

EXECUTIVE SUMMARY

“The objectives of a comprehensive program should include improving the child’s physical health and physical abilities.”

Dr. Robert Cooke and the Head Start Panel of Experts, 1965

Overview

A Descriptive Study of the Head Start Health Component was designed to provide a "national snapshot" of how local Head Start programs meet the medical, dental, nutrition, and mental health needs of the children and families they serve. The Head Start Bureau requires this information for the development of policies that will assist programs in responding to the populations of families served and the conditions faced by local programs. This need was noted in both the *Final Report of the Advisory Committee on Head Start Quality and Expansion*, (1993) and the *Head Start Research and Evaluation Report: A Blueprint for the Future* (1990). This descriptive study was undertaken because little current information was available regarding how program procedures address the health conditions that are common among Head Start children, the community health risks faced by families participating in Head Start, and the health resources available in the communities served by Head Start.

The health services provided to or arranged for Head Start children and their families are expected to be comprehensive. In general, the success of the program in the health area has helped identify Head Start as a model for other child service programs (Gomby, Lerner, Stevenson, Lewit, and Behrman, 1995).

“[In Head Start] We’re teaching them habits they will hopefully carry with them the rest of their life.”
-Head Start staff

This Executive Summary and the associated report detail the historical context of the Health Component and the study methodology and includes the descriptive findings regarding three aspects of the Health Component, as noted below.

Content Areas of Study Findings

- **Program Issues**
 - Staffing and Staff Qualifications
 - Linkages with Medicaid and Community Resources

- **Prevention**
 - Immunizations
 - Health Education

- **Health and Health Services Within the Four Health Domains**
 - The Medical Health Domain
 - The Dental Health Domain
 - The Mental Health Domain
 - The Nutrition Domain

Because this study was descriptive, this report does not evaluate or judge the quality of individual programs, groups of programs, or the entire sample of participating programs; similarly, it is not intended to report on the compliance of local programs with the Head Start Program Performance Standards. The findings from this study are focused on a set of research questions adapted from the original Request for Proposals (see the Summary of Project Research Questions) and designed to provide a baseline description of Health Component activities and the health status of Head Start children. Based on these findings, several implications are discussed regarding Head Start program practices, and recommendations are made regarding future research activities related to the Health Component.

A Summary of the Project Research Questions

- What are the current procedures used by Head Start grantees to provide or obtain health screenings, examinations, immunizations, referrals and treatment services for enrolled children across the four health domains?
- What are the major health problems and risk factors (perceived and actual) present within the four health domains for children and families enrolling in Head Start?
- How promptly are health screenings, examinations, immunizations, referrals and treatment provided across the four health domains? What is the range of treatments children receive?
- What are the Health Component staffing patterns? What are the staff credentials and training for each position.
- What community resources have Head Start programs utilized to meet the health needs of children and their families across the four health domains?
- How is the cost of health services paid for Head Start children covered ?
- What barriers do families and programs face in attempting to access community and State health services?
- What health education efforts are directed towards children and parents?

The Historical Context of the Health Component

Head Start was created in 1965 to enhance the social competence of preschool children and foster constructive opportunities for communities to work together with low-income families in solving their problems. In the *Recommendations for a Head Start Program* (Cooke, 1965), a Panel of Experts specified that the basic elements of the Head Start program should emphasize health assessments for children and health education for both children and their families.

Recommended evaluations included a medical examination (e.g., physical measurements; nutrition, vision, hearing and speech assessments; and other selected tests as required), a dental examination, and a screening for social or emotional problems. Programs were designed to assure proper immunization of all Head Start children, to assure families that children would receive proper treatment for health conditions, to establish continuity of care for children, to inform families about available community health resources, and to teach families about sound nutrition.

The overall goal of Head Start is to promote social competence among participating children (Zigler, et al., 1994). Social competence is a comprehensive construct that includes the belief that optimal health is an important factor related to successful social and cognitive functioning. This concept of integrated areas of child development continues to draw support in the child development literature (Novello, DeGraw, & Kleinman, 1992). Because impaired health may have adverse effects on the development of social competence, children's health has always been a focus of Head Start and remains a critical aspect of the program over three decades later (Zigler et al., 1994).

“It has started my baby girl on the road of education, opened her eyes to basic truths in life. Taught her to care for herself as well as teaching her aunt and mom how to help her at home.”
-Head Start parent

The Function and Organization of the Health Component

In 1975, the Head Start Bureau established Program Performance Standards for each of the major program components: Education, Parent Involvement, Social Services, and Health. Grantees are required to comply with the Program Performance Standards, which are accompanied by non-mandated guidance that elaborates on the intent of the Standards and provides information on how they might be carried out. The overall requirements of the Health Component are summarized below:

- Provide a comprehensive program of health services to assist each child in attaining maximum physical, emotional, cognitive, and social development;
- Promote preventive health services and early intervention; and
- Provide families with the skills, insights, and linkages needed to obtain ongoing health care so that children will continue to receive comprehensive health care after they leave the Head Start program.

The Health Component is designed to emphasize the importance of health education and the early identification and treatment of health problems. Because many low-income children have limited access to health care services, Head Start programs ensure that each child receives comprehensive health care services across each of the four health domains:

“I believe our role in regards to health is very important as far as providing services, connecting children to services, and providing education to parents.”
-Head Start staff

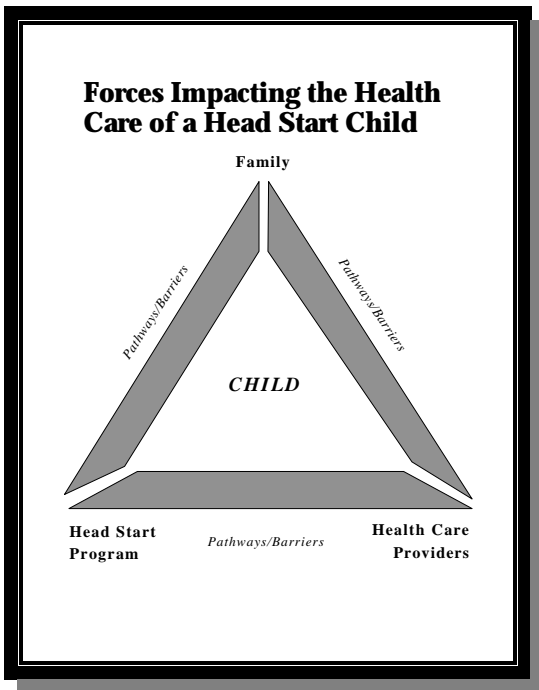
medical, dental, mental health, and nutrition. The Head Start Bureau has recently published a comprehensive revision of all the Program Performance Standards (Federal Register, 1996) effective January 1998, and is developing additional strategies for supporting health activities at the local level.

Health Component activities involve virtually all of the Head Start program staff at some point during the program year. The Health Component is managed by a **Health Coordinator** who is responsible for the organization and administration of health services, including medical, dental, mental health and nutrition elements. The Health Coordinator is assisted by, at a minimum, a full-time or regularly scheduled qualified **nutritionist** or **dietitian**, a **mental health professional** (e.g., child psychiatrist, licensed psychologist, psychiatric nurse, or psychiatric social worker) who is available on at least a consultation basis, and a **Disabilities (or Handicapped Services) Coordinator** responsible for children with special needs.

The health staff undertake a broker role in the connection between the Head Start parents and community health centers, clinics, and private providers. In this effort, Head Start staff support parents who need to develop the necessary skills to negotiate the health care system themselves. This means enabling parents to make and keep appointments with appropriate service providers in the local community and to obtain follow-up treatment for conditions identified through screenings and examinations. Head Start’s objective is for all parents to have the necessary skills to assume responsibility for managing their family’s health care after leaving the program.

“Basically, we are the hub of the child’s health care needs; we are the liaison between the parent, nurse and other health providers.”
-Head Start staff

The parents of Head Start children often face significant barriers to obtaining health care: financial, geographic, and institutional barriers inherent in the community as well as personal and cultural barriers. The health and health care of a Head Start child are influenced by three major resources—the family, the available health care providers, and the Head Start program—as well as the pathways and barriers that affect communication among those support elements. Head Start works to open the pathways between families and health care providers, while also providing families with the knowledge and skills needed to minimize the impact of barriers to accessing quality health care for the child.



Because Head Start does not work as a "stand alone" Federal program, overcoming barriers includes facilitating the use of other Federal programs, such as Women, Infants and Children (WIC) and Medicaid. It became apparent during the study that an important factor in the creation of community linkages is the active integration of Head Start with State and other Federal resources, such as Medicaid, the United States Department of Agriculture (USDA) (i.e., the school lunch program, WIC), and Temporary Assistance for Needy Families (TANF, formerly Aid to Families with Dependent Children). Programs serving low income families are interdependent, and changes in one may affect service delivery in others. Head Start's dependence on other Federal resources is at a point where cuts in other resources would have a serious impact on how local Head Start health staff decide to allocate their limited resources. As noted by the Advisory Committee on Head Start Quality and Expansion:

We must encourage Head Start to forge partnerships with key community and state institutions and programs in early childhood, family support, health, education, and mental health, as we must ensure that these partnerships are constantly renewed and recrafted to fit changes in families, communities, and state and national policies (p. viii; 1993).

Methodology

This study was designed to collect descriptive data on the Health Component from Head Start staff and parents, and to gather data on the health status of Head Start children from the parents and the Head Start health records. All of the data for this study were collected in the late Spring of 1994, as 4-year-old children were completing Head Start and preparing for entry into kindergarten. Using a national probability sample of Head Start enrollees, a total of 1,189 parent interviews and child health file reviews were completed at 81 centers across 40 programs. The sampling strategy resulted in a nationally representative sample of Head Start families stratified across a range of geographic settings and urban or rural program sites, reflective of the national Head Start profile.

The research staff used nine different data sources at both the program and the center level. The primary staff sources were as follows: Health Coordinator (interview); Nutrition Coordinator (interview); Mental Health Coordinator (interview); Center Director/Lead Teacher (interview); Parent Involvement Coordinator (interview); and Budget Manager (questionnaire). As noted, parents of 4-year-old children (approximately 15 per center/30 per program) were interviewed, the Head Start health files for the children of the interviewed parents were reviewed, and meal observations were conducted at each center. A total of 219 staff interviews were completed and 177 meal observations were conducted. Because of the variations in the Budget Manager reports that were received, these data were not included in this report.

The following sections provide summaries of the key findings from each of the chapters in the study's Final Report. More extensive findings on particular topics are found in Volumes I and II of the Final Report.

Program Staffing and Staff Qualifications

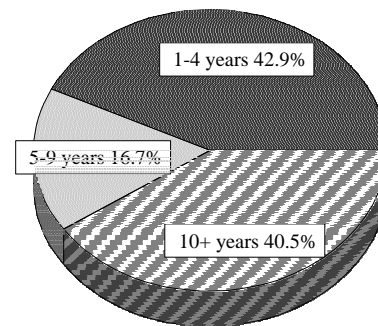
Head Start staff generally reflect a broad range of backgrounds and qualifications. Program staffing patterns and staff training were reported by staff associated with the Health Component. The highlights of those responses are presented below.

“It takes an incredible amount of coordination and commitment by everybody, and it’s worth it. We do it because it makes a difference.”

-Head Start staff

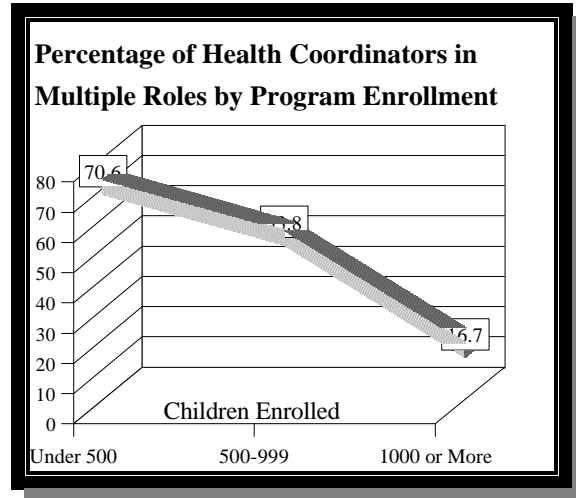
- Staff reported working in Head Start for averages ranging from 9 years (Health and Nutrition Coordinators) and 15 years (Center Directors), and reported working in their current positions for between 5 and 6 years.
- Staff reported working an average of 5 to 7 hours per week beyond the time for which they were paid.
- About 95% of the interviewed staff reported that their highest level of education was a college degree (or higher) or some college; approximately 40% of the Health Coordinators reported that they had nursing training, and approximately one third of the Mental Health Coordinators interviewed indicated that they had a master’s degree. Overall, 64% of the Health Coordinators had either a nursing degree, a Bachelor’s degree, or higher.
- Approximately one third of Center Directors and over half of each of the other staff in positions associated with the Health Component reported performing multiple staff roles. Overall, 49% of the interviewed staff were performing multiple roles, with approximately one third of these (34%) reporting that they had been hired to perform multiple roles.

Number of Years Working at Head Start for Health Coordinators



- There is an inverse relationship between program size (based on the total count of children enrolled) and the performance of multiple staff roles.

Health Component staff in programs with smaller enrollments more often reported performing multiple roles than did staff in larger programs and were generally less likely to have bachelor's or nursing degrees.



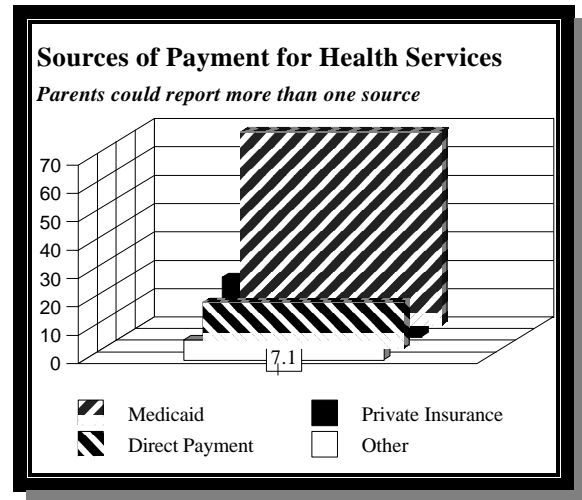
Linkages with Medicaid and Community Resources

Programs are expected to establish cooperative and responsive relationships with institutions and individual service providers in their local communities. This includes aiding families in exploring available financial resources when assistance is needed to pay for services. The major findings of this chapter are summarized below.

“They gave me names of places I could go for medical care for the boys when the clinic wouldn’t see us anymore.”
- Head Start parent

- The major types of organizations most commonly reported by Health Coordinators as being associated with their Head Start programs were public health agencies and private group providers. The most often reported services provided were medical services and screenings, vision screenings and eye care, immunizations, dental services, and nutrition services and meal planning.

- Over two thirds of the parents (68%) reported Medicaid as the primary source of payment for health services. Among the Medicaid enrolled children, almost two thirds were enrolled at or near the time of their birth (1988-90) and an additional one fifth became enrolled during the Head Start program year (1993-94).
- Barriers facing families are both personal and community-based. The latter includes the lack of specialists and general health providers in their respective communities. Major personal barriers to care include parents not understanding the need for treatment services, parents' resistance to using services, and the lack of time for parents to access services for their children. Each of these barriers was reported by at least 20% of the programs. The failure of community providers to assist low-income families continues to be a major barrier to the provision of health services.



Health Education

One way to measure the success of Head Start is to understand how children and their families become better prepared to meet the challenges of improving their health and lifestyles after they leave Head Start. This is the goal of Head Start health education. Health education activities include basic hygiene, safety, and other appropriate health behaviors for children, parents, and staff. The major findings of this chapter are summarized below.

“She has made noticeable changes in grooming—combing hair, trying to look nice; I’m brushing more due to her encouragement; tooth brushing is great. She is improving me also.”
-Head Start parent

- Nutrition, personal hygiene, first aid and safety, and dental health were the most frequently covered classroom health education topics, each being cited by over 85% of the Health Coordinators. Mental Health Coordinators were most likely to list self-esteem and peer relationships as the mental health topics addressed in the classroom curriculum.
- Both the Health and Mental Health Coordinators listed classroom discussions and role playing activities as the classroom activities most often used to incorporate health education into the classroom. Classroom visitors, most often nurses, nutritionists, and dentists, provided education for the children and also served as an important outreach activity by getting community providers involved with the local programs.
- Parent education topics most reported by parents included parenting, child growth and development, and nutrition and meal planning. Nearly all of the programs were reported offering parent classes at least once a month, with a quarter of the programs holding classes at least once a week.
- Almost the entire sample of parents stated that they discussed health topics at home with their children. Changes in either child or adult health behaviors since starting Head Start were noted by two thirds of the parents. Over one quarter of the parents and almost half of the children were described as having some general improvement in their health behavior. Over one tenth (11%) of the parents indicated that their child had acquired attitudes and behaviors in Head Start which have helped change the health behavior of other children or adults in their home.

