

A Descriptive Study of the Head Start Health Component

Volume I: Summary Report

December 1996

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Prepared for:
U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families

This study, entitled *A Descriptive Study of the Head Start Health Component*, was conducted under Contract # 105 93 1911 for:

Research, Demonstration, and Evaluation Branch
Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

Additional copies are available from:

Head Start Bureau
P.O. Box 1182
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LIST OF ABBREVIATIONS

Abbreviation	Unabbreviated Term
AAP	American Academy of Pediatrics
ACF	Administration for Children and Families
ACIP	Advisory Committee on Immunization Practices
ACYF	Administration on Children, Youth, and Families
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Syndrome
AOA	American Orthopsychiatric Association
CAA	Community Action Agency
CACFP	Child and Adult Care Food Program
CDA	Child Development Associate
CDC	Centers for Disease Control and Prevention
CDF	Children's Defense Fund
CDM	The CDM Group, Inc.
CPR	Cardiopulmonary Resuscitation
DBP	Diastolic Blood Pressure
DHHS	Department of Health and Human Services
DPT	Diphtheria, Pertussis, and Tetanus
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FY	Fiscal Year
GAO	General Accounting Office
HepB	Hepatitis B
Hib	<i>haemophilus influenzae</i> type b
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization

HSAC	Health Services Advisory Committee
HSCOST	Head Start COST System
HSFIS	Head Start Family Information System
HSMTS	Head Start Management Tracking System
IM	Information Memorandum
LPN	Licensed Practical Nurse
mg/dcl	Micrograms/deciliter
MMR	Measles, Mumps, and Rubella
MMWR	Morbidity and Mortality Weekly Report
NCHS	National Center for Health Statistics
NHANES II	National Health and Nutrition Examination Survey Phase II
NHIS	National Health Interview Survey
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OPV	Oral Polio Vaccine
OSPRI	On-Site Program Review Instrument
OTA	Office of Technology Assessment
PIR	Program Information Report
PNSS	Pediatric Nutrition Surveillance System
PPS	Probability Proportional to Size
RN	Registered Nurse
SBP	Systolic Blood Pressure
STD	Sexually Transmitted Disease
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
USDA	United States Department of Agriculture
WIC	Special Supplemental Food Program for Women, Infants and Children

ACKNOWLEDGMENTS

The authors are extremely grateful to these individuals who contributed in countless ways to the successful completion of this study and report. First we thank the staff from the Head Start Regional Offices and from the programs and centers that were visited. Their cooperation and genuine interest in the study contributed, in large part, to the success of this study. Also, we thank the Head Start parents who were interviewed for this study.

The staff of this project recognize the support and dedication of *James A. Griffin*, Ph.D., the Administration on Children, Youth and Families (ACYF) Federal Project Officer. His energy and enthusiasm combined with a productive blend of oversight and collaboration continually served to improve the study as well as make it a project on which people enjoyed working.

We also are grateful for the guidance and suggestions of other Federal staff throughout the various aspects of the project. In particular, we recognize the contributions of the following Federal staff:

Robin Brocato, Henry Doan, Henlay Foster, James Harrell, Mireille Kanda, Esther Kresh, Michael Lopez, Jim O'Brien, Louisa Tarullo, M. Bruce Webb, ACYF;
Mary Faltynski, Office of the Assistant Secretary for Planning and Evaluation, DHHS;
Heather Block, Child Nutrition Division, United States Department of Agriculture;
Cindy Ruff, Medical Bureau, Health Care Financing Administration; and
Denise Sofka, Maternal-Child Health Bureau, Health Resources & Services Administration.

Special thanks are extended to our Technical Advisory Panel and local Head Start representatives:

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The data collection effort was possible only because of a tremendous effort on the part of a highly professional group of field data collectors and the on-site staff who recruited families for the study. In addition to the authors, the following staff from The CDM Group, Inc, and Abt Associates, Inc. performed major roles in the data collection process:

The CDM Group: *Alejandro Arias, Chris Booker, Andrea Burland, Atiba Coppock, Roberta Hochberg, Lacie Gray, Elizabeth Lee, Karen Feggans-Yates, and Lois Wiechmann.*

Abt Associates: *Hope Coelen, Julia Cradle, Gabriella Garcia, Charles Greene, Linda Hailey, Karen Johnson, Lisa Livens, and Brenda Rodriguez.*

We also acknowledge contributions to various aspects of the project made by the following past and present staff from The CDM Group, Inc. and Abt Associates, Inc.:

The CDM Group: *Lois Wiechmann (Corporate Supervisor); Kent Boyd, Andrea Burland, Kim Cohen, MaryAnn D'Elio, Clare Feinson, Michael Gage, Patricia Greene, Roberta Hochberg, Michelle Jacobs, MaryLou Leonard, Ted McCarthy, Anne Nelson, Tracy Scott, Marilyn Spear, Rosemary Staley, and John Swisher.*

Abt Associates: *Michael Battaglia, Hope Coelen, Julia Cradle, Gabriella Garcia, Charles Greene, Linda Hailey, Jeff Reneau, and Brenda Rodriguez.*

Finally, the authors express their greatest appreciation to those individuals who have shown enormous patience and consistent support throughout this project...our families.

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

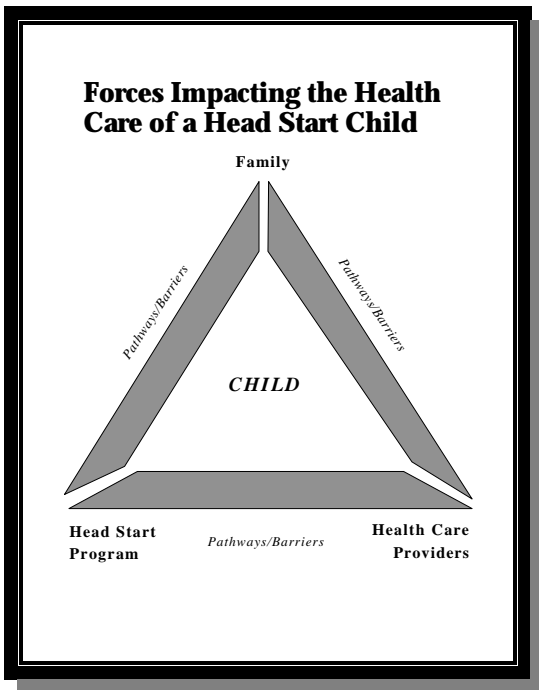
medical, dental, mental health, and nutrition. The Head Start Bureau has recently published a comprehensive revision of all the Program Performance Standards (Federal Register, 1996) effective January 1998, and is developing additional strategies for supporting health activities at the local level.

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

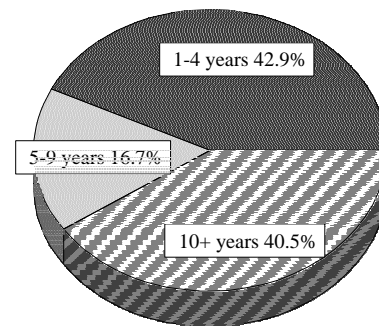
Head Start staff generally reflect a broad range of backgrounds and qualifications. Program staffing patterns and staff training were reported by staff associated with the Health Component. The highlights of those responses are presented below.

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

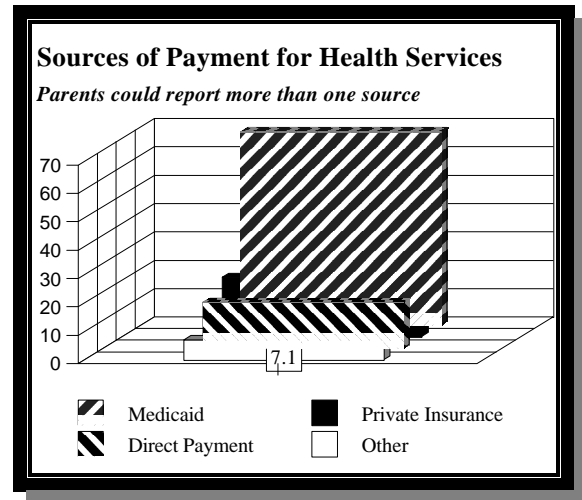
-Head Start staff

- 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



- 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.

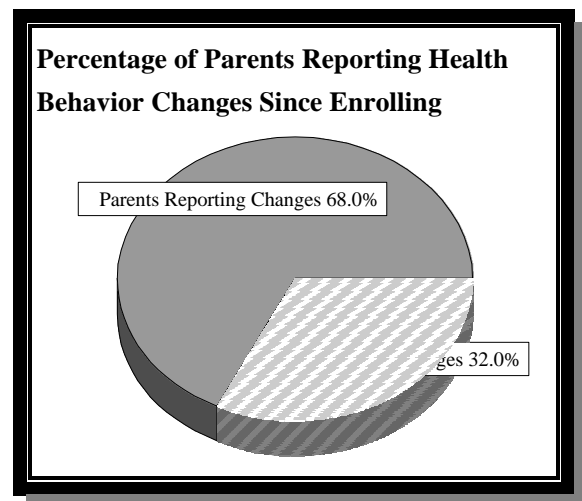


Health Education

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

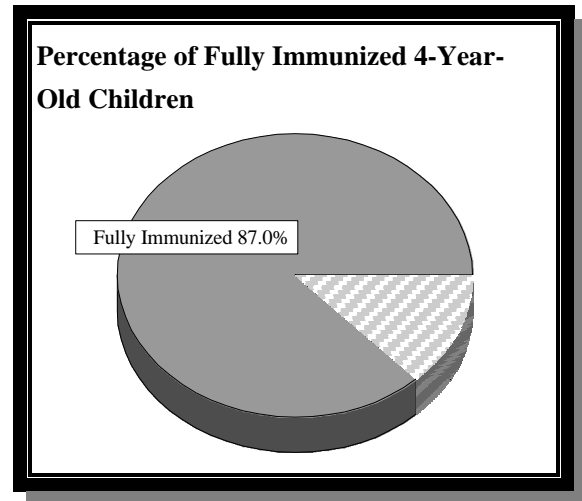
- Nutrition, personal hygiene, first aid and safety, and dental health were the most frequently covered classroom health education topics, each being cited by over 85% of the Health Coordinators. Mental Health Coordinators were most likely to list self-esteem and peer relationships as the mental health 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.



Immunizations

Under the Program Performance Standards, programs are required to obtain or provide services to assure that age-appropriate immunizations are provided for children before the end of the Head Start year (§ 1304.3-4). The major findings regarding immunizations are summarized below.

- Immunization rates based on the children's health record review showed that over four fifths (87%) of the 4-year-old children were fully immunized in accordance with the Program Information Report (PIR) reporting requirements (4 DPT, 3 OPV, 1 MMR, 1Hib). Recently, the CDC reported that only 75% of preschool children are immunized to this level nationally.
- Children typically received 9 of the 11 required immunizations needed by the time they left the program. The missing immunizations were almost always the final oral polio vaccine (OPV) and the final diphtheria, pertussis, and tetanus (DPT) shots. Immunizations requirements for entry into kindergarten vary by State.
- Parent-held records indicated that 10-15% of the children had additional immunizations that were not noted in the child health files kept at the Head Start Program.
- A majority of the Health Coordinators interviewed were not able to correctly report the Head Start requirements for DPT and OPV vaccinations in effect at the time of the study.



Health Status and Health Services Within the Four Health Domains

Guidelines under the Program Performance Standards address program activities specifically related to each of the four health domains: medical health, dental health, mental health, and nutrition. These guidelines include procedures for assuring that children receive appropriate screenings and examinations and also receive required treatments as necessary. Health records and parent interviews yielded information on these areas as well as on children's health status across each of the four health domains.

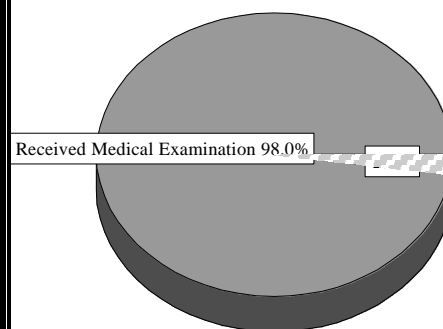
The Medical Health Domain

Head Start staff encounter a wide range of health conditions among children each year. Activities related to the provision of medical screenings and examinations provided or arranged for by Head Start programs were reported. Data from this chapter came from multiple sources (e.g., parents, child health files, and staff). The highlights of the findings are presented below.

“The health check and dental checks would have never been done without Head Start's help.”
-Head Start parent

- Parent reports, in conjunction with reviews of the child health files, indicate that over 98% of the Head Start children received physical examinations during the past year. These findings are consistent with those from the annual PIR reports.
- Health conditions requiring follow-up were reported by parents for almost 20% of the children. The health conditions most reported were ear problems, speech and language problems, gastrointestinal

Percentage of Children Receiving Medical Examinations in the Past Year



problems, asthma and other lower respiratory problems. No single condition was reported by more than one tenth of the parents.

- Screenings and examinations conducted while children were enrolled in Head Start helped detect several health conditions that were not noted during screenings and examinations conducted prior to Head Start enrollment. Conditions more likely identified after enrollment include speech and language problems, blood disorders, and hernias. Dental problems were also more likely to be detected after Head Start enrollment.

Child Health conditions more likely identified after enrollment:

- **Speech and Language Problems**
- **Blood Disorders**
- **Hernias**
- **Dental Problems**

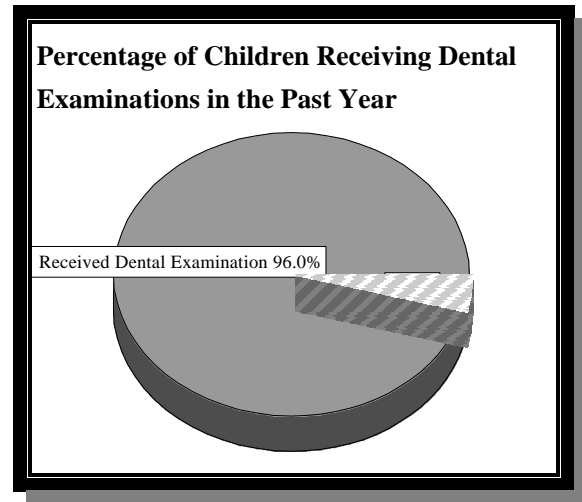
- Over 80% of the health records that reported a health condition requiring treatment contained no documentation on the status of these recommended treatments.

The Dental Health Domain

Dental problems are of particular interest to Head Start because of the higher incidence of problems among low-income families and the shortage both of dentists in low-income communities and of dentists willing to accept Medicaid payments. Activities related to the provision of dental screenings and examinations provided or arranged for by Head Start programs were again collected from multiple sources (parents, child health files, and Health Coordinators). The highlights are presented below.

“I hadn’t been able to find a dentist who would take a medical (Medicaid) card.”
-Head Start parent

- Overall, parent reports, in conjunction with reviews of child health files, indicate that about 96% of the Head Start children received dental examinations in the past year.
- Almost 42% of the parents reported that their child had an identified dental condition, and over 80% of the identified conditions were dental caries. Only 11% of the health files indicated that a child had a reported dental problem. However, 42% of the child health files had no recording of whether or not the child had dental problems.
- Based on parents' reports, at least 76% of the conditions had been treated or were currently being treated, while less than 1% of the parents reported not seeking treatment for their children. A significant portion of parents, 24%, did not indicate the treatment status of their children's dental conditions, but this is not necessarily an indication that necessary treatment did not take place or was not scheduled.

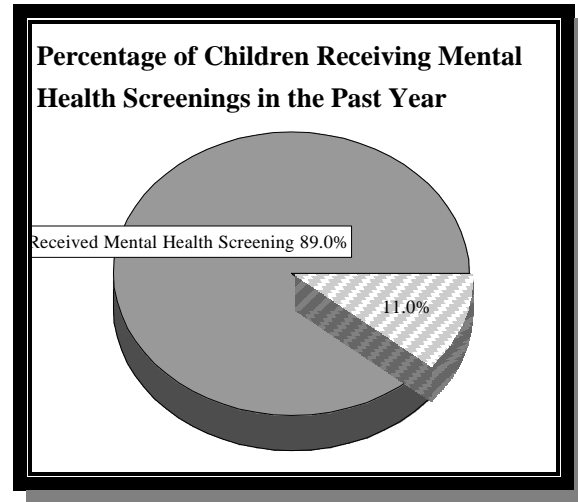


The Mental Health Domain

Mental health is sometimes overlooked within the Health Component. A number of difficulties were encountered in studying the mental health domain (e.g., definitions and terminology, record keeping practices, confidentiality), making it difficult to paint an accurate picture of the mental health status of Head Start children. The findings that are available are summarized below.

“Thanks to Head Start [she] is able to go the psychologist.”
-Head Start parent

- Almost 90% of the Mental Health Coordinators said that all children in their program are screened for mental health or developmental concerns through observation of classroom or group socialization activities, individual mental health screenings, or both.
- When asking about the mental health of their children, less than 7% of the parents reported that someone from the Head Start center had suggested that their children be evaluated for possible behavior problems.
- Less than 3% of the parents reported that a condition was identified through a developmental assessment. The conditions they were likely to mention were speech and hearing problems, cognitive or developmental delays, or emotional disorders. Many parents listed speech and language concerns under medical problems. Little information was available on the status of treatment.



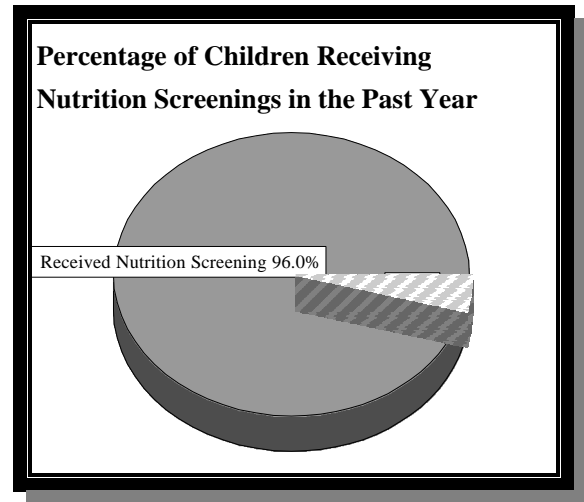
The Nutrition Domain

The nutrition requirements for Head Start programs include preparation of meals which provide children with between one and two thirds of their daily nutritional needs, depending on the length of their school day. Other nutrition activities include the conduct of nutrition screenings provided or arranged for by Head Start programs and educational opportunities for parents on proper nutrition.

The highlights of the parent and staff reports are presented below.

“I couldn't make them eat vegetables and fruits. Now she comes home and tells me and her sisters that they have to eat meat, milk, bread, fruit, and vegetables in order to be strong.”
-Head Start parent

- About 96% of the children received a nutrition screening during the previous year. Almost 90% of the Nutrition Coordinators reported that children enrolled in their program routinely received individual nutrition screenings.
- Nutrition summaries were available in only a few of the child health files. Approximately 5% of the children were described as being in need of nutrition services. Very few parents (less than 5%) reported their child being obese or underweight as a health condition.
- Meals provided an excellent opportunity for staff to provide nutrition and general health education for children as well as socialization experiences. Healthful activities, such as hand washing, were incorporated into the daily classroom routine surrounding meals.



Study Strengths and Limitations

As a descriptive study, the findings from this project fit a specific need of the Head Start Bureau: objective information on the implementation of the Health Component. To this end, it is recognized that the study has both strengths and weaknesses. A principal strength is that this descriptive study provides a sample that is representative of the overall Head Start population. The stratification plan used for the random sample provides a representative view of the general Head Start population, allowing child-level data to be weighted and national estimates produced.

The use of multiple data sources is an important element of the study. For example, receiving information from Head Start staff, Head Start parents, and child health records was especially useful in clarifying the immunization data. Interviews with staff and parents clearly indicated that immunization rates are higher than reflected in the Head Start records.

The study limitations include the use of Head Start child health files which were not always complete and which often varied in content from program to program. Variations across programs in record-keeping practices made preparation for data collections difficult, and sometimes made specific pieces of information inaccessible to the research staff.

Unfortunately, the data collection was restricted to only one visit per site. Longitudinal data reflecting the impact of specific Health Component activities on the behavior of children and their families would be very useful for staff in determining the distribution of program resources. The research team was also unable to undertake direct health checks on the children or review primary provider or clinic health records to supplement or validate those held by parents or Head Start programs.

Implications for Head Start Program Practices

After visits to 81 centers in 40 programs and completing almost 1,500 interviews with Head Start parents and staff, the picture of the Head Start Health Component is not yet complete, but it is becoming much clearer. The Head Start Bureau has the opportunity to integrate the information from this report into policy initiatives and program support. For example, information gained from this study will be useful to ACYF as it provides support and direction to local Head Start programs' efforts to implement the newly revised Head Start Program Performance Standards. Based on the findings of this study, six areas are discussed here in terms of their implications for the provision of health services within Head Start.

Staff Training and Support. One of the more striking findings on how programs implement the Health Component was the number of Health Coordinators who reported having multiple roles within their program. While comprehensive staff training is crucial to the provision of appropriate care and education for enrolled children, training is even more critical for staff with responsibilities for managing multiple health domains or multiple program components, as staff persons with multiple responsibilities may not have prior training or experience related to each responsibility. This issue may be particularly true for smaller programs with fewer resources for

providing or accessing staff training. Data from the study suggest that component coordinators in smaller Head Start programs have fewer educational credentials, yet are far more likely to perform multiple roles. Program managers should ensure that training activities address the range of backgrounds noted among the staff, and help individuals with multiple roles develop strategies to best manage these responsibilities. Beyond the training of existing staff, the revised Program Performance Standards support the development of consultative relationships with health professionals outside the program to assist center staff in carrying out specific health-related functions.

Immunizations Records and Knowledge. Improvements in record-keeping strategies will help Head Start programs maintain up-to-date information on the immunization status of the children they serve. As noted earlier, between 10-15% of the children had received additional immunizations which were noted on the parent-held records, but were not found in the Head Start records.

Subsequent to the data collection for the present study, the Head Start Bureau updated the immunization requirements for children attending the program and modified the PIR reporting requirements to be consistent with these requirements. Given that the revised Program Performance Standards require programs to follow, at a minimum, the immunization schedule implemented in the Medicaid/EPSDT program in their State, technical assistance regarding the State Medicaid/EPSDT immunization requirements is needed for all health staff, not just the Health Coordinators. In addition, systems to ensure that immunization status and all relevant health information are recorded, reviewed regularly, and kept current during the program year will assure that immunization records are complete as children leave Head Start. Linkages with State health departments and Medicaid will ensure programs access to the most recent State immunization requirements and would promote “best practices.”

Mental Health Issues. Head Start's developmentally appropriate activities for children, and its emphasis on parent involvement, form the foundation of its role in mental health

promotion and primary prevention. However, this study found that most programs' efforts to identify the mental health needs of individual children and to track the provision of services to them, were not well-documented. As suggested by the American Orthopsychiatric Association study of Head Start mental health services (AOA, 1994), programs were reluctant to identify and make referrals for mental health interventions except in the most serious cases, did not keep sufficient records about the interventions which did occur, and preferred describing concerns about children's behavior as developmental/language delay issues rather than as mental health needs. National and local leadership is needed to address Head Start staff and family attitudes which may be limiting the provision of needed mental health services, including: concerns about the perceived stigma attached to children receiving mental health services; reluctance to record information without more certainty about the safeguards for confidentiality; and, a failure to acknowledge the costs of under-reporting mental health concerns or waiting until problem is more serious. In addition to information and training, the Head Start leadership should provide significant direction and support for developing and sustaining responsive mental health services in Head Start programs that can demonstrate more immediately to parents and staff the value of a more systematic approach to mental health intervention. Head Start programs' self-examination of mental health services in light of the revised Program Performance Standards presents a critical opportunity to implement the improvements needed.

Treatment Follow-Up. As part of a comprehensive health program, it is necessary for staff to receive training on the importance of carefully tracking the medical progress of the children they serve. Reviews of the child health files in the present study yielded information that indicate that Head Start children are being properly screened for medical and dental problems; however, the health files contained relatively little documentation about whether treatments actually were completed, in progress, or ongoing, as in the case of chronic health conditions. Over 80% of the health records that reported a health condition had incomplete or no follow-up data on the status of the recommended treatments. This situation does not necessarily mean that treatments are not taking place, because parents' reports indicated a higher percentage of completed treatments. It does suggest, however, that better information is needed to

appropriately document and monitor the status of what happens to Head Start children when medical, dental, mental health, or nutrition screenings indicate the need for treatment services. The tracking procedures required under the revised Program Performance Standards should have a positive impact in this area.

Record Keeping. Continued encouragement and support for efforts such as the Head Start Family Information System (HSFIS) and other automated data collection systems containing similar data elements is needed to help programs standardize the collection of information about the families they serve as well provide a simple, automated system for updating and retrieving information on these families. Record-keeping practices varied greatly across the programs and centers studied. This was particularly true for the fiscal information collected from the Budget Managers. Efforts to expand the systematic and comprehensive tracking of services consistent with the revised Program Performance Standards should improve the comparability of records across centers and programs, provide a consistent basis for national training activities related to record keeping issues, and help ensure appropriate documentation of quality service provision. Key issues in the implementation of the HSFIS or similar systems are the provision of equipment and adequate training to program staff that emphasizes the need for such information from every program.

Collaboration Activities. In an era that will be noted for reforms in welfare and other public assistance programs, local, Tribal, State, and Federal agencies serving low-income families have an increasing need to coordinate their services. The creation of useful community linkages for Head Start is dependent on the active integration of local programs with community and State programs as well as with other Federal resources, such as Medicaid, the United States Department of Agriculture Nutrition Programs (USDA), (e.g., the Women, Infants, and Children program (WIC)), and Temporary Assistance for Needy Families (TANF). This study found evidence through the staff and parent reports that these activities are occurring, making it clear that Head Start does not work as a "stand alone" Federal program. However, a re-emphasis in this area is warranted in light of the revised Program Performance Standards, requiring that

children be linked to a “medical home” where health services are not provided to families by Head Start. Individual Head Start programs must actively pursue partnerships with other Federal, State, Tribal, community and local health agencies so that the combined resources maximize the health services available to children and families while containing costs to local programs.

Recommendations for Future Research

One of the original intentions of this descriptive study was to generate hypotheses and methodological recommendations for future research on both the Health Component and the Head Start program in general. In terms of future research activities, the following suggestions are offered to help guide future studies of the Head Start program:

- **Determining the Impact of the Program on Families.** Head Start parents come to the program with a wide range of skills and knowledge needed to manage the acquisition of health care services for their families. It is necessary to learn what basic, health-related skills and strengths families bring to Head Start and how different these skills are when they leave the program.
- **Staffing Patterns.** The present study revealed a wide variety of staffing patterns that should be explored in subsequent studies in order to assess whether there are specific models of health service delivery that are more effective than others under certain programmatic and community conditions.
- **Investigating Links with Community Services.** It was difficult in this study to determine the level of formality of the Head Start-community links that have been established. It may be necessary to survey community providers to determine, from their perspective, how Head Start serves the community and how these providers work with Head Start families as well as what specific factors appear to contribute to efficient and effective collaborations with Head Start and/or service delivery to Head Start families.

- **Sampling Considerations.** The development of any sampling plan intended to produce appropriate representation of urban and rural programs must take into account the fact that many Head Start programs include centers that serve both types of areas. More detailed information is required on individual Head Start centers and the geographic areas or populations they serve.
- **Instrument Development.** A review of the findings from this study has led to the conclusion that instrument development activities in future projects must consider the use of multiple data sources in order to understand differences across staff roles and to provide comparisons across sources, including the possibility of gathering data directly from community health providers.

Summary

It appears that, in serving Head Start families, programs engage in three levels of activities: assuring that children get screenings and needed health services, that children receive preventive care, and that both children and families learn to take responsibility for their own health care and health-related behaviors. The Health Component provides the opportunity for all families to benefit through prompt diagnosis and treatment, and by ensuring that the children are as healthy as possible before they enter kindergarten. Not all families need Head Start's assistance in accessing health services. The program is designed so that those in need of assistance receive care, and that these families develop the skills necessary to access appropriate care and develop a "medical home" independent of the Head Start program. These steps are a primary focus of the revisions in the Program Performance Standards.

**"The program is concerned about the health of the children. They care a lot for the girl and I am very grateful for that."
-Head Start parent**

Clearly, the Health Component is a very valuable and unique piece of the overall Head Start program. It is hoped that the "snapshot" taken by this study will generate useful questions that will drive future research activities. The research team completes this project with both admiration and respect for the

Head Start families as well as the local Head Start staff. These individuals work endlessly, often under less than ideal conditions, to improve the lives of the children in local programs. We hope that the information gathered during this study will directly benefit their work.

“I love Head Start—This is my third child in Head Start. It is the best program available for children.”

-Head Start parent

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During fiscal year 1994, the year in which study data for this report were collected, Head Start served an estimated 740,000 children and their families in almost 2,000 programs nationwide. The FY 1994 budget was \$3.3 billion (General Accounting Office, 1994).

In 1993, with an eye toward the future of Head Start, the Advisory Committee on Head Start Quality and Expansion issued a document, *Creating a 21st Century Head Start: Final Report of the Advisory Committee on Head Start Quality and Expansion* (1993), which made recommendations for Head Start as the program prepares for the next century. The report recommended 1) improving Head Start staff training in order to increase the quality of the services provided, and expansions in the numbers of children served and the range of services provided to Head Start children and their families; 2) improving community partnerships to more effectively meet the needs of Head Start families in the areas of family support, health, and education; and 3) strengthening Federal oversight of Head Start. The collection of reliable and valid baseline information on the Health Component will assist Federal staff in accurately identifying program needs.

Also in 1993, DHHS' Office of the Inspector General (OIG) focused attention on Head Start by issuing a report on the implementation of expansion funds entitled *Evaluating Head Start Expansion Through Performance Indicators* (OIG, 1993). This study covered many aspects of Head Start, including the Health Component. The policy analyses of the Advisory Committee and the OIG share at least one common conclusion: that additional baseline data from children's Head Start records, parent interviews, and staff interviews are needed to increase understanding of the health problems and service needs of Head Start children and their families.

The descriptive findings presented in this report are one step in a long-term research strategy to meet these program needs. They also provide data critical for implementing many of the Advisory Committee's recommendations. This study goes beyond the usual compilation of Head Start child health records and standard data from the Head Start Program

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Because many low-income children have limited access to health care, Head Start programs are required to ensure that each child receives a comprehensive health care program across four health domains: medical, dental, mental health, and nutrition (see Exhibit 2-1).

Exhibit 2-1 Head Start Program Performance Standards: Health Care Services Provided to Children Under the Health Component

Medical Services

- Medical screenings and examinations;
- Vision and hearing tests;
- Identification of disabling conditions;
- Immunizations; and
- Follow-up referral or care for problems identified through this process.

Dental Services

- Dental screenings and examinations; and
- Follow-up referral or care for problems identified through this process.

Nutrition Services

- Children in part-day programs receive at least one hot meal and one snack per day to meet at least one third of a child's daily nutrition needs; children in full-day programs receive between one half and two thirds of their daily nutritional needs;
- A trained nutritionist provides information on nutrition and meal planning to parents; and
- Head Start nutrition services are closely coordinated with the Food and Consumer Service of the U.S. Department of Agriculture.

Mental Health Services

- Mental health training is provided for staff and parents to make them aware of the need for early attention to the special mental and emotional problems of children;
- Services are planned and directed by a Mental Health Coordinator with the assistance of an outside mental health professional; and
- Staff members arrange for individual or group assessments and subsequent services, as needed, for individual children.

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.

The Health Coordinator is assisted by, at a minimum, (1) a full-time or regularly scheduled qualified **nutritionist** or **dietitian** to oversee menu planning, food purchasing, food preparation, sanitation, personal hygiene, activities and staff training; (2) a **mental health professional** who is available on at least a consultation basis to assist in planning mental health activities; train Head Start staff; examine and observe children and consult with teachers and other staff; provide appropriate information to individual and groups of parents; and oversee appropriate referrals for diagnostic examinations as needed; and (3) a **Disabilities (or Handicapped Services) Coordinator** responsible for recruitment, enrollment, and arranging for the delivery of services for children with special needs.

The health section of the Program Performance Standards requires that Head Start programs be responsive to community health needs that affect the children they serve. As part of Head Start's efforts to help families obtain the health services indicated by screening efforts, programs are required to explore and use all available community resources—including health departments, school health programs, clinics, private practitioners, prepaid medical groups, armed forces medical services, hospitals, community health centers, dental service corporations, voluntary agencies, public assistance programs, the Medicaid/EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) program, and other insurance programs—to the maximum extent possible. Programs also are required to inform parents about available health resources and to assist parents in gaining access to care. Sometimes, local providers are willing to volunteer their services to a center or program as “in-kind” contributions of goods and services.² In coordinating its work with families, Head Start has a

² Head Start programs are required to generate 20% of the total cost of the program through “in-kind” support from their community to support program activities.

care services for Head Start children. Overall, the health of the Nation's children has improved in recent decades. Promising statistics include a reduction in infant and child mortality rates, a reduced incidence of preventable childhood diseases through effective immunization programs, and reductions in the prevalence of dental caries through fluoridation and improved preventive dental care. Additionally, information about the long-term impact of tobacco products, alcohol and illicit drugs, and poor dietary habits are increasingly being promulgated through health education programs.

However, in the three decades since the inception of Head Start, many elements of poverty have been altered by sociological forces, and these changes often have had negative implications for the physical and mental health of children in low-income families (several studies examining these implications are reviewed in the following sections). In turn, impaired health can be expected to have adverse effects on school achievement and on other indices of social competence (Zigler, et al., 1994).

Medical Health. Attention to chronic health conditions related to the physical and social environment has recently increased. These conditions include otitis media, chronic respiratory disease, asthma, tuberculosis, lead poisoning, infection with human immunodeficiency virus (HIV) or other sexually transmitted diseases before birth, and conditions related to maternal behavior during pregnancy. Other health conditions, such as physical injury and behavioral/emotional problems, may result from stress caused by exposure to violence or other elements of the environment common to low-income families.

Dental Health. Studies of children indicate that dental disorders are higher among low-income children than other children. In 1984, the largest study of Head Start children yet conducted found that one fourth of the children were urgently in need of dental care (Fosburg, 1984). A similarly high prevalence of dental caries in Head Start children has been reported in several recent studies (Barnes, Parker, Lyon, Drum & Coleman, 1992; Jones, Schlife & Phipps, 1992; Kaste, Marianos, Chang & Phipps, 1992; Katz, Ripa & Petersen, 1992),

funding is undoubtedly welcomed at the local level, the additional mandates to serve more children and to improve the quality of the services provided also adds complexity to the mission of serving low-income families.

Thus, the context of child health conditions faced by Head Start program staff has become increasingly complex during recent years. Its effects may often be first recognized and identified by Head Start health screenings and/or Head Start classroom observations. Given the new program mandates, the importance of Head Start's role in 1) identifying the often subtle early-warning signals of health conditions; 2) facilitating diagnoses and treatment of those conditions; and 3) providing health education that can prevent or limit the effects of such conditions is significantly increased. This study is an investigation into how local programs make the effort to remain true to the original vision of the founders of Head Start regarding the role of good health in the growth and development of children.

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The primary objective of providing a national probability sample of children enrolled in Head Start was accomplished through a multi-stage sampling strategy. The first-stage sample consisted of 40 Head Start programs selected from the universe of programs identified in the 1992-93 PIR database. The second stage of sampling yielded 80 Head Start centers (two centers per program). The final stage selected 15 children per center, to yield 1,200 interviews with parents, for a nationally representative sample of Head Start families. The details of each stage of sampling are described below.

The first-stage sample generated 40 randomly selected Head Start programs. The available programs were stratified on the basis of three variables—Census Region (Northeast, Midwest, South, and West), Urbanicity (whether or not the Zip Code associated with the address of the Head Start program was located inside an Urbanized Area),² and the percentage of minority Head Start children (greater than or equal to 50% minority enrollment versus less than 50% minority enrollment).

In the second stage of sampling, two Head Start centers were selected from each of the 40 programs. For several programs where centers selected had fewer than twenty 4-year-old children enrolled, an additional backup center was identified.

The third stage of sampling involved the selection of individual Head Start children. The target population consisted of 4-year-old children enrolled in Head Start at the beginning of the academic year. Using enrollment lists provided by the centers, the research staff identified a random sample of 15 primary children and 8 alternates per center. The data collection effort was directed at completing 15 interviews per center from 80 centers for a total of 1,200 parent interviews. In cases where the family of one of the 15 pre-selected

² During the process of selecting centers for the study, it became apparent that Head Start programs often manage centers located at substantial distances from the main program address. In such cases, the program address is often in an Urbanized Area while most or all of the program centers are located in rural areas surrounding the main program location. Occasionally, the reverse was true as well. Therefore, any comparisons of urban and rural data for this study should be viewed with considerable caution before any conclusions are drawn.

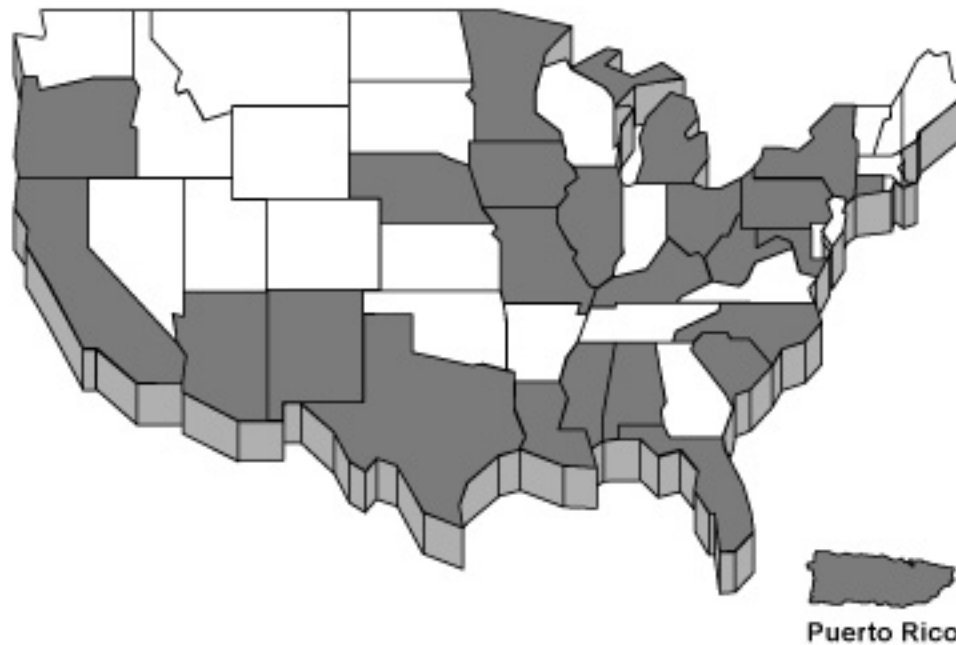
children could not be located or if a parent declined to be interviewed, alternates were used. A total of 1,189 parents were actually interviewed.

3.4 Description of Study Sample

3.4.1 Head Start Children and Parents

The national distribution of States covered by this sample of 40 Head Start programs is shown in Exhibit 3-2. All programs selected on the first draw agreed to participate, making

Exhibit 3-2 States Covered During Site Visits



it unnecessary to draw any replacement programs. A total of 81 centers were visited. One of the programs was entirely home-based, and consequently had only one center. In two other

cases, a center was drawn that did not have the requisite number of 4-year-old children (15), and an additional center was drawn to complete the sample.

Descriptive statistics for the sample of children represented by the 1,189 parent interviews are found in Exhibit 3-3. Of these, 51% of the children whose parents were interviewed were male. The broad racial background of the children was assessed in the parent interview using the standard U.S. Bureau of the Census classification, included 6% of the sample identified as “Other,” a category which was used by parents to record a multiracial or multiethnic background for their child.

analysis, categorical and ordinal data were compared across the three stratification variables (urbanicity, geographic region, and above or below 50% minority enrollment). These findings are only reported in the text in cases where meaningful differences are noted across the sub-groups.

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to be delivered to children in need, and also in following up on referrals made by other Health Component staff.

Multiple Staff Roles. Many staff reported that they performed roles in multiple staff positions. While approximately one third of the Center Directors (32.2%) interviewed reported that they had responsibilities in addition to their Center Director responsibilities, half or more of the respondents in each of the other staff positions associated with the Health Component reported performing multiple roles: 50.0% of the Health Coordinators, 56.4% of the Nutrition Coordinators, 66.7% of the Parent Involvement Coordinators, and 78.4% of the Mental Health Coordinators. Health Component staff in programs with enrollments of fewer children were more likely to perform multiple functions.

There is an inverse relationship between the number of Head Start Centers a Health Coordinator is responsible for and the likelihood of that coordinator working in multiple roles, with the proportion of Health Coordinators reporting multiple roles decreasing as the number of centers increases. Thus, it appears that while staff in smaller programs are more likely to wear “multiple hats,” the staff roles and functions in larger programs seem to be more cleanly delineated. It should be pointed out that this issue may be related to the locus of activity (e.g., Program level versus Center level), and the fact that many large programs may have extra staff working under the direction of the Health Coordinator.

In general, multiple role respondents reported that they had been hired to perform more than one role. Between one half and two thirds of the respondents in each staff position indicated that this was the primary reason for performing multiple roles. Other reasons, also cited by substantial proportions of Center Directors and Mental Health Coordinators, were program evolution and staff changes.

When asked what, if any, problems accompanied performing more than one role, large proportions (between 66% and 86%) of the respondents in each staff category cited time

Program Coordinators with Bachelor or Nursing Degrees who supervise staff who have not attained these qualifications.

Exhibit 4-2 Highest Level of Education as Reported by Staff

	Respondents				
	Health Coordinator	Mental Health Coordinator	Nutrition Coordinator	Parent Involvement Coordinator	Center Director
Some High School	2.4	—	—	—	—
High School/ GED Diploma	4.8	2.7	7.7	4.8	3.4
Some College	23.8	16.2	17.9	33.3	25.4
Associate's Degree	4.8	8.1	—	7.1	33.9
Nursing Diploma (no college degree)	30.9	5.4	7.7	—	—
Bachelor's Degree	19.0	27.0	38.5	35.8	22.0
Graduate School (no degree)	—	2.7	10.3	7.1	5.1
Master's Degree	11.9	32.5	17.9	9.5	8.5
Doctorate/MD	2.4	5.4	—	2.4	1.7
N	42	37	39	42	59

Much higher and consistent proportions of staff from Head Start programs sponsored by School Systems reported Bachelor Degrees than did staff from programs sponsored by other types of organizations (see Exhibit 4-3). This may reflect a value placed on academic credentialing in school systems. It should also be noted that none of the respondents from an Indian Tribe reported a Bachelor or Nursing Degree.

Exhibit 4-3 Percentage of Health Component Staff Reporting Bachelor or Nursing Degrees (or Higher) by Type of Sponsoring Agency

Program Sponsor	Respondents				
	Health Coordinator	Mental Health Coordinator	Nutrition Coordinator	Parent Involvement Coordinator	Center Director
CAA*	58.8	56.3	64.7	42.1	20.8
School System	100.0	100.0	100.0	83.3	66.7
Private/ Public Non-Profit	60.0	53.8	83.3	58.3	35.0
Government Agency**	100.0	100.0	100.0	66.7	100.0
Indian Tribe	0.0	0.0	0.0	0.0	0.0

*Community Action Agency

**Any government agency other than a public school system or a Community Action Agency (CAA).

When staff respondents were asked to volunteer (open-ended question) the fields in which they held degrees, Center Directors, Mental Health Coordinators, and Parent Involvement Coordinators most often reported Education and/or Early Childhood Development. Nutrition Coordinators generally indicated academic training in the areas of Food and Nutrition/Dietetics and Home Economics.

Of the one third of the Health Coordinators who had completed college and/or at least some graduate school, over half had specialized in the field of nursing. Approximately another third (30.9%) of the Health Coordinators reported that they had a Nursing Diploma, and these respondents were fairly evenly divided between Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Overall, approximately two out of five of the Health Coordinators interviewed reported having received training in nursing. However, the fact that more Health Coordinators tended to have nursing diplomas than baccalaureate degrees may be an indication of when the individuals received their training. Three quarters of the respondents reporting a nursing diploma received their credential in the 1950s, '60s and '70s,

Exhibit 4-4 Percentage of Staff Holding Selected Certificates and/or Licenses

Certificate/ License	Respondents				
	Health Coordinator	Mental Health Coordinator	Nutrition Coordinator	Parent Involvement Coordinator	Center Director
CPR	14.3	8.1	2.6	2.4	8.5
First Aid	41.3	5.4	5.1	2.4	6.8
State Nursing License	9.5	—	2.6	—	—
Licensed Practical Nurse (LPN)	9.5	2.7	2.6	—	—
Registered Nurse	11.9	2.7	—	—	—
Certified Nurse's Aid	2.4	—	—	2.4	—
Licensed Social Worker	4.8	2.7	—	14.3	1.7
Unspecified Teaching Certificate	9.5	13.5	5.1	7.1	10.2
Child Development License	9.5	10.8	2.6	11.9	35.6
Registered Dietician	—	—	15.4	—	—
Child Center Permit	—	—	—	—	11.9
Other*	11.9	32.4	23.1	11.9	20.3
N	42	37	39	42	59

Note: Question was open-ended. Staff could report multiple certificates/licenses.

*The "Other" category includes areas in which only one or two individuals reported holding specific certificates/licenses.

Staff Training. Staff interviewers also inquired about the training provided to Head Start staff. Center Directors and Health Coordinators were asked about the training provided at their centers during the 1993-94 program year. Three quarters or more of the respondents

interviewed reported that they provided training on the following health topics: nutrition, neglect/abuse, children with special needs, growth/development, CPR, and First Aid/safety.

Since the training of Health Coordinators was deemed to be of critical importance to the functioning of the Health Component, these individuals were asked what training on health issues for young children and their families they, personally, had received since September, 1993. When presented with a list of training topics, a majority of the Health Coordinators reported that they had received training in 15 of the 20 topic areas cited. This training was generally provided by other program staff or by local consultants or community providers.

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When parents were asked how they paid for health care services when their children became ill, 68.1% reported Medicaid as a source of payment (see Exhibit 5-1). It should be noted that parents could report multiple payment sources and that, over the course of a year, parents could have made use of several, perhaps all, of the payment sources listed.

Exhibit 5-1 Payment Sources for Health Services as Reported by the Parents

Payment Source for Health Services	Percent
Medicaid	68.1
Private Insurance	20.9
Direct Payment (out-of-pocket)	16.1
Free Care	4.2
Other	2.9
N	1,189

Note: Parents could report multiple payment sources.

Of the 729 children for whom the date of Medicaid enrollment was available, almost two thirds (64.0%) were enrolled at or near the time of their birth (during the years 1988-90), and an additional one fifth (21.0%) were enrolled in Medicaid at about the time they enrolled in Head Start (during the years 1993-94). The enrollment of the latter group may have been influenced by the children’s enrollment in Head Start. However, since parents were not specifically asked whether their child’s enrollment in Medicaid was directly linked to their enrollment in Head Start, there is no direct evidence to support this conclusion. Parents of children not enrolled in Medicaid reported that they either had other insurance coverage (48.2%) or were ineligible for Medicaid at the time of the interview (41.9%). Few parents reported a lack of knowledge about Medicaid, how it works, or how to enroll as reasons for non-enrollment.

Exhibit 5-2 Responsibilities Relative to Community Collaborations as Reported by Staff

Responsibilities	Percent				
	Health Coordinator	Mental Health Coordinator	Nutrition Coordinator	Parent Involvement Coordinator	Center Director
Review Health Providers	78.6	73.0	--	--	27.1
Select Providers	78.6	73.0	--	--	5.9
Negotiate Payments	68.3	48.6	--	--	5.1
Establish Interagency Collaborations	92.9	91.9	89.7	83.3	55.9
N	42	37	39	42	59

Community Linkages. In providing services to Head Start families, programs must develop relationships with a variety of health providers, consultants, health-related agencies, and service-providing institutions. The Health Coordinators responded to the open-ended questions regarding the types of individuals and organizations with whom they had formal or informal arrangements and the types of services or resources which they provided. The responses were summarized through content analysis procedures. The percentages presented reflect the number of Health Coordinators with a response coded under each category. Because the information provided was not always sufficient for coding (e.g., when a respondent only gave the name of an organization without clearly indicating the type of service provided), not all organizations cited could be linked with the specific services or resources.

Public health agencies (50.0%) and private group providers (28.6%) were the most often reported organizational categories, followed by mental health organizations (23.8%) and

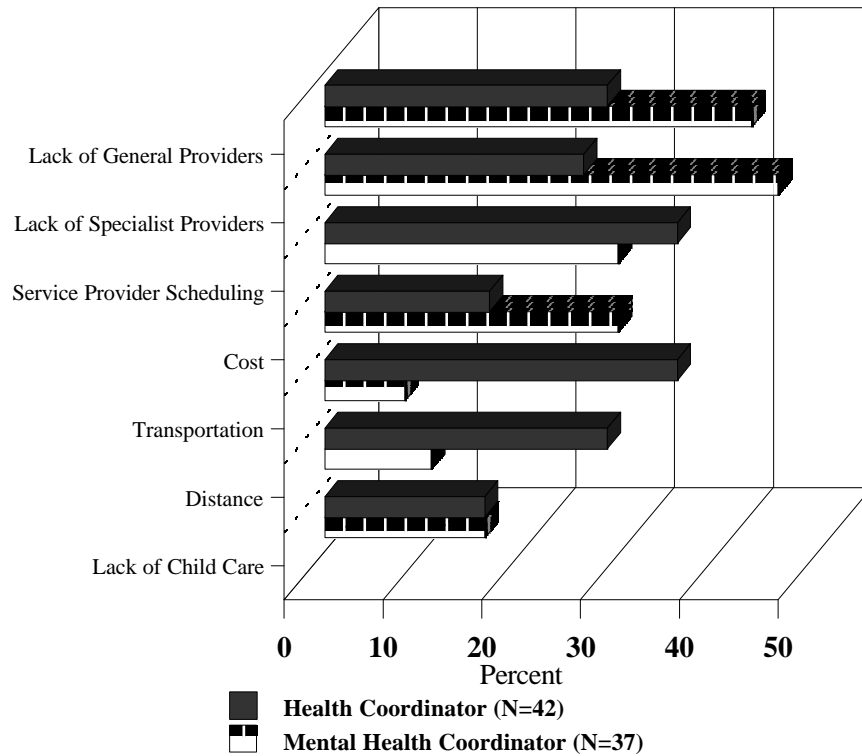
public interest/service organizations (23.8%). Because of the great diversity across the communities visited, the Health Coordinators reported a broad range of services and resources as being available to their programs. The most commonly reported services provided by these organizations include medical services (40.5%) and screenings (35.7%), vision screenings and eye care (23.8%), immunizations (23.8%), dental services (21.9%), and nutrition and meal planning services (16.7%). In reviewing the reports on collaboration with community providers, it appears that programs are more likely to link with and receive services from organizations or agencies than from individual providers. However, it was not clear from the responses whether specific agencies, institutions, or individual consultants were used for referrals only or maintained more formal and comprehensive links with Head Start. Aside from screening activities, many services were not available from individual providers or consultants, and were provided primarily by agencies or institutions with greater resources.

The Health Coordinators also furnished information on the affiliations of the individuals who provided specific screening and examination services for enrolled children. A broad range of community organizations and individuals provided physical examinations, most often private practitioners (71.4%), community health centers or clinics (64.3%), and State or local health departments (61.9%). Additional tests, such as vision and hearing screenings and dental screenings, were often provided through Head Start programs. The Program Performance Standards do allow for non-trained staff to conduct some screenings, including height and weight, vision, and hearing. However, information on the actual responsibilities of staff in completing these examinations or screenings were not compiled. This information would be particularly useful in clarifying the role of Head Start staff in conducting physical examinations, hematocrit and hemoglobin testing, and dental screenings.

limited communication across program components, 2) limited component budgets, 3) limited staff education and training, and 4) staff shortages were the most common barriers. Because these responses were to open-ended questions, the frequencies for these categories are likely to be lower than if staff were prompted by limited-choice questions.

External Barriers. Of particular interest in this study were staff perceptions of the barriers to care directly faced by the families they serve and how Head Start responds to these barriers. Exhibit 5-4 presents staff reports of community-based barriers that affect parents. Parent Involvement Coordinators' reports of barriers were generally quite high, regardless of the type of barrier. Health Coordinators focused on scheduling and provider-related issues, as did the Mental Health Coordinators. Almost 50% of the latter also cited problems resulting from the lack of specialist providers. This is consistent with the 1994 GAO report, which cited the lack of health professionals willing to accept Medicaid reimbursements to treat Head Start children as a major barrier to care and service provision. Staff reported a number of barriers that impede families in obtaining needed health services for children. These barriers, taken from a list presented during the interviews, are shown in Exhibit 5-5. Across staff positions, the most often reported parent-related problems were lack of time and the failure to understand a child's need for treatment, with almost 60% of the Health and Mental Health Coordinators citing the lack of parental understanding. The Mental Health Coordinators were approximately three times more likely than other staff to report parental resistance as a frequent barrier. The staff differences presented in Exhibit 5-5 clearly reflect the different responsibilities and domains represented by the staff, particularly when focusing on the often misunderstood field of mental health.

Exhibit 5-4 Specific Community Barriers to Care That Occur Frequently or Always Within Programs as Reported by Staff



Parents also were given the opportunity to report on barriers to care through an open-ended question about their experiences with accessing health services while enrolled in Head Start. Unfortunately, parental reports of barriers to care were almost nonexistent, allowing no comparison with the staff reports. This may have been due to the open-ended nature of the question. However, some program staff suggested that parents become so caught up in their day-to-day activities that the barriers they face are not always apparent to them. These staff members predicted a low frequency of parental reports.

there was a high degree of variability, based on the staff position of the respondent. For example, while substance abuse was rated as being critical by respondents in each staff position, 56% of the Mental Health Coordinators listed concerns in this area. This was about 15% more than the other staff positions. Child physical and sexual abuse was also a key risk factor cited by more than twice as many Mental Health Coordinators as by any other staff position. However, some of the risk factors addressed by staff in other positions—inadequate housing or clothing, low immunization rates, poor hygiene, and infection with human immunodeficiency virus (HIV) or other sexually transmitted diseases (STDs)—were not mentioned by the Mental Health Coordinators. The lack of parent education and parenting skills were consistently mentioned as risk factors by approximately 20% of the staff in each position. Surprisingly, the lack of immunizations was rated much higher by the Parent Involvement Coordinators than by other staff. This ranking may reflect the roles that these Coordinators assume in assisting parents obtain health services, particularly parents preparing their children to leave Head Start and enter kindergarten. For example, Parent Involvement Coordinators take an active role in working with parents to prepare families for kindergarten, a transition that involves updating immunizations.

Exhibit 5-6 Community Health Risk Factors as Reported by Staff

Risk Factors	Percent			
	Health Coordinator	Mental Health Coordinator	Parent Involvement Coordinator	Center Director
Substance Abuse	36.0	56.0	28.0	41.0
Lack of Parenting Skills	21.4	16.7	16.7	16.9
Lack of Access to Support Services	19.0	13.5	22.0	15.5
Poor Nutrition	18.9	3.0	21.7	7.0
Poverty	16.5	25.0	9.5	2.5
Lead	16.5	0.0	14.5	5.0
Inadequate Housing or Clothing	0.0	7.1	11.9	
Physical/Sexual Abuse/Neglect	9.5	38.7	14.5	5.0
Community Violence	7.1	19.4	0.0	11.9
Poor Hygiene	7.1	0.0	4.8	8.5
Lack of Immunizations	7.1	0.0	44.9	5.1
Adolescent Pregnancy	2.4	11.1	4.8	3.4
HIV/AIDS/STDs	2.4	0.0	14.3	11.9
N	42	37	39	59

Program Responses to Health Risk Factors. Head Start staff were very consistent in describing how programs address local risk factors. Parenting workshops were listed by 50-70% of the staff as a frequently used method of helping families overcome risk factors, although each of the methods, including interagency collaborations, job counseling and referral, advocacy training for parents, and individual and family counseling, was frequently used by at least 40% of the programs. This is validated by the staff reports that a majority of programs address health risk factors through their parent education activities. Specific parent

education topics, such as providing information on immunizations (see Chapter 6: Health Education), address some of the risk factors reported by individual staff.

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program. The reports of nutrition activities were very consistent among the Nutrition Coordinators. Listed nutrition activities were identified as being used at 80% or more of the programs. Many activities, such as setting the table (100.0%) and cleaning up after the meals (100.0%), were ones easily incorporated into regular meal-related classroom activities.

Exhibit 6-1 Health-Related Activities Included in Children’s Educational Programs as Reported by the Health Coordinators

Activity	Percent
Washing Hands Before Meals	100.0
Talking About Good Nutrition and Healthy Foods	100.0
Talking About Safety in the Neighborhood or Playground	100.0
Supervised Tooth Brushing	97.6
Learning Good Grooming Habits	92.9
Talking About Safety at Home	90.5
Talking About Feelings and Friendships	81.0
Talking About the Use of Tobacco or Drugs	61.9
Talking About Disabilities	46.3
Talking About Physical and Dental Examinations	45.2
N	42

Parent Reports of Health Education Topics Discussed with Children. One feature of health education is the focus on increasing health knowledge to produce attitudes and behaviors related to good health. A very positive note was that 96.3% of the parents (N=1,145) reported discussing health topics and activities at home with their children during the Head Start program year. The topics discussed are listed in Exhibit 6-2. As shown, oral health, sanitary and grooming practices, safety, interpersonal relationships and good nutrition are the most frequently discussed topics, which are well matched to the classroom activities identified by staff.

Tooth Brushing	52.0	21.7
Feelings and Friendships	44.6	22.6
Sanitary Practices	44.6	18.8
Good Grooming Habits	44.3	19.1
Good Nutrition and Healthy Foods	38.1	28.2
Safety at Home	37.2	22.9
Safety in the Neighborhood or Playground	34.5	21.3
Physical Activity and Fitness	27.7	17.4
Disabilities (Their Own and Other People's)	20.3	12.0

*Percentages based on 1,189 parents sampled; a total of 791 (66.5 percent) reported behavioral changes.

Parents most often mentioned an improvement in their children's tooth brushing behavior. This is particularly important in light of the results of dental examinations reported in Chapter 9: The Dental Health Domain. The areas where behavioral changes in children were reported by their parents include sanitary and grooming practices, interpersonal relations (feelings and friendships), safety, and nutrition. Again, these areas are quite consistent with the health-related classroom activities reported by Head Start staff.

Parent behavior changes that were most frequently reported were in the areas of nutrition, safety, feelings and friendships, and oral health. It remains unclear from these reports how much of the parents' behavior change is due to formal parent education activities, informal discussions with Head Start staff, or the impact of children sharing the information at home, but each of these likely had some impact. One interesting result is that 10.7% of the parents reported that since entering Head Start their children had helped to change the health habits of other children and/or adults in their household.

Observations of Head Start Meals. In the daily routine of Head Start programs, meals provided the research staff with an opportunity to observe a common nutrition education activity across all of the study sites. The staff observed 177 meals, of which 58.3% were lunches, 24.6% were breakfasts, and 17.1% were snacks. The purpose of observing

meals was to note how programs incorporated health education activities into the regular classroom routine. Head Start staff sat with the children 97.2% of the time, and 87.6% of the time they ate with the children. This suggests a great opportunity for exchanging nutrition information with the children. At 61.4% of the meals, staff were observed providing children with information about the food on the table. The children were encouraged to eat the available foods 74.6% of the time, and were encouraged by staff to taste specific foods at 77.7% of the meals. Many child-centered activities designed to encourage appropriate health behaviors among the children were observed before, during, and after the meals. The observations of these activities, summarized in Exhibit 6-4, show that washing hands (88.1%) and clearing the tables after meals (87.0%) were the most common activities that children engaged in at mealtimes.

Whether or not snacks were included, children were observed brushing their teeth after less than 60% of the meals. While many Head Start classrooms have facilities for the children to brush their teeth in the classroom, this was not always the case. Because the data collectors were instructed to include only behaviors that they actually observed, certain behaviors, such as tooth brushing, may be under-reported. Although a higher percentage was expected, it is noted that this particular activity is recommended, but not required, under the Program Performance Standards.

topics covered parenting, child development, and the linking of families to health services in the community as well as specific health-related topics. The education topics most frequently reported were parenting (83.3%), child growth and development (82.8%), and nutrition and meal planning (80.8%). These figures do not, however, provide an indication of the extent of parents' participation in these activities.

Exhibit 6-5 Topics for Activities and Educational Information Presented by Head Start as Reported by the Parents

Topic Area	Percent
Parenting	83.3
Understanding Child Growth and Development	82.8
Nutrition and Meal Planning	80.8
Safety in the Home	78.1
“Helping Agencies” in the Community	75.0
Preventive Medical and Dental Care for Family Members	73.7
Physical Fitness	70.0
Substance Abuse	67.0
First Aid	66.2
Domestic Violence	64.0
Medical and Dental Care for Family Members Needing Services	56.5
N	1,189

Staff Reports on Parent Education. A primary responsibility of the Parent Involvement Coordinator is to develop parent education programs. The frequency with which such classes were offered varied greatly across the programs studied. According to the Parent Involvement Coordinator reports, 26.2% of the programs held classes once a week or more, 14.3% held classes only once a week, 42.9% held them less than once a week but at least every month, and 9.5% offered classes less than once a month.

Staff reports of the health-related topics covered by the Head Start-sponsored classes varied by staff position. Some individual items were not included on the interview forms for

all of the staff positions (e.g., Mental Health Coordinators were not asked about cooking classes). Most staff, regardless of their position, agreed that their programs offered classes covering parenting, child growth and development, domestic violence (including child abuse and neglect), discipline, and health risk factors (See Exhibit 6-6). The first three of these are consistent with the parent reports on the education activities and with the specific health risk factors identified by staff.

Exhibit 6-6 Parent Education Topics as Reported by Staff

Service	Percent		
	Health Coordinators	Mental Health Coordinators	Center Directors
Nutrition	97.6	—	90.5
Health Education	95.2	—	95.2
Immunizations	92.9	—	78.6
Parenting	88.1	89.2	95.2
Preventive Health Care	88.1	—	85.7
Safety	85.7	—	88.1
First Aid	85.7	—	85.7
Child Abuse and Neglect	83.3	92.1	85.7
Child Growth and Development	81.1	83.8	90.5
Family/Domestic Violence	81.1	75.7	76.2
Discipline	78.6	89.2	85.7
Cooking	61.9	—	42.9
Health Risk Factors	54.8	67.6	71.4
Fitness	35.7	—	50.8
N	42	37	59

Note: — indicates that responses for this item were not obtained from that staff position.

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year-old children. First, individual State requirements for entrance into kindergarten were generally less stringent than the Head Start requirements. In a survey completed by the CDC in 1992, the majority of States required 4 or fewer DTP and 3 or fewer OPV for school entrance. This may be due, in part, to the high cost of DTP vaccinations across multiple administrations, compared to the other specific vaccinations (CDC, 1996). Second, the Program Information Report (PIR) reporting requirements through 1993-94 employed the “4-3-1-1” standard (beginning in the 1994-95 year, those requirements were modified to reflect Head Start IM 94-13). Throughout the 1990s, the combined PIRs from all of the Head Start programs indicated that well over 85% of the children were fully immunized according to the “4-3-1-1” criterion. That criterion was, and remains, consistent with national advisory group recommendations for 3-year-old children.

This chapter presents immunization rates for the 4-year-old children in the study sample relative to immunization data obtained from other Head Start-based reports. Rather than simply evaluating immunization rates to estimate compliance with the Program Performance Standards, a primary focus has been to explore differences across multiple sources of immunization information in order to establish whether or not problems exist in obtaining, recording, and/or reporting immunizations or if there are other areas of concern that should be addressed to assure that the immunizations of Head Start children meet program expectations.

administrations were required. For DPT, only 9.5% of the Health Coordinators reported that five administrations were required; for OPV, only 26.2% accurately stated the requirement for four administrations. The source of confusion on this issue might be traced to the more lenient State school immunization requirements, the PIR reporting requirements, or both. However, no statistical association was found between individual State requirements and the Health Coordinators' reports. Nor were there any relationships between the Health Coordinators' reports and educational qualifications, program size or auspice.

It is important to note that the responsibility for ensuring that 4-year-old children completing Head Start are immunized at the nationally-recommended level for school entrance is generally that of the Parent Involvement Coordinator. As indicated earlier in Exhibit 5-6, the most frequently reported health risk factor reported by the Parent Involvement Coordinators was the lack of immunizations, while other Health Component staff identified other risk factors far more often. Nevertheless, additional clarification and consistent information regarding the immunization of children after their fourth birthdays would improve the understanding of key Head Start staff regarding program responsibilities for immunization.⁴

⁴ The revised Head Start Program Performance Standards currently may provide local Head Start programs with some flexibility with regard to immunization requirements.

conditions that their program confronted during the past year. Staff responses were based on recall; the respondents did not have the opportunity to review records or reports prior to providing their answers. All of the responses were coded into categories similar to those used with the child-level health condition data. Because these are not child-level reports, the staff reports of health problems are presented separately from the actual child data.

The reports provided by the Health Coordinators and Center Directors had interesting similarities and differences. Exhibit 8-1 provides lists of the health conditions most often reported by the Center Directors and Health Coordinators. These lists shared some common concerns, such as lice, asthma, dental and other oral health problems, and childhood illnesses (e.g., measles, chicken pox). However, more than 20% of the Health Coordinators also mentioned blood disorders and more than 10% mentioned malnutrition, while neither problem was on the list of conditions reported by the Center Directors. Dental conditions were named by just under 50% of the Health Coordinators and by only 25% of the Center Directors. On the other hand, Center Directors placed childhood illnesses and lice at the very top of their list (27.8% for each), while 18.0% mentioned the flu and colds as being serious problems. The latter condition was not listed by the Health Coordinators. While the Health Coordinators were likely to focus on problems that place demands on program resources (e.g., arranging screenings and treatments, securing funding), the Center Directors were more likely to report health problems, such as colds, flu, and lice, which have a significant impact on classroom activities and attendance.

