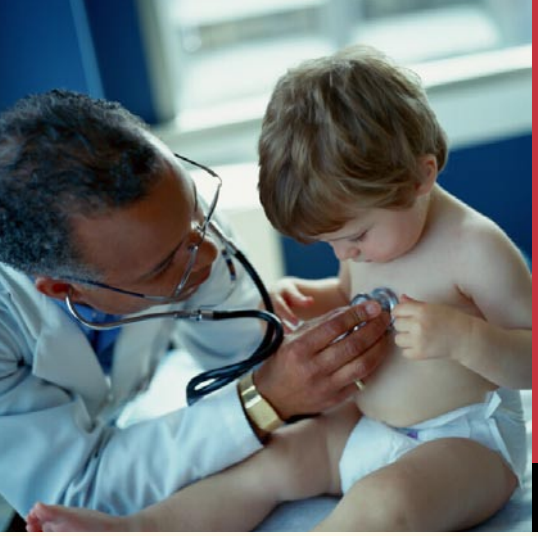

RESEARCH TO PRACTICE

Health and Health Care Among Early Head Start Children

EARLY HEAD START RESEARCH AND EVALUATION PROJECT

Health services are a central focus of Early Head Start because good health is important to children's development. Some Early Head Start programs facilitate access to health care, while others provide health services directly. The Head Start Program Performance Standards (U.S. Department of Health and Human Services [DHHS], 1996) require programs to assist families in obtaining health insurance and a regular source of health care. The Performance Standards also require programs to ensure that children receive all recommended well-baby care and treatment for health problems.

Health Findings and Lessons from the Research

Health status and access to health care were studied as part of the Early Head Start Research and Evaluation Project. This rigorous, random-assignment study involved 3,001 families and 17 programs around the country (see page 4). Findings provide valuable information on the impact of Early Head Start services on children's health (Administration for Children and Families, 2004). Other findings examine variations in health services among program families.

Did Early Head Start impact the health status of children?

Early Head Start had small but statistically significant favorable impacts on the percentage of children who visited a doctor for treatment of illness (83 vs. 80 %), receipt of immunizations (99 vs. 98%), and the likelihood of hospitalization for accident or injury (0.4 vs. 1.6%).[1]

[1] Findings for impacts on health service use and health outcomes may be limited by the high rate of health care services received by the program and control groups and the fact that many of the research programs recruited families at health clinics or WIC offices, where families were linked to health services before applying to Early Head Start.

What was the health status of children in Early Head Start?

The majority of children were in excellent or very good health. Fifty-six percent were reported by their parents to have excellent or very good health as infants (at 14 months). This increased to 65% when children were 24 months old and 71% at 36 months. The health status of program children was similar to the health status of low-income children in other national studies.

The youngest children in Early Head Start were most vulnerable. More children were reported by their parents to be in fair or poor health at 14 months (19%) than at 36 months old (8%).

What were the most frequent health and safety problems?

The incidence of asthma and respiratory problems was high. By the time of the 28-month interview (when children were on average 32 months old), 28% of the children were reported by their parents to have been diagnosed with asthma or respiratory problems.

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The Challenge for Early Head Start

Meeting the health care needs of Early Head Start infants and toddlers is challenging. In general, children in low-income families are more likely than other children to experience fair or poor health, less likely to have health insurance and access to quality health care, and more likely to experience exposure to environmental risks (DHHS, 2002). For Hispanic children, language and cultural issues also pose barriers to health care (Flores & Vega, 1998).

The health status of infants and toddlers can support or limit efforts to enhance development in other domains; therefore, it is important for Early Head Start staff to learn about the health of participating children. Knowledge of health problems can help staff identify and begin to address gaps in health services in the families' service plans.

EARLY HEAD START

Exposure to household smoking was also high and a likely contributor to the high rate of asthma and ear infections among Early Head Start children. Fifty-seven percent of children were exposed to household smoking. Children exposed to household smoking were more likely to have asthma or respiratory problems (31%) than children who were not exposed to household smoking (24%). Further, children exposed to household smoking were more likely than those who were not to have ear infections (55 vs. 47%).

Most parents implemented important safety precautions but needed more information on poison control measures. Most parents (94%) reported using guards at stairs and maintaining a working smoke detector. More than 80% of parents also reported using window guards, covering electrical outlets, and maintaining a safe play environment. However, 48% did not know how to access the telephone number for a poison control center.

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Almost all parents used car seats when children were infants, but fewer used car seats when children were toddlers. Car seat use declined from 96% when children were 14 months old to 71% at 36 months old. The decline in car seat use may reflect the fact that older children did not like to be restrained or that parents did not have the resources to replace an infant car seat with a toddler seat.

Few children were reported by their parents to have been diagnosed with more serious problems, including seizures (2%), heart problems (4%), and diabetes (2 children). According to parent reports, 6% of children had been diagnosed with high lead levels. The incidence of high lead levels was higher in urban areas and lower in center-based programs.

Did Early Head Start children have health insurance and access to care?

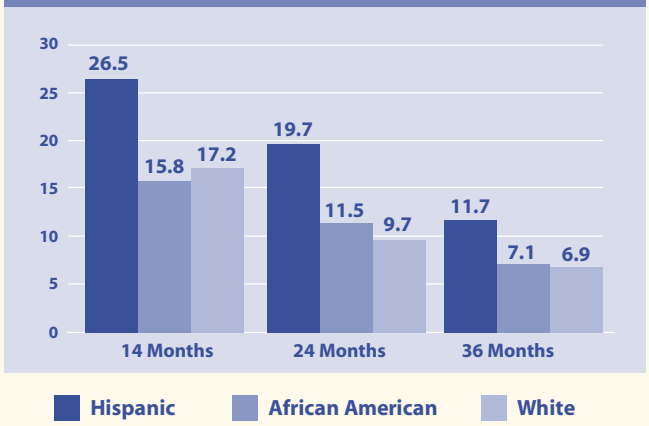
Early Head Start children were more likely than low-income children nationally to have health insurance; however, the rate of coverage declined across time. Nationally, 79% of children under 18 in low-income families had health insurance (U.S. DHHS, 2002). Insurance coverage among Early Head Start children declined from 91% six months after enrollment to 87% twenty-eight months after enrollment. Children not covered by insurance were more likely than those with insurance to be Hispanic children and to have mothers who had not completed high school or received a GED. Children in center-based programs were more likely than children in other types of programs to have private health insurance. This may reflect the fact that families in center-based programs were more likely to be employed and have access to employee health benefits than families in home-based or mixed programs.

All children had received some health services (according to their parents, they had been seen by a health professional or received immunizations or screening tests). By 28 months after enrollment, 95% had received one or more well-child exams, 99% had received some immunizations, and two-thirds were reported to have received some screening tests. Parents reported that 41% had had a hearing test and 28% had received lead screening. Children in center-based and mixed programs were more likely to have had screening tests, particularly hearing and lead screening, than children in home-based programs.

Were some groups at greater risk for health concerns than others?

Hispanic families in Early Head Start were at increased risk due to a number of factors. Hispanic children were less likely to have health insurance (73%) than African American/Black children (92%) and White children (90%). Hispanic children were also less likely to have a regular health care provider (88%) than other children (96%). Parents of Hispanic children were more likely to report their children were in fair or poor health (see Figure). Reasons for the increased health risk among Hispanic children may include the increased environmental risks and the language and cultural barriers faced in accessing care (Flores et al., 2002).

Percentage of Children in Fair or Poor Health, by Race/Ethnicity



Also, some Hispanic parents may have been reluctant to seek needed health care due to concerns about legal immigration status.

African American children were more likely to have asthma or respiratory problems (36% compared to 29% of White and 19% of Hispanic children). Increased exposure to environmental pollutants and decreased access to specialized health care may be related to the increased rate of asthma among African American/Black children (American Lung Association, 2003).
Teen mothers were in need of information on safety practices and appropriate use of health care services. Mothers who were teenagers when their children were born reported implementing fewer safety practices (average of 4.8 vs. 5.2 for older mothers), were more likely to report using hospital emergency rooms (59 vs. 52%), were more likely to use an emergency room as their usual place of care (3 vs. 1%), and were less likely to report their child had received a well-child exam (94 vs. 96%). Lack of knowledge among teen mothers about important safety practices and the appropriate use of health care services may have contributed to these differences.

Implications for Programs

Ongoing monitoring of health insurance coverage is important. In addition to asking about health insurance coverage at enrollment, programs can be alert to gaps in coverage by **continuing to monitor children's health coverage**, particularly if parents' employment status changes. Programs may want to explore with their Health Advisory Committee reasons why families in their program may be losing health insurance. Is it lack of knowledge of requirements to maintain eligibility in Medicaid or the state's Child Health Insurance Program (CHIP)? Are families obtaining jobs and no longer eligible for Medicaid or CHIP, but not able to afford or not eligible for employee health coverage? Programs can partner with social service agencies to identify health insurance for which children might be eligible and facilitate families' enrollment in the appropriate program.

Programs can offer parent education to increase parents' awareness of safety precautions related to poison control. Programs can establish links with the nearest poison control center to provide parents with written information on poison control practices, including the phone number of the poison control center.

Programs can also offer **parent education on car seat use and link with community resources to ensure parents have car seats in the appropriate size for a toddler's weight.** Programs can explore reasons why parents in their program may not continue using car seats for toddlers. Are parents aware of the need for car seats past infancy? Do parents need suggestions for ways to entertain children so they remain in their car seat? Or, do parents lack resources to replace the infant car seats their toddlers have outgrown? Programs can offer parent education and partner with local SAFEKIDS coalitions to assist families in obtaining free or low-cost car seats.

Parent education is needed to reduce children's exposure to household smoke and prevent asthma. Programs can link with local health providers to offer parent education on the relationship of asthma and household smoke and to refer families for smoking cessation programs. Programs may want to target more intensive education efforts for African American families, where the incidence of asthma is highest.

Programs need to be aware that health risks and health care needs vary among groups of families. **Hispanic families have a number of health risks and experience language and cultural barriers in accessing health care for their children**. Programs can explore with their Health Advisory Committee what barriers Hispanic families in their community may experience in accessing health care for their children. For example, are translators available at health centers used by Hispanic families? Do Hispanic parents have concerns about their legal status? If so, programs can link with the community health centers that provide care regardless of families' legal status. Some Early Head Start programs have

arranged translation services for parents during health care visits. Other programs have addressed Hispanic children's increased environmental risk by working to be sure children receive needed assessments, including lead screening.

Programs should continue efforts to **ensure children receive all recommended screenings**. Programs can work with their Health Advisory Committee to determine if children in their program have increased exposure to particular environmental risks such as lead poisoning and partner with local health providers to conduct screening for children in their program. Home-based programs, where children are less likely to receive hearing and lead screenings, can provide parent education on recommended child health screenings to empower parents to advocate for these services for their children at well-baby visits.

The Study

The Early Head Start Research and Evaluation Project included studies of the implementation and impacts of Early Head Start. The research was conducted in 17 sites representing diverse program models, racial/ethnic makeup, auspice, and region. In 1996, 3,001 children and families in these sites were randomly assigned to receive Early Head Start services or to be in a control group who could utilize any community services except Early Head Start. This research brief draws on data collected in the Early Head Start Research and Evaluation Project and findings from a sub-study that examined the health status and health care of 1,500 Early Head Start program families. The data on children's general health status and parent safety practices were collected in birthday-related interviews when children were approximately 14, 24, and 36 months old. All other health data were collected during the parent interviews on service use at approximately 7, 16, and 28 months after random assignment and at program exit. It is important to note that the information on health and health care was collected from the children's primary caregivers-not from medical records-so the data were subject to caregivers' recall of health histories and services received, as well as caregivers' understanding of medical terminology and children's health conditions. Several research briefs have been published based on findings from this study. A prekindergarten followup was completed and a 5th grade followup is currently underway.

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