smoking Cessation Interventions In Head Start Programs Demonstrates That They Can Impact Attendance And Readiness With A Minimal Burden.

Finally – and perhaps most important -- both the impact and feasibility of the proposed performance standard are supported by the actual experience of our Head Start partners. It bears emphasizing that the proposed standard simply includes a requirement to inquire about parental smoking status and make appropriate referrals. It does not require Head Start to become a

smoking cessation counseling center nor does it require Head Start to develop its own medical expertise. Nonetheless, evidence shows that even brief interventions such as motivational interviewing and the “5 A’s” model can make a real difference.¹⁵⁻¹⁸ The standard can be naturally integrated into the already existing family services component of Head Start through the family partnership agreement process. Indeed, Head Start already has a similar requirement in §1302.81 for pregnant women.

We urge you to consider and take into account the very positive views of Head Start directors and family advocates who have actually implemented these programs and seen them work.

- For example, Paul Behrman, Chair of the Vermont Head Start Association and Director of Champlain Valley Head Start, stated, “Statewide, we’ve elevated tobacco cessation as a Head Start program priority. The Head Start Tobacco Cessation Initiative is very straightforward in terms of implementation. It is low-cost, and fits precisely within our existing service models. And, the initiative aligns with our mission and multi-disciplinary approach in terms of education, health and family services.”⁶ According to Mr. Behrman, “Head Start builds meaningful, trusting relationships with children and their parents. These relationships provide the basis for conversations with parents around their tobacco use, and how Head Start can be a support in terms of parents making a quit attempt or changing their behaviors around the use of tobacco. As a result of these interventions, some parents will make one or more quit attempts, and some will be successful. Even more frequently, Head Start parents will modify their behavior – such as prohibiting the use of tobacco within their homes or cars. In so doing, parents are able to create healthier environments for their families, and reduce significantly their children’s exposure to secondhand smoke.”
- Cathy Wamsley, former Director of Umatilla Morrow Head Start: “As a recently retired long-term director of an Oregon Head Start program, our agency personnel understood the important role Head Start staff play in building healthy relationships with parents and communicating the importance that positive behaviors have on the long term health of their children. We were one of the early adopters of training our staff on how to work with families to address the impacts of second hand smoke on their children. Through this work we saw real changes in parent’s behaviors ranging from not allowing smoking in the home or car to quitting the use of tobacco all together. This was important work for our staff and was adopted by all the Oregon Head Start programs. Our parents always want what is best for their children - they just need the support that Head Start staff offer.”
- Claire Wilson, Executive Director of Policy, Governance, School, Family, Community Partnerships at Puget Sound Educational Service District: “As an Executive Director of Early Learning programs, we became an original pilot for work around smoking cessation because of a strong health focus and because many of our Head Start families have children that suffer from tobacco related asthma and allergies. In Head Start, our staff now ask questions on the child health and developmental history form about smoking/tobacco use of the mother during pregnancy as well as when asthma/allergy is identified as a health issue for a child. Since initiating our intentional focus on tobacco it

has been exciting to see staff change their conversations with families with increased understanding about second and third hand smoke, and ultimately supporting positive changes in parents and family members regarding when and where they smoke. At the end of the day, Head Start is relationship based – staff have relationships developed with families and there is trust and open lines of communication established. Families feel supported and not judged so are willing to hear and consider making changes – whether that be quit attempts, smoking outside, or not smoking in the car. It’s supporting them where they are in taking their next steps.”

- Debbi Baldwin, Child Development Division Director of RurAL CAP Head Start in Alaska: “The Growing Up Tobacco Free in Alaska initiative has made a marked impact on increasing knowledge, understanding and incremental lifestyle changes for RurAL CAP Head Start/Early Head Start families and staff. Prioritizing our focus on personal choices, such as tobacco use and its resulting impact on the long term well-being of children resonated with our staff, families and communities. Further linking the relationship between absenteeism in program services of children and/or families members as a result of illnesses, aided our understanding of how tobacco use in the home environment can be correlated to higher incidents of asthma, upper respiratory infections, ear infections and other health disparities. We continue to remain committed to ensuring healthy futures for all and helping all children grow up tobacco-free in Alaska.”
- The impact of these programs is also evident to family advocates and not just program directors. A family support worker in Puget Sound Education Service District stated, “Parents seem to be relieved to learn that there is support for quitting tobacco use and that any steps toward stopping usage are great steps. They appear encouraged by the nonjudgmental approach and begin to think about the effects that tobacco has on the rest of the household. Some parents don’t realize that even smoking in a car or outside does not eliminate the exposure to toxins when they re-enter the home.” A family support worker, who was surveyed anonymously, said, “I find myself feeling much more confident having conversations around tobacco use with parents because I now have some understanding and education around tobacco use.” Another shared the story of a family in which both parents decided to quit. “I know I have made an impression on our smoking parents relative to second and third-hand smoke exposure. Last year we had a mom and dad ask for information at the start of school and then quit smoking together so that mom could become pregnant again and have a healthy pregnancy.”⁶ Family advocates develop relationships that make them ideally suited for this kind of intervention. Frank Ranger, former President of the Head Start Association of Hawaii and Former Director of Kauai Head Start, stated, “We have a personal relationship with our families, which makes it possible to talk about health issues like smoking on a little more intimate level than one of our families deciding that they’re going to call the Health Department, or call a toll-free number that’s advertised on TV to stop smoking.”⁶
- But for these interventions to have scale, they must be included in a national standard. Terry Reid, Director of the Washington State Tobacco Prevention and Control Program from 2001-2011, put it well when he said, “I think we’ve demonstrated the effectiveness of this Initiative as systems-based intervention model. From here, it’s got to become

something of value at the national level of Head Start. Their policy needs to require tobacco intervention with families.”⁶

That is precisely the step we are urging be taken by adopting the proposed program standard.

Thank you for considering this proposal. We strongly believe it has the ability to improve the lives of your clients.

Sincerely,

Action on Smoking and Health
Advantage Dental
African American Tobacco Control Leadership Council
Albina Head Start & Early Head Start (*Oregon*)
Altarum Institute
American Academy of Family Physicians
American Association for Respiratory Care
American Cancer Society Cancer Action Network
American College of Obstetricians and Gynecologists
American College of Preventive Medicine
American Heart Association
American Lung Association
American Lung Association in Alaska
American School Health Association
Arizona Smokers’ Helpline (ASHLine)
Asian Pacific Partners for Empowerment and Leadership
Bennington County Head Start, United Children’s Services (*Vermont*)
Blue Mountain Early Learning HUB (*Oregon*)
BlueCross BlueShield Minnesota Center for Prevention
Brattleboro Town School District’s Early Education Services (*Vermont*)
Campaign for Tobacco-Free Kids
Capstone Community Action Head Start (*Vermont*)
Central Missouri Community Action
Champlain Valley Office of Economic Opportunity (*Vermont*)
Barbara Cimaglio, Vermont Deputy Commissioner of Health
ClearWay Minnesota
Clinical Outcomes Group, Inc. (*Pennsylvania*)
Coalition of National Health Education Organizations
Education Connection (*Connecticut*)
Good Shepherd Community Health Foundation (*Oregon*)
Good Shepherd Health Care System (*Oregon*)
Greater Oregon Behavioral Health, Inc.
Head Start of Yamhill County (*Oregon*)
InterMountain Education Service District (*Oregon*)
Lake County Health Department and Community Health Center (*Illinois*)

LULAC Head Start (*Connecticut*)
Luzerne County Head Start, Inc. (*Pennsylvania*)
Lynn Management Consulting (*Vermont*)
Maine Head Start Directors Association
March of Dimes Foundation
Minnesota Department of Health
Morrow County Public Health (*Oregon*)
National African American Tobacco Prevention Network
National Alliance for Hispanic Health
National Head Start Association
National Latino Alliance for Health Equity
North American Quitline Consortium
Northeast Kingdom Community Action Child and Family Development Program (*Vermont*)
Partnership for a Tobacco-Free Shoals (*Alabama*)
Pennsylvania Department of Health
Prevention Institute
Puget Sound Education Service District (*Washington*)
Rural Alaska Community Action Program, Inc.
Rutland County Head Start (*Vermont*)
Society for Public Health Education
Society for Research on Nicotine and Tobacco
The Society of Thoracic Surgeons
South Caroline Tobacco-Free Collaborative
Southeastern Vermont Community Action
Southwestern Community Services Head Start (*New Hampshire*)
TEAM Inc. / Training, Education and Manpower, Inc. (*Connecticut*)
Tobacco Control Legal Consortium
Tobacco Free Northeast PA
Tobacco-Free Alliance of Pierce County (*Washington*)
Tobacco-Free Coalition of Weld County (*Colorado*)
Trust for America's Health
Truth Initiative
Umatilla County Public Health (*Oregon*)
Umatilla Morrow Head Start, Inc. (*Oregon*)
University of Detroit Mercy School of Dentistry
University of Texas MD Anderson Cancer Center
Vermont Department of Health
Vermont Head Start Association
Vermont Head Start State Collaboration Office
Washington State Association of Head Start & ECEAP
Washington State Department of Health
Grace Whitney, Director of Connecticut Head Start State Collaboration Office
John Wiesman, DrPH, MPH, Secretary of Health, Washington State Department of Health

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