Nutrition and Public Health

VII

Chapter 49

Preventing Food Insecurity—Available Community Nutrition Programs

The need for providers to become familiar with their local nutrition resources came into sharper focus when the American Academy of Pediatrics (AAP) published its policy statement on food insecurity in 2015.[1] A food-insecure household is one in which the "access to adequate food is limited by lack of money or other resources."[2,3] Rates of food insecurity in the United States vary year by year, but in most years, approximately one fifth of children are food insecure. Families living below the poverty level are not the only food-insecure US families; children of immigrant families, large families, and those headed by a single woman or experiencing parental separation or divorce are at greater risk.[3-5]

Food insecurity is an important risk factor for increased childhood illness, increased rates of hospitalization, developmental problems, dysregulated behavior, and reduced academic achievement.[6,7] Adolescents in food-insecure families are more likely to experience dysthymia and suicidal ideation.[8] Food insecurity is also associated with obesity.[9,10] Importantly, the health effects of food insecurity may persist beyond childhood, increasing the risk of diabetes, hyperlipidemia, and cardiovascular disease in adults.[11,12]

Because of the substantial impact of food insecurity on children and adults and the fact that it is not limited to traditional underserved neighborhoods, the AAP developed recommendations for screening at each annual health care visit using the Hunger Vital Sign to identify food insecurity.[13,14] The AAP recommendations are found in Table 49.1, and the Hunger Vital sign is found in Table 49.2.

The following chapter sections summarize the available community nutrition programs that provide food and nutrition assistance to children and their families.

VII

Introduction

Promoting the nutritional health and wellness of children and their families is a common goal of the nutrition services offered by a wide variety of public and private agencies, organizations, and individuals in communities across the nation. These include federal government agencies; state health and education departments; local health agencies, such as city and county health departments; community health centers; health maintenance and preferred

Table 49.1.
Recommendations for Pediatricians[12]

Practice Level
1. A 2-question validated screening tool (Table 49.2) is recommended for pediatricians screening for food insecurity at scheduled health maintenance visits or sooner if indicated. 2. It is beneficial for pediatricians to familiarize themselves with community resources so that when children screen positively for food insecurity, referral mechanisms to WIC, SNAP, school nutrition programs, local food pantries, summer and child care feeding programs, and other relevant resources are accessible and expedient. 3. When advocating for programs targeted at families with food insecurity, it is important that pediatricians be aware of the nutritional content of food offered in supplemental programs. 4. In the office setting, pediatricians who are aware of the factors that may increase vulnerability of food-insecure populations to obesity and factors that disproportionately burden food-insecure households may address these issues at clinic visits.
System Level
1. Food insecurity, including screening tools and community-specific resource guides, can be incorporated into education of medical students and residents, to prepare future generations of physicians to universally screen for and address food insecurity. 2. Pediatricians can advocate for protecting and increasing access to and funding for SNAP, WIC, school nutrition programs, and summer feeding programs at the local, state, and national levels. Advocacy must also include keeping the food offered in these programs high in nutrient quality and based on sound nutritional science. 3. Pediatricians can strongly support interdisciplinary research that elucidates the relationship between stress, food insecurity, and adverse health consequences, the barriers to breastfeeding for women under stress in food-insecure households; and evidence-based strategies that optimize access to high-quality, nutritious food for families facing food insecurity.

provider organizations; hospital and ambulatory outpatient clinics; nutritionists and dietitians in public and private practice; voluntary health agencies, such as the American Diabetes Association and the American Heart Association; social service agencies; elementary and secondary schools; colleges and universities; and business and industry.

Table 49.2.
Screening for Food Security

For each statement, ask if it is "often true," "sometimes true," or "never true":
1. Within the past 12 months, we worried whether our food would run out before we had money to buy more.
2. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

Adapted from Hager et al.[14] Although an affirmative response to both questions increases the likelihood of food insecurity existing in the household, an affirmative response to only 1 question is often an indication of food insecurity and should precipitate further questioning.

Nutrition Services Provided Through Federal, State, and Local Health and Nutrition Agencies

Each year, Congress appropriates funds for a variety of nutrition and health programs, many of which are targeted to low-income mothers and their children and families. Such programs are administered at the national level by the US Department of Agriculture (USDA) and the US Department of Health and Human Services (DHHS). USDA services include Child Nutrition Programs (National School Lunch Program, School Breakfast Program, Special Milk Program, Summer Food Service Program, Fresh Fruit and Vegetable Program, and the Child and Adult Care Food Program); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the Supplemental Nutrition Assistance Program (SNAP; formerly known as the Food Stamp Program); the Emergency Food Assistance Program; and the Food Distribution Program on Indian Reservations. Services of the DHHS include maternal and child health services block grant programs; preventive health services block grant programs; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services under Medicaid; Indian Health Services, and programs from the Centers for Disease Control and Prevention (CDC). There are also programs such as community health centers and migrant health projects that serve at-risk populations.[15]

In addition to federal support, considerable state and local funds also support child health programs. An example of a local resource is community-based food programs that are nonprofit, nongovernmental, grass-roots, self-help community developmental programs. One such resource is Feeding America (formerly known as America's Second Harvest),

which coordinates a vast network of local food pantries and meal programs across the country. Many of these food programs are tied to other services that low-income mothers and children may need.

Physicians and other primary health care professionals should be knowledgeable about local food and nutrition programs so they can assist families to become informed consumers and appropriate referrals can be made. An informed health care professional can also serve as an advocate to strengthen policy and budget decisions that guide the provision of quality, cost-effective nutrition programs focused on improving the health of the nation.

Although nutrition services were introduced into public health programs as early as the late 1920s, Title V of the Social Security Act of 1935 (Pub L No. 74-721) initiated the federal-state partnership for maternal and child health that served as the major impetus for the development of nutrition services for mothers and children.[16] A census of public health nutrition personnel in 1999–2000 showed that approximately 10 904 public health nutritionists are employed in federal, state, and local public health agencies.[17] Public health nutritionists provide a wide range of services related to core public health functions, including assessment, assurance (support to meet nutritional needs), and policy development. Public health nutritionists provide direct clinical services (eg, screening, assessment, nutrition counseling, monitoring); population-based research; development and implementation of nutrition services and policies that focus on disease prevention and health promotion; provision of technical assistance to a range of providers and consumers; collection and analysis of health-related data, including nutrition surveillance and monitoring; investigation and control of disease, injuries, and responses to natural disasters; protection of the environment, housing, food, water, and workplaces; public information, education, and community mobilization; quality assurance; training and

education; leadership, planning, policy development, and administration; targeted outreach and linkage to personal services; and other direct clinical services.[18]

Many community nutrition services include screening, education, counseling, and treatment to improve the nutritional status of an individual or a population. These services are designed to meet the preventive, therapeutic, and rehabilitative health care needs of all segments of the population. The focus of nutrition services, including nutrition education, in an agency is based on several factors, including the mission of the agency, funding, analysis of data from a community-needs assessment, resources, and politics.[19] Public agencies provide nutrition services for individuals throughout the life cycle, provided in a variety of inpatient and outpatient settings. The broadest range of nutrition services may be most evident in community-based nutrition programs, in which services are based on core public health functions. It is important for physicians and other primary health care professionals to familiarize themselves with the location of these services in their communities. Professional and federal resources for nutrition services are listed in Table 49.3. The Maternal and Child Health (MCH) Library at Georgetown University maintains the MCH Organizations Database (https://library.tmc.edu/website/mch-library-maternal-child-health-library-at-georgetown-university/), which lists more than 2000 government, professional, and voluntary organizations involved in MCH activities, primarily at a national level. This is a useful resource for pediatricians and other primary care providers. Qualified providers of nutrition services include physicians, registered dietitian nutritionists (RDNs)/registered dietitians (RDs) and/or licensed dietitians, licensed nutritionists, nurses, and other qualified professionals. The Academy of Nutrition and Dietetics (AND), the largest organization of professional dietitians and nutritionists, has identified qualified providers as RDNs/RDs and other qualified professionals who meet licensing and other standards prescribed at the state level.[20]

Table 49.3.
Selected Professional and Federal Resources for Nutrition Services

Selected Professional Nutrition Organizations
Academy of Nutrition and Dietetics (AND) 120 S. Riverside Plaza, Suite 2000 Chicago, IL 60606-6995 Phone: 800-877-1600; Consumer Nutrition Hot Line: 800-366-1655 www.eatright.org
School Nutrition Association (SNA) 700 S. Washington Street, Suite 300 Alexandria, VA 22314 Phone: 703-739-3900; Fax 703-739-3915 www.schoolnutrition.org
Association of State and Territorial Public Health Nutrition Directors PO Box 1001 Johnstown, PA 15907-1001 Phone: 814-255-2829 http://www.astphnd.org/
National WIC Association 2001 S Street, NW, Suite 580 Washington, DC 20009-3405 Phone: 202-232-5492; fax: 202-387-5281 http://www.nwica.org/
American Public Human Services Association (APHSA) 810 First Street, NE Suite 500 Washington, DC 20002 Phone: 202-682-0100 Fax: 202-289-6555 http://www.aphsa.org/Home/home_news.asp
Feeding America E. Wacker Drive, Suite 2000 Chicago, IL 60601 Phone: 800-771-2303 www.feedingamerica.org (Web site has a search function to locate local services)

Selected Federal Resources
US Department of Agriculture Resources
US Department of Agriculture Food and Nutrition Service (FNS) 3101 Park Center Drive Alexandria, VA 22302 Phone: 703-305-2062 Information on USDA nutrition assistance programs including associated research, nutrition education initiatives, such as WIC Breastfeeding Campaign, Team Nutrition, Eat Smart Play Hard, State Nutrition Action Plans (SNAP), and Food Stamp Nutrition Education, are found at: http://www.fns.usda.gov/fns/ and www.wicworks.fns.usda.gov. US Department of Agriculture Center for Nutrition Policy and Promotion (CNPP) 3101 Park Center Drive Alexandria, VA 22302 Phone: 703-305-7600 The CNPP develops and promotes dietary guidance that links scientific research to the nutrition needs of consumers. For information on CNPP resources, the Dietary Guidelines for Americans, and MyPlate, see http://www.cnpp.usda.gov/ and http://www.choosemyplate.gov US Department of Agriculture Cooperative State Research, Education, and Extension Service (CSREES) 1400 Independence Avenue, SW, Stop 2201 Washington, DC 20250-2201 Phone: 202-720-7441 The CSREES provides linkages between federal and state components of a broad-based national agricultural higher education, research, and extension system designed to address national problems and needs related to agriculture, the environment, human health and well-being, and communities; see http://www.csrees.usda.gov/. National Agricultural Library (NAL) US Department of Agriculture Abraham Lincoln Building 10301 Baltimore Avenue Beltsville, MD 20705-2351 Phone: 301-504-5414 (for FNIC); Fax: 301-504-6409 (for FNIC) http://www.nal.usda.gov/ The NAL sponsors the Food and Nutrition Information Center (FNIC the Food Stamp Nutrition Connection Resource System, and the USDA/FDA Foodborne Illness Education Information Center. The FNIC/NAL also sponsors the “Nutrition.gov” Web site, which provides easy access to the best food and nutrition information from across the federal government.

Continued

Table 49.3. *Continued*

Selected Professional and Federal Resources for Nutrition Services

US Department of Health and Human Services Resources
Centers for Disease Control and Prevention Division of Nutrition and Physical Activity 4770 Buford Highway, Mailstop K25 Atlanta, GA 30341 Phone: 770-488-6042 Information and resources on infant and child nutrition, physical activity, and the obesity epidemic are available from the CDC Web site at http://www.cdc.gov/nccdphp/dnpa. Food and Drug Administration 5600 Fishers Lane Rockville, MD 20857 For general inquiries: 1-888-INFO-FDA (1-888-463-6332) For Office of Public Affairs: 301-827-6250 This Web site is a central source of information about FDA activities and resources and includes a section on consumer advice and publications on food safety and nutrition: www.fda.gov. The National Center for Education in Maternal and Child Health (NCEMCH) Georgetown University Box 571272 Washington, DC 20057-1272 Phone: 202-784-9770; fax 202-784-9777 Funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services, the NCEMCH Web site (www.ncemch.org) provides online access to NCEMCH initiatives, educational resources, and publications; a virtual MCH library and MCH databases; bibliographies; and knowledge paths.

US Department of Health and Human Services Resources—*Continued*

US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
For more information by mail, write:
National Health Information Center
PO Box 1133
Washington, DC 20013-1133
Phone: 301-565-4167
Toll Free: 1-800-336-4797
The HealthierUS initiative is a national effort, sponsored by the Department of Health and Human Services and the Executive Office of the President, to improve people's lives, prevent and reduce the costs of disease, and promote community health and wellness. See the Web site, which includes information on nutrition, physical activity, and healthy choices: www.HealthierUS.gov.

National Heart, Lung, and Blood Institute
PO Box 30105
Bethesda, MD 20824-0105
Phone: 301-592-8573 or toll-free 866-35-WECAN
We Can! or "Ways to Enhance Children's Activity and Nutrition" is a national education program from the National Institutes of Health designed for families and caregivers to help children 8 to 13 years of age achieve a healthy weight. This program offers communities and families resources including materials for healthcare providers, physicians, and parents. See the Web site: http://wecan.nhlbi.nih.gov.

Indian Health Service
The Reyes Building
801 Thompson Avenue, Ste. 400
Rockville, MD 20852-1627
Phone: 301-443-1083
For information on how the Indian Health Service works to improve the health of patients with nutrition related diseases, and prevent these illnesses in future generations through interventions in schools, community health programs, and hospital and clinic based services, see the Web site: http://www.ihs.gov.

Health and Nutrition Agencies: A Nutrition Resource to Provide Services and Identify Qualified Providers

Federal, state, and local health and nutrition agencies, particularly those employing public health nutritionists, can be helpful resources for physicians and other primary health care professionals. Nutritionists provide extensive technical assistance to clients and their families and physicians, especially for children with special health care needs. One example is services for children with an inborn error of metabolism. The diet prescription includes special medical formulas and foods that are modified to meet medical and socioeconomic needs. The formulas and foods are expensive, and the costs are generally not reimbursed by insurance companies. Many states have provisions for coverage for special formulas and foods.[21] Physicians can contact the special needs program of their state health department for information about patient eligibility for coverage for these formulas and foods and procedures for obtaining them.

Another example in which a nutritionist and nutrition services are instrumental in supporting feeding and growth is an early intervention program. In an early intervention program, nutritionists work with the child's family, other team members, and the child's primary health care professional to optimize development from birth to 3 years of age.[22] This national early intervention program for infants and toddlers with disabilities and their families was created by Congress in 1986 under the Education for All Handicapped Children Act (Pub L No. 94-142 [1975]), which then became the Individuals with Disabilities Education Act (Pub L No. 101-476 [1990]), and is administered by states. To be eligible for services, children must be younger than 3 years and have a confirmed disability or established developmental delay as defined by the state, in 1 or more of the following areas of development: physical, cognitive, communication, social-emotional, and/or adaptive. A complete evaluation of the child and family must be conducted, at no cost to the family, to determine whether a child is eligible for this early intervention program. The evaluation would include an assessment of the child's nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and food habits and food preferences. If a child and family are found eligible for services, the parents and a team will develop a written plan (Individualized Family Service Plan [IFSP]) for providing early intervention services to the child and, as necessary, to the family. The child's and family's IFSP can include nutrition, or nutrition may be listed as another service that

the child receives but is not provided or paid for by the early intervention program. Depending on the child's assessed nutritional needs, a qualified nutritionist, as a member of the IFSP team, would develop and monitor appropriate goals and objectives to address any nutritional needs and also make referrals to appropriate community resources to focus on nutrition goals, if needed. For more information on disabilities in infants, toddlers, children, and youth and the Individuals with Disabilities Education Act, which is the law authorizing special education and the early intervention program, see the website of the National Dissemination Center for Children with Disabilities (www.nichcy.org).

Other types of nutrition services provided by many state and local health agencies include nutrition counseling, classes on specific aspects of nutrition (eg, infant feeding, breastfeeding, diet and prevention of heart disease, and weight management), radio and cable television programs on nutrition topics, publications and educational materials on a wide range of topics for the lay public, and nutrition seminars and workshops. Local nutrition education resources are available from the USDA-funded Cooperative Extension Service. This service provides up-to-date information about the science of nutrition and its practical application in planning low-cost, nutritious meals. Many nutrition publications provided by the Cooperative Extension Service and other public health agencies are available in various foreign languages and for clients with low literacy skills.[19,23]

The National Institute of Food and Agriculture (formerly the Cooperative State Research, Education, and Extension Service) of the USDA operates the Expanded Food and Nutrition Education Program in all 50 states and in American Samoa, Guam, Micronesia, Northern Marianas, Puerto Rico, and the Virgin Islands. The Expanded Food and Nutrition Education Program is designed to assist limited-resource audiences in acquiring the knowledge, skills, attitudes, and behavior changes necessary to follow nutritionally sound diets and to contribute to their personal development and improvement of the total family diet and nutritional well-being (for more information, see https://nifa.usda.gov/program/expanded-food-and-nutrition-education-program-efnep).

The director of the nutrition department at the state health department is another excellent resource for identifying specific state, regional, or national resources and services. Similar information can be obtained from the Association of State and Territorial Public Health Nutrition Directors (Table 49.3). The state affiliate of the AND or the AND consultant directory

can help identify an RDN/RD with specific clinical expertise (Table 49.3). Consumers may also call the AND consumer hotline number and speak directly to an RDN/RD who can assist them with answers to general questions ranging from food labeling to food sanitation and other topics.

In addition to federal, state, and local health agencies, agencies such as visiting nurse associations, the American Diabetes Association, the American Heart Association, health maintenance organizations, and hospital inpatient and outpatient departments frequently employ personnel with nutrition expertise. They usually provide technical consultation in nutrition to physicians and nurses and nutrition counseling to patients and other agencies in the community. An increasing number of RDNs/RDs have also established private or independent practices.

Nutrition-Assistance Programs

National policy has long provided for publicly supported nutrition-assistance programs to safeguard the health of individuals whose nutrition status is compromised because of poverty or complex physiologic, social, or other stressors. The National School Lunch Act of 1946 (Pub L No. 79-396) provided for a major federal role in food service for school children. The Food and Nutrition Service (FNS) and Center for Nutrition Policy and Promotion (CNPP) are agencies of the USDA's Food, Nutrition, and Consumer Services. FNS works to end hunger and obesity through the administration of 15 federal nutrition assistance programs, including WIC, Supplemental Nutrition Assistance Program (SNAP), and school meals. In partnership with state and tribal governments, FNS programs serve 1 in 4 Americans during the course of a year.

The CNPP was created within the US Department of Agriculture in 1994. The mission of the CNPP is to improve the health of Americans by developing and promoting dietary guidance that links scientific research to the nutrition needs of consumers. The CNPP carries out its mission to improve the health of Americans by (1) serving as the federal authority on evidence-based food, nutrition, and economic analyses to inform policy and programs; (2) translating science into actionable food and nutrition guidance for all Americans; and (3) leading national communication initiatives that apply science-based messages to advance consumers' dietary and economic knowledge and behaviors.

Supplemental Nutrition Assistance Program

SNAP—formerly known as the Food Stamp Program—is a nutrition-assistance program that enables people with low income to buy nutritious food and make healthy food choices within a limited budget.[24] It is the largest of the federal nutrition-assistance programs. States have the option to include nutrition education and obesity prevention activities to SNAP participants and eligible individuals as part of their administrative services through the SNAP Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed). Every state now conducts SNAP-Ed, which works by building partnerships with community organizations. SNAP-Ed activities include social marketing campaigns, holding nutrition education classes, and improving policies, systems, and environments where people live, work, learn, eat, and play. The average monthly household benefit level in fiscal year 2015 was $254. SNAP benefits are provided on an electronic card that is used by participants at authorized retail stores to buy food. SNAP benefits redeemed at local stores not only provide nutrition benefits for the participants but also provide an economic boost to the local community. Every $5 in new SNAP benefits generates $9.00 in total community spending.[25]

SNAP is a federal program, but it is administered by state and local agencies. As an entitlement program, it is available to all who meet the eligibility standards. In 2015, the program served 83% of all individuals eligible for SNAP. Nearly two thirds of SNAP participants were children, elderly, or people with disabilities. Forty-four percent of participants were younger than 18 years, 11% were 60 years or older, and 10% were disabled nonelderly adults.[26] The FNS, which oversees SNAP, offers numerous resources and tools to help community and faith-based organizations, state and local offices, food retailers, and other health and social service providers teach their clients with low income about the nutrition benefits of food stamps and help them enroll. These materials are available free online (https://www.cbpp.org/research/policy-basics-the-supplemental-nutrition-assistance-program-snap).

To qualify for SNAP benefits, a person must apply through a local SNAP office and have income and resources under certain limits. The FNS Web site offers the "step 1" online prescreening tool (https://www.snap-step1.usda.gov/fns/) in English and Spanish, which privately tells users whether they may be eligible for benefits and how much they could receive. The FNS website also provides SNAP application and local office locators (https://www.fns.usda.gov/snap/state-directory).

School Nutrition Programs *(See Also Chapter 9)*

The National School Lunch Program (NSLP), the School Breakfast Program (SBP), the Fresh Fruit and Vegetable Program (FFVP), and the Special Milk Program are administered in most states by the state education agency, which enters into agreements with officials of local schools or school districts to operate nonprofit food services. Most public and private schools in the United States participate in the NSLP. Participating schools can receive cash reimbursements and USDA Foods regardless of the number of children eligible for free lunch program. Any public or nonprofit private school of high school grade or less is eligible. Public and licensed, nonprofit, private residential child care institutions, such as orphanages, community homes for disabled children, juvenile detention centers, and temporary shelters for runaway children, are also eligible. For more information on USDA school meals programs, visit https://www.ers.usda.gov/topics/food-nutrition-assistance/child-nutrition-programs/.

Schools participating in the federal school meals programs agree to serve nutritious meals and offer them at a reduced price or free to children who are determined to be eligible on the basis of uniform national poverty guidelines, determined annually by the DHHS. A child's eligibility to receive reduced-price or free meals is based on their household size and income. Additionally, a child from a household currently certified to receive SNAP benefits or benefits under the Food Distribution Program on Indian Reservations (FDPIR) or Temporary Assistance to Needy Families (TANF) is categorically eligible for free benefits. Foster and homeless children are also categorically eligible to receive school meals. The school meals program provides some level of federal reimbursement for program meals served to children from all income levels; however, free and reduced-price meals served to children determined to be eligible by income criteria are subsidized at a higher rate.

The Healthy, Hunger-Free Kids Act (HHFKA) of 2010 (Pub L No. 111-296) required the Food and Nutrition Service to review and update the meal pattern requirements for the NSLP and SBP. Federal nutrition requirements are specified in program regulations to ensure that the nutrition goals of the school meal programs are met and are intended to enhance the diet of school children nationwide and help mitigate childhood obesity. They provide children daily access to fruits, vegetables, whole grains, and fat-free and low-fat fluid milk in school meals; limit sodium, saturated fat, and trans fat in school meals; and establish calorie ranges to ensure that children receive age-appropriate school meals. In 2012, the USDA updated

the meal patterns and dietary specifications for the National School Lunch and School Breakfast Programs on the basis of recommendations from the Institute of Medicine (now the National Academy of Medicine) to align them with the latest Dietary Guidelines for Americans. The Dietary Guidelines for Americans (Dietary Guidelines) are the cornerstone of federal nutrition policy and nutrition education activities. They are jointly issued and updated every 5 years by the USDA and DHHS. The *MyPlate* food guidance system provides food-based guidance to help implement the recommendations of the Dietary Guidelines. The Dietary Guidelines provide authoritative advice for people 2 years and older about how good dietary habits can promote health and reduce risks of major chronic diseases. Note that dietary guidelines for pregnant women and children from birth to 2 years of age are expected with the 2020 Dietary Guidelines for Americans. For more information the Dietary Guidelines, see http://www.dietaryguidelines.gov and for more information on *MyPlate*, see http://www.choosemyplate.gov.

The new meal pattern requirements were phased in over multiple school years to facilitate implementation. The majority of the lunch meal pattern took effect in school year 2012–2013, and the breakfast meal pattern was implemented over school years 2013–2014 and 2014–2015. The USDA is continuing to provide guidance, training programs, and technical assistance resources to assist school nutrition operators in implementing the nutrition standards and offering healthy school meals.

The HHFKA of 2010 also directed the USDA to establish nutrition standards for all foods and beverages sold to students in school during the school day (ie, competitive foods, or foods sold in competition with school meals), including foods sold through school fundraisers. The Smart Snacks in School final regulation ensures that nutrition standards for competitive foods are consistent with those used for the NSLP and SBP, holding competitive foods to standards similar to those applied to other foods made available during the school day. These standards, combined with recent improvements in school meals, will help promote diets that contribute to students' long-term health and well-being. In addition, these standards continue to support a healthy school environment and the efforts of parents to promote healthy choices for children at home and at school. The competitive foods nutrition standards have been implemented in schools since July 1, 2014. The standards are designed to help schools to make the healthy choice the easy choice by offering students more of the foods and beverages that should be encouraged—whole grains, fruits, and vegetables; leaner

protein; and lower-fat dairy—while limiting foods with higher levels of sugars, saturated and trans fats, and sodium. For more information, visit USDA's Smart Snacks website at https://www.fns.usda.gov/school-meals/tools-schools-focusing-smart-snacks.

The Special Milk Program reduces the cost of each half-pint of milk served to children by providing cash reimbursement at an annually adjusted rate. A school district can choose to provide milk free to children who meet the eligibility guidelines. This program is available only to schools, child care institutions, and summer camps that do not participate in other federal meal service programs. Schools in the NSLP or SBP may also participate in the Special Milk Program to provide milk to children in half-day pre-kindergarten and kindergarten programs where children do not have access to the school meal programs. At present, the Special Milk Program allows schools or institutions to offer only pasteurized fluid types of milk that are low-fat (1% milk fat or less, unflavored) or fat-free (unflavored or flavored). These milks must meet all state and local standards. All milk types offered are required to contain vitamins A and D at levels specified by the FDA.

Local School Wellness Policies

Under the Child Nutrition and WIC Reauthorization Act of 2004 (Pub L No. 108-265), each local educational agency participating in a program authorized by the National School Lunch Act or the Child Nutrition Act of 1966 (Pub L No. 89-642) was required to establish a local school wellness policy by school year 2006. The purpose of implementing local wellness policies is to create healthy school nutrition environments that promote healthy eating and physical activity for students. The HHFKA of 2010 expanded the scope of local school wellness policies to include goals for nutrition promotion and guidelines for all foods available on the school campus that are consistent with the updated school meal and competitive food nutrition standards. It also added requirements to existing wellness policy standards related to wellness committee participation and review and reporting of wellness policies. The final regulation on local school wellness policies, published in July 2016, requires all local educational agencies that participate in the NSLP and SBP to meet expanded local school wellness policy requirements consistent with the requirements set forth in the HHFKA. The final rule requires each local educational agency to establish minimum content requirements for the local school wellness policies, ensure stakeholder participation in the development and updates of such policies, and periodically assess and disclose to the public schools' compliance with the local school wellness

policies. These regulations are intended to result in local school wellness policies that strengthen the ability of a local educational agency to create a school nutrition environment that promotes students' health, well-being, and ability to learn. In addition, these regulations will increase transparency for the public with regard to school wellness policies and therefore contribute to integrity in the school nutrition program.

The legislation placed the responsibility of developing and implementing a wellness policy at the local level so that the individual needs of each local educational agency can be addressed. Preventing childhood obesity is a collective responsibility requiring family, school, community, corporate, and governmental commitments. The key is to implement changes through coordinated and collaborative efforts from all sectors. For more information, and access to school wellness policy implementation resources, visit the USDA website at https://www.fns.usda.gov/tn/local-school-wellness-policy.

The AAP has encouraged its members to become involved in assisting their local school districts in developing and implementing school wellness policies. School districts are required to permit school health professionals and the general public to participate in the wellness policy committee; as such, AAP members are encouraged to seek out their local school districts' wellness committee and participate as they are able. The AAP and the AND are cooperating with the Action for Healthy Kids, a national nonprofit organization, to address the epidemic of overweight, undernourished, and sedentary youth through tangible changes in the school environment. Useful information for how pediatricians can become involved in school wellness policies is available (www.actionforhealthykids.org). The USDA School Nutrition Environment and Wellness Resources website includes many resources to support implementation of the school wellness policy process (http://healthymeals.fns.usda.gov/school-wellness-resources).

Child and Adult Care Food Program

The Child and Adult Care Food Program (CACFP) provides cash reimbursement and USDA Foods for the provision of meals and snacks to child and adult care institutions and family or group day care homes. Institutions eligible to participate include at-risk after-school care centers, adult day care centers, nonprofit child care centers, Head Start centers, family day care homes, and emergency shelters. Some for-profit child care centers and adult care centers serving children from families with low incomes may also be eligible to participate in the program.

Although federal subsidies continue to be provided for meals and snacks served to children from all income levels, program benefits are primarily directed to needy children. Children up to 18 years and younger are eligible to receive up to 2 meals and 1 snack or 2 snacks and 1 meal each day at an at-risk after-school care center, child care center, or day care home. Children who reside in emergency shelters may receive up to 3 meals each day. Migrant children 15 years and younger and people with disabilities, regardless of their age, are eligible to receive reimbursable meals. After-school care snacks and meals are available to children through 18 years of age. For more information on the Child and Adult Care Food Program, visit the website (https://www.fns.usda.gov/cacfp/child-and-adult-care-food-program).

The HHFKA of 2010 also required the USDA to update the CACFP meal patterns and make them more consistent with the most recent version of the Dietary Guidelines for Americans. The final regulation for the CACFP meal patterns, published in April 2016, helps ensure the most vulnerable citizens have access to the nutrition they need. Informed by evidence-based recommendations, this final regulation updates meal patterns in the CACFP using science-based standards to improve the nutritional quality of meals and snacks served to millions of children and adults every day and ensuring young children develop healthy habits from the start. This is the first major revision of the CACFP meal patterns since the program's inception in 1968. Since the beginning of the CACFP, nutrition-related health problems have greatly shifted from malnutrition to overconsumption of calories, saturated fats, added sugars, and sodium as well as underconsumption of fiber and other essential nutrients. Under the updated meal patterns, young children and adults in day care will receive meals with more whole grains, a greater variety of vegetables and fruits, and less added sugars and solid fats. The changes also improve access to healthy beverages, including low-fat and fat-free milk and water, and encourage breastfeeding among the youngest program participants. For more information, visit the USDA website on the nutrition standards for CACFP meals and snacks: https://www.fns.usda.gov/cacfp/meals-and-snacks.

Summer Food Service Program

The Summer Food Service Program (SFSP) provides nutritious meals for children 18 years and younger during school vacations at centrally located sites, such as schools or community centers in neighborhoods with low incomes, or at summer camps. Meals are served free to all children in

eligible sites and must meet the nutritional standards established by the USDA. Sponsors of the program must be public or private nonprofit schools, public agencies, or private nonprofit organizations. For more information on the Summer Food Service Program, visit the website (https://www.fns.usda.gov/sfsp/summer-food-service-program).

Fresh Fruit and Vegetable Program

The Fresh Fruit and Vegetable Program (FFVP) is a federally assisted program providing free fresh fruits and vegetables to students in low-income elementary schools during the school day. The goal of the FFVP is to improve children's overall diet and create healthier eating habits to impact their present and future health. The FFVP helps schools create healthier school environments by providing healthier food choices, expanding the variety of fruits and vegetables children experience, and increasing children's fruit and vegetable consumption. The FFVP has been highly effective in increasing consumption of fruits and vegetables among low-income students. Studies have shown that children participating in the FFVP have statistically significant increased consumption of fruits and vegetables. The USDA FNS administers the FFVP at the federal level. At the state level, the FFVP is usually administered by the state education agency, which operates the program through agreements with school food authorities. The FFVP is targeted to elementary schools with the highest free and reduced price meals enrollment. The state agency decides the per-student funding amount for the selected schools based on total funds allocated to the state and the enrollment of applicant schools. With these funds, schools purchase additional fresh fruits and vegetables to serve free to students during the school day. They must be served outside of the normal time frames for the NSLP and SBP. The state agency or school food authority determines the best method to obtain and serve the additional fresh produce. Schools are also encouraged to develop partnerships to help implement the program, such as with local universities, extension services, and local grocers. Schools must also agree to widely publicize the availability of the program. For more information on the FFVP, visit the USDA website at https://www.fns.usda.gov/ffvp/fresh-fruit-and-vegetable-program.

Use of Local Foods in the Child Nutrition Programs

The USDA is committed to helping child nutrition program operators incorporate local foods in the school meal programs as well as the Summer Food Service Program and Child and Adult Care Food Program. This is

accomplished through grants, training and technical assistance, and research. The USDA Farm to School Grant Program assists eligible entities in implementing farm to school programs that improve access to local foods in eligible schools. On an annual basis, the USDA awards competitive grants for training, supporting operations, planning, purchasing equipment, developing school gardens, developing partnerships, and implementing farm to school programs. For more information on the Farm to School Program, visit the USDA website at https://www.fns.usda.gov/farmtoschool/farm-school.

Team Nutrition Initiative

In June 1995, the USDA launched the Team Nutrition initiative, which continues to support the federal child nutrition programs through training and technical assistance for food service, nutrition education for children and their caregivers, and school and community support for healthy eating and physical activity. Team Nutrition is an integrated, behavior-based, comprehensive initiative for promoting the nutritional health of the nation's children. The funding supports the efforts of the USDA FNS to establish policy, develop materials and trainings that meet the needs of state and local partners, disseminate resources and materials in ways that meet state and local needs, and develop partnerships with other federal agencies and organizations. Team Nutrition provides resources to schools, child care settings, and summer meal sites that participate in federal child nutrition programs. Team Nutrition uses 3 strategies to change behavior: (1) provide training and technical assistance to child nutrition professionals to enable them to prepare and serve nutrition meals that appeal to children; (2) increase nutrition education through multiple communication channels to help children have the knowledge, skills, and motivation to make healthy food and physical activity choices as part of a healthy lifestyle; and (3) build support for healthy school and child care environments that encourage nutritious food choices and physically active lifestyles. Team Nutrition brings together public and private networks to promote food choices for a healthy diet and deliver consistent nutrition messages through multiple communication channels including food service initiatives, classroom and child care activities, school-wide events, home activities, community programs and events, and traditional and social media. Schools participating in the NLSP are invited to sign up as Team Nutrition Schools and join an important network of schools working towards healthier school nutrition and physical activity environments.

Team Nutrition funds a limited number of competitive grants to state agencies each year to help states establish or enhance sustainable infrastructures to achieve Team Nutrition's goals of improving children's lifelong eating and physical activity habits. The Team Nutrition Training Grants, authorized in 1978, are one of the anchor delivery systems for supporting the implementation of the USDA's nutrition requirements and the Dietary Guidelines for Americans in meals served in schools and child care institutions. Some efforts by state agencies receiving these grants have resulted in child nutrition program foodservice personnel receiving training and technical assistance that equips them to prepare and serve nutritious meals that appeal to students; providing mini grants to local school districts and child care institutions to enhance promotion of healthy eating and physical activity; nutrition education in schools and child care settings using many USDA-developed Team Nutrition materials; integrating nutrition education into students learning content standards, including trainings and workshops provided to teachers; and building community support for healthy eating and physical activity. More information on Team Nutrition Training Grants can be found at https://www.fns.usda.gov/tn/team-nutrition-training-grants.

Nutrition education resources are available from the USDA's Team Nutrition initiative. These Team Nutrition materials help schools and child care providers integrate nutrition education into classroom learning and also include materials for home, cafeteria, and community connections. In addition to the nutrition education materials for schools being standards-based, materials are child-, teacher-, and parent-tested through extensive research including focus group testing, in-depth interviews, and field-testing. Materials are based on the social cognitive theory, as this theory addresses personal, behavioral, and environmental factors that influence behavior. Team Nutrition materials also include curriculum kits, lesson plan posters, games, stickers, event planning guidebooks, brochures, and more for both schools and child care institutions.

Team Nutrition also has materials to help school nutrition professionals provide students with nutritious and delicious meals that meet meal pattern requirements. These resources provide guidance on using sound business practices to ensure continued availability of healthy meals as well as the financial viability and accountability of the school meal programs.

Team Nutrition print materials are available only to schools and child care institutions that participate in the federal child nutrition programs; all

others are welcome to download Team Nutrition materials at http://teamnutrition.usda.gov. Many Team Nutrition publications are also available in Spanish, and a small selection of family newsletters are available in other languages.

Supplemental Food Programs

WIC

The WIC program is the premiere public health nutrition program serving low-income, nutritionally at-risk pregnant, breastfeeding, and nonbreastfeeding postpartum women, infants, and children up to 5 years of age. The WIC program is administered at the federal level by the FNS of the USDA and was created by Congress to serve as an adjunct to health care during critical times of growth and development. The legislative requirements for the WIC program are contained in section 17 of the Child Nutrition Act of 1966. Because WIC is a nondiscretionary program, each year Congress appropriates funds to support the program through an appropriation law. FNS then awards grants to state agencies (typically state health departments) annually to fund the program in their states. The benefits of the WIC program include nutritious supplemental foods, nutrition education, and referrals for health and social services, which are all provided to participants at no cost. Many studies show that the WIC program has made many contributions toward improving maternal and child health and saving children's lives.[27–30]

The WIC program is available in all 50 states, 34 Indian Tribal Organizations, American Samoa, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Commonwealth of the Northern Marianas Islands. As of 2016, state agencies administered the WIC program through 1800 local agencies and 9000 clinic sites. Of the 7.7 million people who received WIC benefits each month in fiscal year 2016, approximately 51.7% were children, 24.4% were infants, and 23.9% were women. In 2013, 84% of infants eligible for WIC were participating in the program (2 387 233 infants).[31] Services under WIC are provided in county health departments, hospitals, mobile clinics (vans), community centers, schools, public housing sites, Indian reservations, migrant health centers and camps, and Indian Health Service facilities.

Since the piloting of the WIC program in 1972, the appropriated funding level has increased to approximately $6.35 billion annually. Program funds

are allocated to state agencies according to a formula that considers both nutrition services and administration costs and supplemental food costs. The average monthly food package cost for fiscal year 2016 was $42.76.[32]

The food packages provided to WIC participants are scientifically based and intended to address the supplemental needs of pregnant, breastfeeding, and nonbreastfeeding postpartum women, infants, and children and provide nutrients frequently lacking in the diets of the target population. In 2014, the FNS published the final WIC Food Package Rule, which required all WIC state agencies to provide food packages that align with the Dietary Guidelines for Americans and infant feeding practice guidelines of the AAP. The final food package regulation represents the culmination of the first comprehensive revisions to the WIC food packages since 1980.

The WIC food packages provide breakfast cereals, eggs, milk and milk alternatives (including soy based beverage, cheese and tofu), whole wheat bread and other whole grains, fruit and vegetable cash value vouchers, peanut butter, legumes, canned fish, juice, infant foods, infant formula, exempt infant formula, and WIC-eligible nutritionals. For the complete provisions and requirements for foods in the WIC food packages, refer to the full regulation at www.fns.usda.gov/wic.

Although federal regulations specify the minimum nutritional requirements for the WIC foods, state agencies are responsible for using the federal regulations when determining the brands, types, and forms of foods authorized on state food lists. The process of food package design at the state level involves maximizing the nutritional value of WIC food packages while managing cost. Acceptability and availability of eligible foods to participants are also important considerations in designing state agency food lists.

WIC food packages promote and support the establishment of successful, long-term breastfeeding and provide WIC participants with a wide variety of foods, including fruits, and vegetables, and whole grains; provide less saturated fat and cholesterol and more fiber to women and children; reinforce the nutrition messages provided to participants; and provide WIC state agencies greater flexibility in prescribing food packages to accommodate the cultural food preferences of WIC participants. Nutrition education is an important benefit of the WIC program. Efforts are made to provide client-centered nutrition education that focuses on the individual participant's nutritional needs, cultural preferences, and education level. Breastfeeding promotion and support activities are an important component of WIC nutrition education. WIC supports breastfeeding mothers by

providing: (1) information and support through counseling and educational materials; (2) a greater quantity and variety of foods than for mothers who formula feed their infants; (3) eligibility to participate in WIC longer than nonbreastfeeding mothers—up to 1 year postpartum; (4) mother-to-mother support through WIC breastfeeding peer counselors; and (5) breast pumps and other aids that are necessary to help support the initiation and continuation of breastfeeding.

The WIC Farmers' Market Nutrition Program provides additional coupons to WIC recipients that can be used to buy fresh fruits and vegetables from authorized farmers, farmers markets, or roadside stands.

For more information on the WIC program, see http://www.fns.usda.gov/wic.

Food Distribution Programs

USDA Foods Programs

USDA Foods are items that are 100% American grown and produced and purchased by the USDA to support nutrition assistance programs and domestic agriculture. These foods include fresh, frozen, canned, and dried fruits and vegetables; grains; proteins; and dairy products. The USDA purchases more than $2.2 billion of food annually to provide to food assistance programs such as schools, food banks, and Indian Tribal Organizations through a variety of programs, described below.

The Emergency Food Assistance Program

The Emergency Food Assistance Program is a federal program administered by the USDA that helps supplement the diets of low-income Americans by providing them with emergency food and nutrition assistance at no cost. Under the Emergency Food Assistance Program, the USDA makes USDA Foods available to state distributing agencies. States provide the food to local agencies that they have selected, usually food banks, which in turn distribute the food to soup kitchens and food pantries that directly serve the public. These organizations distribute the USDA Foods for household consumption or use them to prepare and serve meals in a congregate setting. Recipients of food for home use must meet income eligibility criteria set by the states. State agencies receive the food and supervise overall distribution. For more information on The Emergency Food Assistance Program, see https://www.fns.usda.gov/tefap/emergency-food-assistance-program.

Food Distribution Program on Indian Reservations

The Food Distribution Program on Indian Reservations provides USDA Foods to low-income households on Indian reservations and to American Indian households residing in approved areas near reservations or anywhere in Oklahoma. Many households participate in the Food Distribution Program on Indian Reservations as an alternative to the SNAP, because they do not have easy access to SNAP offices or authorized food stores. The program is administered at the federal level by the USDA FNS. The Food Distribution Program on Indian Reservations is administered locally by either Indian Tribal Organizations or an agency of a state government. As of 2017, there are approximately 276 tribes receiving benefits through 102 Indian Tribal Organizations and 3 state agencies. Average monthly participation for fiscal year 2017 is approximately 90 000 individuals.

Each month, participating households receive a food package to help them maintain a nutritionally balanced diet. Participants may select from more than 70 products, including: frozen ground beef, beef roast, and chicken; canned meats, poultry, and fish; fresh fruits and vegetables; canned fruits and vegetables, soups, and spaghetti sauce; macaroni and cheese, pastas, cereals, rice, and other grains; cheese, eggs, egg mix, nonfat dry and evaporated milk, and low-fat ultra-high temperature fluid milk; flour, cornmeal, low-fat bakery mix, and reduced sodium crackers; low-fat refried beans, dried beans, and dehydrated potatoes; canned juices and dried fruits; peanuts and peanut butter; and light buttery spread and vegetable oil. For more information on the Food Distribution Program on Indian Reservations, see https://www.fns.usda.gov/fdpir/food-distribution-program-indian-reservations.

Where to Seek Nutrition Assistance (Table 49.3)

Nutrition-assistance programs are usually administered at the local level by the following agencies:

1. Local school food authority: National School Lunch Program, School Breakfast Program, Special Milk Program, and Fresh Fruit and Vegetable Program.
2. State and local health, social services, education, or agriculture agencies; public or private nonprofit health agencies; and Indian Tribal Organizations or groups recognized by the US Department of the Interior:

WIC; Food Distribution Program on Indian Reservations; Summer Food Service Program; Child and Adult Care Food Program; The Emergency Food Assistance Program.

3. Local social services, human services, or welfare department: SNAP.
4. Community or faith-based organizations.

Other Federal Agencies Providing Nutrition Services to Improve Pediatric Health and Well-Being

CDC Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases

The CDC administers the state-based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases. This program is based on a cooperative agreement between the CDC Division of Nutrition and Physical Activity and Obesity and all 50 state health departments. The program was established in fiscal year 1999 to prevent and control obesity and other chronic diseases by supporting states in developing and implementing nutrition and physical activity interventions, particularly through population-based strategies (eg, policy-level changes, environmental supports).

States receive funding from the program to work to prevent and control obesity and other chronic diseases through these strategies: balancing caloric intake and expenditure, increasing physical activity, increasing consumption of fruits and vegetables, decreasing television-viewing and other screen time, and increasing breastfeeding. The program also helps states work to reduce soft-drink consumption and decrease portion size. States funded by the program partner with stakeholders in government, academia, industry, and other areas to create statewide health plans—one of the most important ways to help guide state efforts. State plans promote working with a variety of partners and using all available resources to prevent and control obesity and other chronic diseases. For more information on CDC programs and campaigns, research reports, surveillance data, training modules, nutrition education, and related resources, see the website (http://www.cdc.gov/nccdphp/dnpa).

Maternal and Child Health Services

The Title V MCH block grant program provides states with federal funds that support a wide variety of health services, including nutrition services. Title V seeks to improve the health of all mothers and children (including

children with special health care needs) by assessing needs, setting priorities, and providing programs and services. Specifically, the Title V MCH program seeks to:

1. Ensure access to quality care, especially for those with low-incomes or limited availability of care;
2. Reduce infant mortality;
3. Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women);
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
5. Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children;
6. Implement family-centered, community-based systems of coordinated care for children with special health care needs; and
7. Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

On the basis of a comprehensive 5-year needs assessment, state Title V MCH programs identify their priority needs and develop a program plan and state performance measures to address these needs, to the extent that they are not addressed by the program's 18 national performance measures. Each state is unique in the type of services it provides under its Title V MCH block grant. The conceptual framework for the services of the Title V MCH block grant is a pyramid, which includes 4 tiers of services (ie, direct health care services, enabling services [such as coordination with Medicaid and WIC services], population-based services, and infrastructure building services). The MCH block grant program is the only federal program that provides services at all 4 levels, including state population-based capacity and infrastructure-building services and that targets the entire population and not only the low-income population.

In 2006, the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) included a new national performance measure that addresses the "percentage of children, ages 2 to 5 years, receiving WIC services with a body mass index at or above the 85th percentile." Another national performance measure, which had previously focused on the "percentage of mothers who breastfeed their infants at hospital discharge," was revised to reflect the "percent of mothers who breastfeed their infants at 6 months of age."

The Title V Information System electronically captures data reported in the annual Title V MCH block grant applications and reports on 59 states, territories, and jurisdictions. State-reported financial data, program data, and information on key measures and indicators of MCH in the United States are posted on the Title V Information System Web site (https://mchb.tvisdata.hrsa.gov).

In addition to the formula block grants to states, Title V supports activities under the Special Projects of Regional and National Significance grants and the Community Integrated Service Systems grants. Activities supported under Special Projects of Regional and National Significance include MCH research, training, breastfeeding promotion and support, nutrition services, and a broad range of other MCH initiatives and grant projects. The Community Integrated Service Systems program seeks to improve the health of mothers and children by funding projects for the development and expansion of integrated health, education, and social services at the community level. Additional information on MCHB-funded programs is available on the MCHB Web site (http://http://mchb.hrsa.gov/).

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is the child health component of Medicaid. The EPSDT program is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. State Title V agencies can play an important role in fulfilling the potential of EPSDT services. Federal rules encourage partnerships between state Medicaid and Title V agencies to ensure better access to and receipt of the full range of screening, diagnostic, and treatment services.

Bright Futures, initiated in 1990, is a longstanding, major effort of the MCHB and its partners to improve the quality of health promotion and prevention for infants, children, and adolescents and their families. Over the years, Bright Futures has evolved to encompass a vision, a philosophy, and a set of expert guidelines, tools, and other resources to implement a practical developmental approach to providing health supervision for children of all ages, from birth through adolescence.

Recognizing the need for more in-depth materials in certain areas to complement the guidelines, the MCHB launched the Building Bright Futures Project to foster the implementation of the Bright Futures health supervision guidelines by publishing practical tools and materials and by providing technical assistance and training. Through a cooperative agreement between MCHB and the AAP, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* Fourth Edition[33] and *Bright Futures: Nutrition*, Third Edition[34] are available at https://brightfutures.aap.org.

Conclusion

As the key provider of child health care, the pediatrician has a major role in ensuring that nutrition services for children include assessment of nutritional status and provision of a safe food supply adequate in quality and quantity, nutrition counseling, and nutrition education for children and parents. This includes assessment and intervention for the presence of food insecurity. The pediatrician can, together with other school stakeholders, join the school or district wellness committee to contribute to and support the development and implementation of local school wellness policies. As the primary expert on health in the community and as a concerned citizen, the pediatrician, in coordination with other members of the health care team, including the nutritionist or dietitian and nurse, can provide meaningful leadership and advocacy in the formulation of sound nutrition policy that includes preventive measures for food insecurity, and the education of legislators, administrators, and others who influence the response of the community to the nutritional needs of its children. The pediatrician also has the responsibility to join with additional stakeholders to advocate for nutrition policy at the national, state, and local levels, working with the resources provided by the AAP Department of Federal Affairs and the AAP Division of State Government Affairs. Funding for the federal and state programs that support community nutrition services are renewed on a regular basis, and pediatricians have the responsibility and the opportunity to influence such legislation and its funding.

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