

A Descriptive Study of the Head Start Health Component

Volume I: Summary Report

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TABLE OF CONTENTS

Executive Summary

1.0	Introduction	1-1
1.1	Research Questions	1-3
1.2	Study Overview	1-4
1.3	Organization of the Report	1-5
2.0	Historical Context of the Health Component	2-1
2.1	Functions and Organization of the Head Start Health Component	2-2
2.2	Barriers to Health Care for Head Start Children and Families	2-6
2.3	Current Health Context for the Head Start Program	2-7
2.4	Head Start Program Growth and Quality	2-9
3.0	Methodology	3-1
3.1	Overview	3-1
3.2	Description of Head Start Universe	3-1
3.3	The Sampling Plan	3-3
3.4	Description of Study Sample	3-4
3.4.1	Head Start Children and Parents	3-4
3.4.2	Head Start Staff	3-6
3.5	Data Collection Instruments	3-7
3.5.1	Data Sources	3-7
3.5.2	Instrument Development	3-8
3.6	Staffing	3-8
3.7	Data Collection Procedures	3-9
3.8	Record Keeping Issues	3-10
3.9	Data Analysis	3-11
4.0	Program Staffing and Staff Qualifications	4-1
4.1	Overview	4-1
4.2	Findings	4-2
4.2.1	Program Staffing	4-2
4.2.2	Staff Qualifications	4-6
4.2.3	Staff Certification and Training	4-9
5.0	Program Procedures and Linkages with the Community	5-1
5.1	Overview	5-1
5.2	Findings	5-3

5.2.1	Community Resources	5-3
5.2.2	Staff Activities with Community Providers	5-5
5.2.3	Child Health Files	5-8
5.2.4	Health Screening and Examination Procedures	5-8
5.2.5	Treatment Procedures	5-9
5.2.6	Barriers to Care	5-10
5.2.7	Perceived Community Health Risk Factors	5-13
6.0	Health Education	6-1
6.1	Overview	6-1
6.2	Findings	6-2
6.2.1	Health Education Provided to Children	6-3
6.2.2	Health Education Provided to Parents	6-8
7.0	Immunizations	7-1
7.1	Overview	7-1
7.2	Findings	7-4
7.2.1	Head Start Child Health Records	7-4
7.2.2	Parent-Provided Immunization Records	7-5
7.2.3	Health Coordinators' Knowledge of Immunization Requirements	7-6
8.0	The Medical Health Domain	8-1
8.1	Overview	8-1
8.2	Findings	8-2
8.2.1	Staff Reports of Perceived Health Problems	8-3
8.2.2	Health Histories and Child Health Files	8-4
8.2.3	Timing and Methods of Completing Physical Examinations	8-5
8.2.4	Medical Conditions and Injuries	8-6
8.2.5	Findings From the Health Assessments	8-12
8.2.6	Medical Treatments	8-14
9.0	The Dental Health Domain	9-1
9.1	Overview	9-1
9.2	Findings	9-2
9.2.1	Timing and Methods of Completing Dental Examinations	9-3
9.2.2	Dental Conditions	9-4
9.2.3	Dental Treatments in the Study Sample	9-5
10.0	The Mental Health Domain	10-1
10.1	Overview	10-1
10.2	Findings	10-3
10.2.1	Issues Encountered While Studying the Mental Health Domain	10-3
10.2.2	Staffing the Mental Health Domain	10-5

10.2.3	Perceived Mental Health Problems	10-6
10.2.4	Screenings and Assessments	10-7
10.2.5	Conditions	10-10
10.2.6	Treatments	10-12
11.0	The Nutrition Domain	11-1
11.1	Overview	11-1
11.2	Findings	11-2
11.2.1	Screenings	11-2
11.2.2	Conditions	11-2
11.2.3	General Status	11-4
11.2.4	Treatments	11-4
11.2.5	Head Start Meals	11-5
12.0	Summary and Recommendations	12-1
12.1	Overview	12-1
12.1.1	Study Background	12-2
12.1.2	Study Procedures	12-3
12.2	A Review of the Key Study Findings	12-4
12.2.1	What Are the Qualifications of the Health Component Staff?	12-4
12.2.2	What Kinds of Training Do the Health Component Staff Receive?	12-5
12.2.3	What Are the Primary Community Health Risk Factors Faced by Head Start Programs?	12-5
12.2.4	How Does Head Start Provide or Access Health Services for Children and Their Families?	12-6
12.2.5	What Health Services Are Provided at Head Start Centers?	12-6
12.2.6	What Are the Community Resources That Are Used Most by Head Start Programs?	12-8
12.2.7	How Do Other Federal and State Programs Play a Role in the Health Component?	12-7
12.2.8	How Are the Costs of Health Services Covered?	12-8
12.2.9	What Are the Barriers to Obtaining Health Services for Head Start Children?	12-9
12.2.10	How Does Head Start Incorporate Health Education into the Program?	12-9
12.2.11	How Successful Is Head Start in Encouraging Parents to Get Their Children Immunized?	12-10
12.2.12	What Are the Primary Medical Health Problems of Head Start Children?	12-12
12.2.13	What Are the Primary Dental Health Problems of Head Start Children?	12-13

12.2.14	How Does the Health Component Integrate Mental Health Services?	12-14
12.2.15	What Is the Nutritional Status of Head Start Children?	12-15
12.3	Strengths and Limitations	12-15
12.4	Implications for Head Start Program Practices	12-17
12.4.1	Staff Training and Support	12-17
12.4.2	Immunizations Records and Knowledge	12-18
12.4.3	Mental Health Issues	12-18
12.4.4	Treatment Follow-Up	12-19
12.4.5	Record Keeping	12-20
12.4.6	Collaboration Activities	12-20
12.5	Recommendations for Future Research	12-21
12.6	Conclusions	12-22

LIST OF EXHIBITS

Exhibit 2-1	Head Start Program Performance Standards: Health Care Services Provided to Children Under the Health Component	2-3
Exhibit 2-2	Forces Impacting the Health/Health Care of a Head Start Child	2-6
Exhibit 3-1	Summary of Head Start Program Characteristics From PIR* Data	3-2
Exhibit 3-2	States Covered During Site Visits	3-4
Exhibit 3-3	Demographic Data From the Parent Interviews and Reviews of the Child Health Files	3-6
Exhibit 3-4	Head Start Staff With Completed Interviews	3-7
Exhibit 4-1	Program Staffing of the Health Component	4-3
Exhibit 4-2	Highest Level of Education as Reported by Staff	4-7
Exhibit 4-3	Percentage of Health Component Staff Reporting Bachelor or Nursing Degrees (or Higher) by Type of Sponsoring Agency	4-8
Exhibit 4-4	Percentage of Staff Holding Selected Certificates and/or Licenses	4-10
Exhibit 5-1	Payment Sources for Health Services as Reported by the Parents	5-4
Exhibit 5-2	Responsibilities Relative to Community Collaborations as Reported by Staff	5-6
Exhibit 5-3	Types of Treatment Available On-Site at Head Start Centers as Reported by the Health Coordinators	5-10
Exhibit 5-4	Specific Community Barriers to Care That Occur Frequently or Always Within Programs as Reported by Staff	5-12
Exhibit 5-5	Specific Personal Barriers to Care That Occur Frequently or Always Within Programs as Reported by Staff	5-13
Exhibit 5-6	Community Health Risk Factors as Reported by Staff	5-15
Exhibit 6-1	Health-Related Activities Included in Children’s Educational Programs as Reported by the Health Coordinators	6-4
Exhibit 6-2	Topics of Parent-Child Discussions on Health-Related Activities at Head Start as Reported by the Parents	6-5
Exhibit 6-3	Areas of Health Behavioral Changes Since Enrolling in Head Start as Reported by the Parents	6-6
Exhibit 6-4	Activities Children Were Observed Participating in Around Meal Time/Snack Time	6-8
Exhibit 6-5	Topics for Activities and Educational Information Presented by Head Start as Reported by the Parents	6-9
Exhibit 6-6	Parent Education Topics as Reported by Staff	6-10
Exhibit 7-1	Percentage of 4-year-old Children with DPT, OPV, MMR, and Hib	

	Immunizations as Noted in the Child Health Records	7-5
Exhibit 7-2	Percentage of Children Fully Immunized as Noted in the Parent Records and the Child Health Records	7-6
Exhibit 8-1	The Most Serious Health Conditions as Reported by the Health Coordinators and the Center Directors	8-4
Exhibit 8-2	Specific Screening Tests and Their Inclusion in the Physical Examination as Reported by Health Coordinators	8-6
Exhibit 8-4	The Most Reported Health Conditions from the Child Health Files: a Comparison of Pre- and Post- Head Start Enrollment	8-11
Exhibit 8-3	The Most Reported Health Conditions From Parent Interviews and the Child Health Files	8-8
Exhibit 9-1	Treatments for Conditions Noted During Dental Examinations as Reported by the Parents	9-7
Exhibit 10-1	The Most Serious Mental Health Conditions as Reported by the Mental Health Coordinators	10-6
Exhibit 10-2	Mental Health Services Frequently or Always Provided by Programs as Reported by the Mental Health Coordinators	10-8
Exhibit 11-1	Nutrition Referrals Noted in the Child Health Files	11-3

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

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EXECUTIVE SUMMARY

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

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

Overview

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

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

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

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

Content Areas of Study Findings

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

- **Prevention**
 - Immunizations
 - Health Education

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

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

A Summary of the Project Research Questions

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

The Historical Context of the Health Component

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

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

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

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

The Function and Organization of the Health Component

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

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

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

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

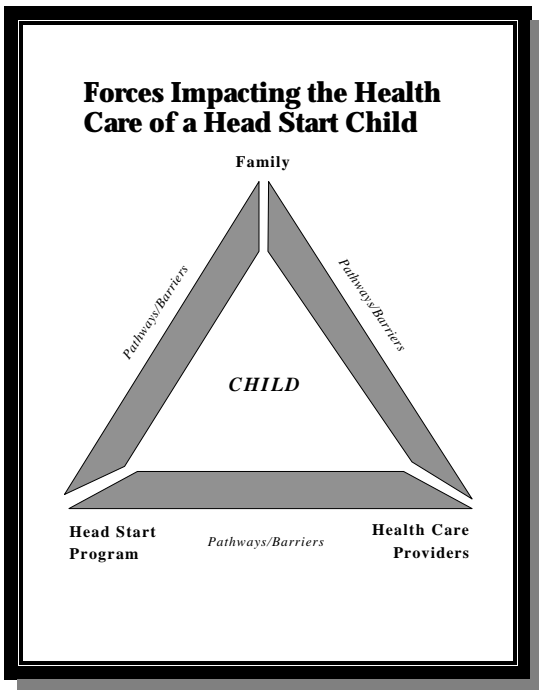
medical, dental, mental health, and nutrition. The Head Start Bureau has recently published a comprehensive revision of all the Program Performance Standards (Federal Register, 1996) effective January 1998, and is developing additional strategies for supporting health activities at the local level.

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

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

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

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



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

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

Methodology

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

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

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

Program Staffing and Staff Qualifications

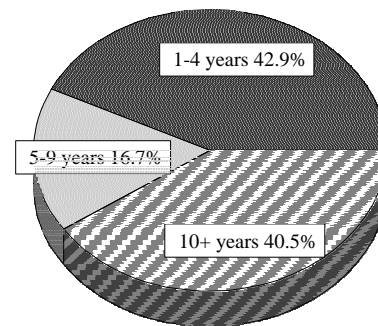
Head Start staff generally reflect a broad range of backgrounds and qualifications. Program staffing patterns and staff training were reported by staff associated with the Health Component. The highlights of those responses are presented below.

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

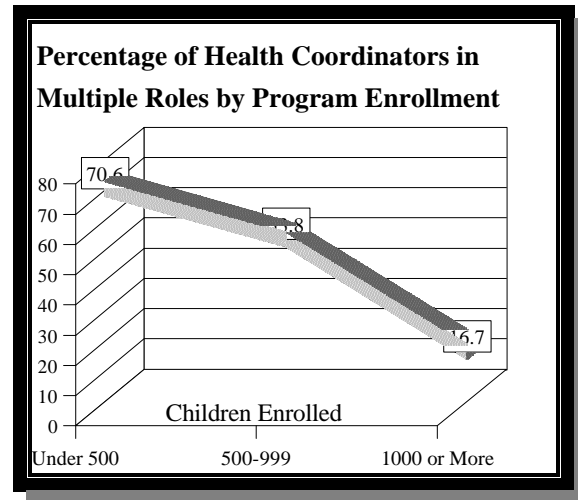
-Head Start staff

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

Number of Years Working at Head Start for Health Coordinators



- There is an inverse relationship between program size (based on the total count of children enrolled) and the performance of multiple staff roles. Health Component staff in programs with smaller enrollments more often reported performing multiple roles than did staff in larger programs and were generally less likely to have bachelor's or nursing degrees.



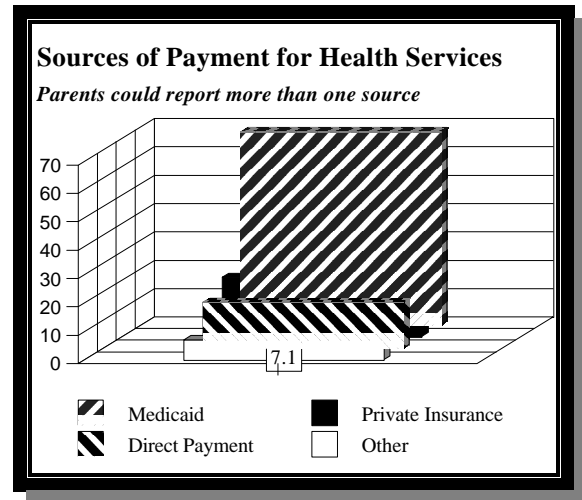
Linkages with Medicaid and Community Resources

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

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

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

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

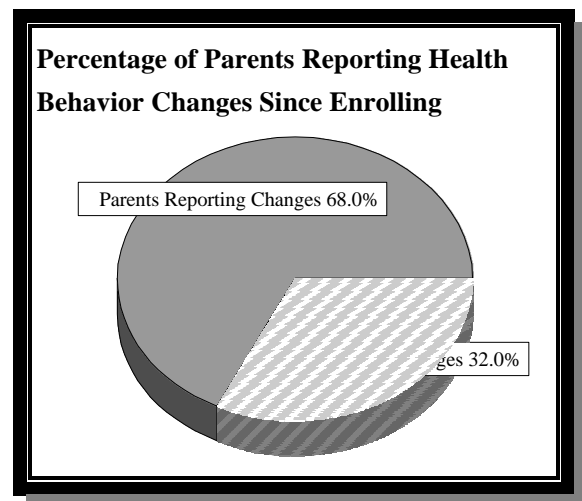


Health Education

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

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

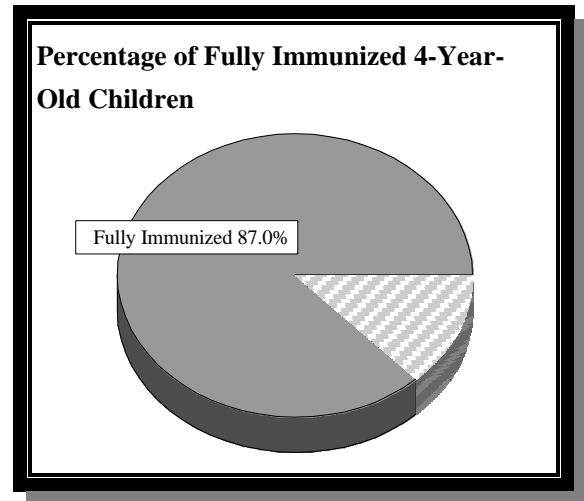
- Nutrition, personal hygiene, first aid and safety, and dental health were the most frequently covered classroom health education topics, each being cited by over 85% of the Health Coordinators. Mental Health Coordinators were most likely to list self-esteem and peer relationships as the mental health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



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.

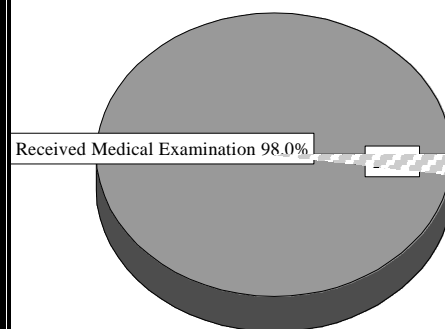
The Medical Health Domain

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**

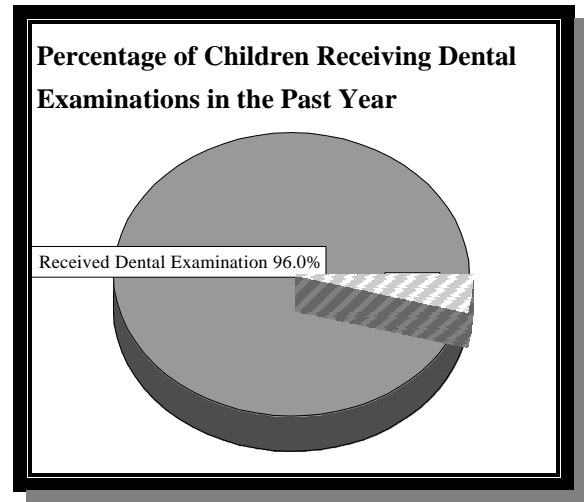
- Over 80% of the health records that reported a health condition requiring treatment contained no documentation on the status of these recommended treatments.

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.

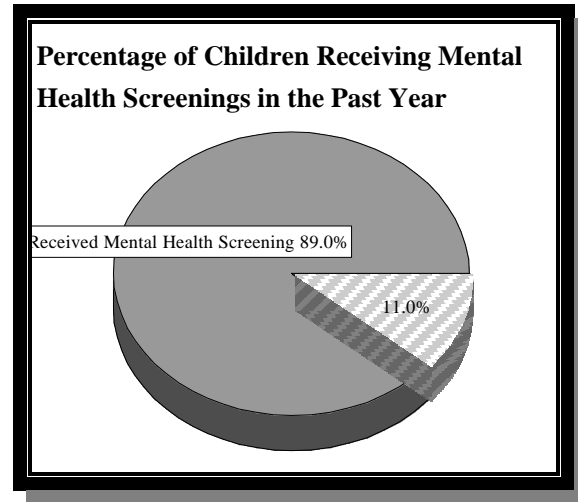


The Mental Health Domain

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.



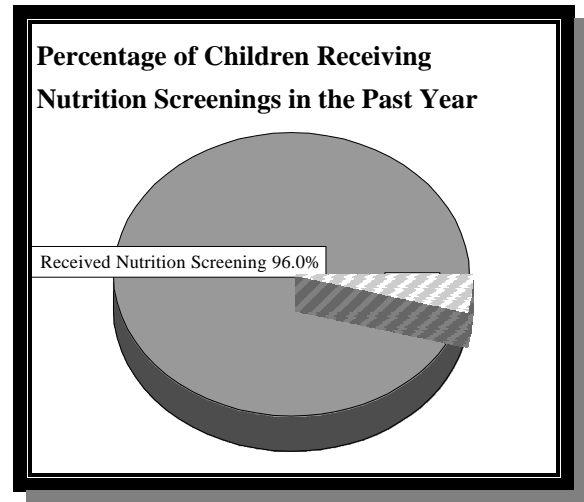
The Nutrition Domain

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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1.0 INTRODUCTION

“I love Head Start. It is the best program available for children. “

Head Start Parent

Founded in 1965, the Head Start program offers comprehensive services including early education, nutrition, health, and social services, along with a strong parent involvement focus, to low-income children nationwide. Its overall goal is to bring about a greater degree of social competence, which is defined as a child’s everyday effectiveness in dealing with both his or her present environment and later responsibilities in school and life, taking into account the interrelatedness of cognitive, intellectual, and social development; physical and mental health; and nutritional needs.

Head Start programs are funded through a direct Federal-to-local relationship, and include a wide range of programs that are community based, so they can respond to local needs and coordinate activities with other community agencies. They are guided by a set of Program Performance Standards that specify requirements in each of the functional areas, including disabilities.

The Head Start Bureau within the Administration on Children, Youth and Families (ACYF) in the Administration for Children (ACF), U.S. Department of Health and Human Services, (DHHS) has responsibility for oversight and leadership of Head Start programs nationwide. It also funds special initiatives, and develops legislative and budget proposals for programs. Local ACYF oversight is provided by 12 Regional Offices, which conduct compliance reviews of local programs every three years.

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

Information Report (PIR). It includes interviews with Head Start parents about how the program helps them obtain health services for their families, and with Head Start staff about the operation of the Health Component. The study results are based upon reports from a nationally representative sample of 1,189 families with 4-year-old children enrolled in 40 Head Start programs spread across the nation. This broad description of the Health Component is an important element of the Head Start Bureau's database on programs and children.

1.1 Research Questions

The purpose of this study is to describe the Head Start Health Component across the four health domains: medical, dental, nutrition, and mental health. The program elements described include:

- Head Start staffing patterns and prior and ongoing staff training and experience related to the Health Component;
- Utilization of community resources in the provision of health services;
- Barriers to the provision of health services for Head Start families and programs;
- Current preventive health efforts provided for children and parents; and
- Current screening, examination, referral, treatment, and follow-up procedures employed in each health domain.

Based on these elements, research questions were developed to drive the data collection effort.

1.2 Study Overview

The ACYF contracted with The CDM Group, Inc. (CDM) and its subcontractor Abt Associates, Inc. (Abt) to undertake this two-phase study. During **Phase I**, the research team designed the study, convened a Technical Advisory Panel, developed the necessary data collection instruments and plans, devised a study sample selection plan, and completed an Office of Management and Budget (OMB) clearance package. **Phase II** consisted of a pilot test, data collection, coding of the qualitative data, data analysis, and report preparation. The timeframe for data collection was April through June, 1994, assuring that all data would be collected before the children left Head Start to enter kindergarten.

The study design called for a sample of 40 Head Start programs. For each selected program, two centers were to be randomly chosen as target sites, for an expected total of 80 Head Start centers.¹ The goal of the research team was to interview program and center staff associated with the operation of the Health Component. At each center, an additional goal was to interview the parents of 15 randomly selected 4-year-old children and to review the Head Start health records for these children.

The research staff obtained information from nine primary data sources: Parents, Head Start child health records, meal observations at Head Start centers, Center Directors (or Lead Teachers), Health Coordinators, Mental Health Coordinators, Parent Involvement Coordinators, Nutrition Coordinators, and Budget Managers. The study was designed to take advantage of multiple sources of information regarding the health status of the children. In this way, the Head Start health records could be supplemented by parents' reports on the same information.

¹ In practice, one of the programs selected was entirely home-based and one had only a single center. Other selected centers were too small to support the intended sample, so additional centers were selected for three programs. A final set of 81 centers participated in the study (see Chapter 3: Methodology).

1.3 Organization of the Report

This report is organized into four volumes. Volume I contains the Executive Summary and a longer summary of the study findings. Volume II is a technical report with a detailed outline of the study methodology, including sampling and data collection methods. Volume II also includes eight chapters related to the study findings, a summary chapter, and the Executive Summary. The chapter structures of Volumes I and II are the same, facilitating the reader's ability to move from one volume to the other when more detailed or technical information is desired.

Volume III presents a summary of the qualitative data not included in Volume II. The qualitative data include follow-up interviews with the research associates who supervised the individual site visits and the detailed information that was summarized in Volumes I and II. It also includes several categories of responses from Head Start staff and parents to open-ended questions that are not summarized in the other volumes. Volume IV is the Appendices and contains the consent form, a summary of the relationship between the research questions and the data collection instruments, the data collection instruments, and a literature review.

1.0 Introduction	1-1
1.1 Research Questions	1-3
1.2 Study Overview	1-4
1.3 Organization of the Report	1-5

2.0 HISTORICAL CONTEXT OF THE HEALTH COMPONENT

“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

For three decades, research on the Head Start program has typically been devoted to the impact of the program on children, families, and communities. Further, there has often been an emphasis on the educational aspects of the program, and rarely have other aspects, including the Health Component, been the focus of a major study of Head Start. The current study is intended to provide descriptive information regarding 1) the characteristics of staff organization and procedures employed by Head Start programs to assure that appropriate health screenings, examinations, and treatments for Head Start children are completed; 2) assessments of perceived problems and barriers to assuring quality health care for Head Start children and families; 3) preventive health activities (health education and immunization) provided by the Head Start program; and (4) reported health conditions in the present population of Head Start children across medical, dental, mental health, and nutritional domains.

These areas have been important concerns for Head Start since the program’s inception in 1965. An intent to enhance social competence and to foster constructive opportunities for society to work together with low-income families in solving their problems was among the original objectives for Head Start. In the *Recommendations for a Head Start Program*, dated February 19, 1965, a panel of experts chaired by Dr. Robert Cooke of The Johns Hopkins University specified the basic elements of the future Head

Start program. Those elements included an extraordinary emphasis on health assessments and health education:

The objectives of a comprehensive program should include ... improving the child's physical health and physical abilities... tailored to the needs of the individual community and the individual child.

The Panel went on to specify in substantial detail the health-related evaluations and programs that should be integral to the Head Start program.

The overall goal of Head Start has always been to promote social competence among participating children (Zigler, et al., 1994), a comprehensive construct that includes, among other components, the concern that optimal health is an important factor related to successful social functioning. Children's health has been a focus of the program from its inception, and remains highly relevant more than 30 years later.

2.1 Functions and Organization of the Head Start Health Component

The Head Start Bureau established Program Performance Standards for each of the major program components (Education, Parent Involvement, Social Services, and Health) in 1975, and for the disabilities areas in 1993.¹ Grantees are required to comply with the Standards, which are accompanied by non-mandated guidance that elaborates on their intent and provides information on how they might be carried out. For the Health component, the overall requirements are to:

- Provide a comprehensive program of health services;
- Promote preventive health services and early intervention; and
- Provide families with the skills, insights, and linkages needed to obtain ongoing health care.

¹ Revisions of the Head Start Program Performance Standards have recently been completed.

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.

critical role as a service broker across a range of different community providers (Pizzo, 1993). After all other funding sources have been explored and exhausted, the Head Start program becomes the “dollar of last resort,” and will help parents pay for the health services needed by their children.

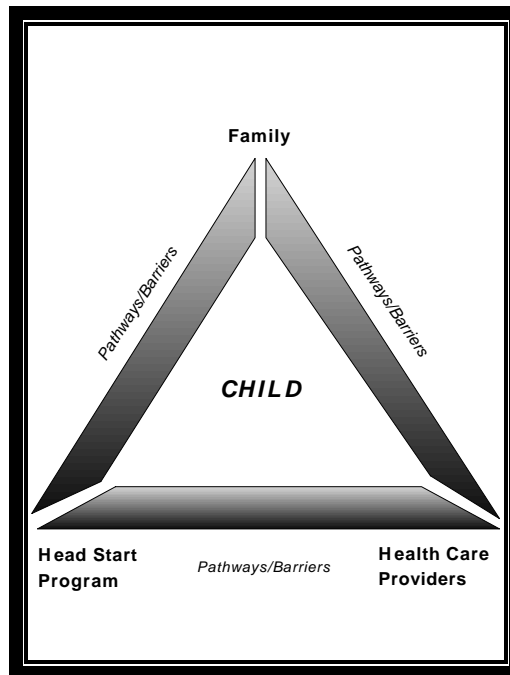
The effective transfer of health care information from the Health Coordinator or a member of the Health Component staff to the family member responsible for connecting the child to the health care system is an essential part of Head Start efforts. The Health Coordinator serves as a broker between Head Start parents and community health centers, clinics, and private providers. By identifying providers, furnishing information and assistance, and securing necessary funding, Head Start staff provide support and encouragement for parents 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 parents to be in a position to assume sole responsibility for these tasks after leaving the program.

In general, the work of Head Start in this area has been identified as a model for other child-service programs (Gomby, Lerner, Stevenson, Lewit, and Behrman, 1995). The program has long recognized that the health status of children and their educational development are inextricably linked (Novello, DeGraw, and Kleinman, 1992; Zigler, et al., 1994). Efforts to create links between child care providers and health care providers are a crucial component of the Health Component, as noted by the Advisory Committee on Head Start Quality and Expansion. In order to make use of available community resources to benefit Head Start children and families, each program is required to establish a working relationship with organizations in the community it serves.

2.2 Barriers to Health Care for Head Start Children and Families.

Parents of Head Start children face a number of significant barriers to obtaining health care: financial, geographic, and institutional barriers inherent in the community, as well as personal and cultural barriers that exist within families. As illustrated in Exhibit 2-2, the health and health care for a Head Start child is influenced by three major resources (the family, available health care providers, and the Head Start program) and by the pathways/barriers that affect communication among those support elements. The Head Start program is designed to improve the pathways between families and health care providers, while also providing families with the knowledge and skills needed to minimize the influence of barriers to quality health care for the child.

Exhibit 2-2 Forces Impacting the Health/Health Care of a Head Start Child



2.3 Current Health Context for the Head Start Program

The current context of health risks that are encountered by children in low-income families is an important factor in an examination of the patterns of delivery and use of health

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),

suggesting that significant numbers of Head Start children require dental treatment when they enter the program.

Nutrition. Inadequate nutrition during childhood has been found to have lifelong effects on the health and functioning of the individual. Nutrition problems (typically iron deficiency anemia) have long been associated with poverty. More recently, the incidence of childhood obesity related to poor dietary selection and inadequate exercise has reportedly increased among children from low-income families (Yip, Scanlon & Trowbridge, 1993).

Mental Health. The number of children receiving mental health services in a given year has increased significantly since 1980. Children in low-income families are increasingly exposed to homelessness, the incarceration of family members, and the death of relatives or close acquaintances due to causes such as acquired immunodeficiency syndrome (AIDS), substance abuse, and violence in their neighborhoods and homes. In addition, reports of child abuse and neglect across all social strata have continued to increase (Gelles, 1995). Faced with such conditions and incidents, national concern for the mental health of children has increased. Left untreated, mental and emotional disorders can lead to impaired social functioning, adaptation, and productivity. Poverty places children at greater risk for “a host of biologic insults that threaten the integrity of the central nervous system,” and epidemiologic studies have shown an association between organic brain dysfunction and psychiatric disorder in children (Hertzog, 1992).

2.4 Head Start Program Growth and Quality

In recent years, many Head Start programs have been granted increased funding. Between 1990 and 1995, the Head Start appropriation increased from \$1.5 billion to \$3.5 billion (Head Start Fact Sheet, February, 1995). This funding is intended to both increase the number of children served and to improve the quality of Head Start programs. While increased

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.

2.0 Historical Context of the Health Component	2-1
2.1 Functions and Organization of the Head Start Health Component	2-2
2.2 Barriers to Health Care for Head Start Children and Families	2-6
2.3 Current Health Context for the Head Start Program	2-7
2.4 Head Start Program Growth and Quality	2-9

Exhibit 2-1	Head Start Program Performance Standards: Health Care Services Provided to Children Under the Health Component	2-3
Exhibit 2-2	Forces Impacting the Health/Health Care of a Head Start Child . . .	2-6

3.0 METHODOLOGY

“Great program—the primary concern is the children and this is evident in the decisions they make.”

Head Start Staff

3.1 Overview

Chapter 3 describes the data collection methodology, with primary focus on the sampling plan, weighting of the study sample to provide national estimates for Head Start, the development of the data collection instruments, and the data collection procedures employed with parents and staff at the study sites.

3.2 Description of Head Start Universe

Data on Head Start programs were obtained from the 1992-93 PIR, a self-completed report submitted by each program at the conclusion of the program year. Because this study was conducted during the 1993-94 academic year, the 1992-93 PIR was the most recent source of information on all Head Start programs available for use in constructing the sampling frame.¹ However, the 1993-94 PIR data best describe the universe of Head Start programs at the time of data collection for this study (April-June, 1994). Exhibit 3-1 compares information from the 1992-93 PIR and the 1993-94 PIR, and contains data specific to the 40 study programs. This table shows that the earlier data from 1992-93 were

¹Since only 4-year-old children were targeted in the study, the universe of Head Start programs included programs operating during the 1992-93 school year that also enrolled 4-year-old children during that year. Migrant programs were excluded because they were participating in a separate study in which the Health Component was one of the primary interests.

sufficiently comparable to the data from the 1993-94 study period to produce a valid sample for this study. Also, the selected sample of programs matched characteristics of the overall Head Start universe very well, with some minor exceptions. These differences were corrected through sample reduction, statistical weighting, and the sampling strategies.

Exhibit 3-1 Summary of Head Start Program Characteristics From PIR* Data

			Sample Programs**	
	1992-93	1993-94	1992-93	1993-94
	PIR	PIR	PIR	PIR
Number of Programs***	1796	1834	40	40
Total Number of Children	666,492	732,218	39,118	42,999
Proportion of Children	Percent	Percent	Percent	Percent
4-Year-Old Children	65.9	64.5	68.5	65.9
Children Enrolled in Second Year of Head Start	19.5	19.2	17.8	18.4
Home-Based Children	7.4	6.8	9.2	9.3
Families Enrolled in Medicaid/EPSDT****	67.3	69.4	66.0	70.4

*PIR - Head Start Program Information Report.

**Data for sample programs are based on all enrolled children, not just the respondents to this study.

***Excluding migrant programs and programs without 4-year-old children.

****EPSDT - Early and Periodic Screening, Diagnostic, and Treatment Program.

3.3 The Sampling Plan

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.

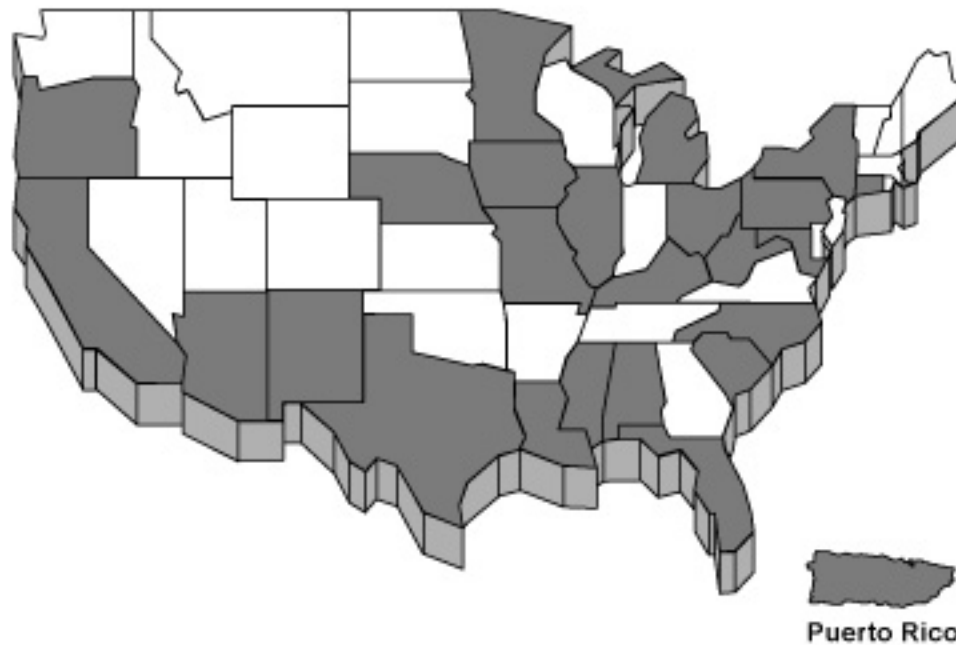
children could not be located or if a parent declined to be interviewed, alternates were used. A total of 1,189 parents were actually interviewed.

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.

Exhibit 3-3 Demographic Data From the Parent Interviews and Reviews of the Child Health Files

Racial Background (Reported by parents)	Unweighted	Weighted
Total	1,189	100
American Indian	36	4.2
Asian or Pacific Islander	19	1.6
Black (not of Hispanic origin)	399	32.8
Hispanic	222	18.2
White (not of Hispanic origin)	438	37.5
Mixed Race	74	5.7
Missing	1	
Gender (Recorded from child health files)	Unweighted	Weighted
Female	602	50.9
Male	582	49.1
Missing	5	
Primary Language Spoken at Home*	Unweighted	Weighted
English	1,029	86.9
Spanish	224	18.1
Other	47	4.7

*Some families indicated more than one language.

3.4.2 Head Start Staff

The final totals for completed staff interviews are shown in Exhibit 3-4. All totals do not equal 40, usually because staff were not available (e.g., on leave) or a staff position was not filled at that time. Some programs had more than one individual filling the Health Coordinator and Parent Involvement Coordinator roles, resulting in totals greater than 40.

While 81 centers were visited, only 59 Center Director reports were available. Occasionally a Center Director was not available, but more often this individual was responsible for more than one center within a program, not an uncommon situation. No staff member refused to be interviewed for this study.

Exhibit 3-4 Head Start Staff With Completed Interviews

Staff Position	Number of Interviews
Center Director	59
Health Coordinator	42
Mental Health Coordinator	37
Nutrition Coordinator	39
Parent Involvement Coordinator	42

Note: Individuals could be counted more than once due to multiple roles.

3.5 Data Collection Instruments

3.5.1 Data Sources

The research staff developed data collection measures for nine data at both the program level or the center level, depending on the type of information needed and the structure of each specific program. In addition, each program office provided documentation concerning the operation of the Health Component. The primary data sources were as follows:

- Center Director/Lead Teacher (interview);
- Health Coordinator (interview);
- Nutrition Coordinator (interview);

- Mental Health Coordinator (interview);
- Parent Involvement Coordinator (interview);
- Budget Manager (questionnaire);
- Parents of 4-year-old children (15 per center) (interview);
- Child health files for the children of the interviewed parents (record abstraction); and
- Meal observations at each center (observation form).

Interview forms and other data collection instruments for these primary data sources are found in Appendix B of Volume IV, including Spanish versions of all the interview forms.

3.5.2 Instrument Development

Where appropriate, specific interview questions were consistent with current Head Start protocols. The instrument developed for abstracting data from the child health records was based on the information detailed in the 1992 version of the Head Start Child Health Record. A Technical Advisory Panel, consisting of five consultants across the four health domains, four representatives from relevant Federal agencies, a local Head Start Health Coordinator, and a Head Start parent, also contributed to the development of the research instruments as well as the data collection procedures.

3.6 Staffing

CDM and Abt organized a three member site visit team for each program. Each site visit team was led by a research associate from CDM or Abt and including a trained, experienced data collector and an on-site staffer from the Head Start program being visited. The research associate spent one week on-site, and the data collector was scheduled for a two week visit, although in most cases all data were collected in the first week. The on-site staffer

helped to recruit parents and schedule interviews. More detailed descriptions are provided below.

- The **research associate**, the senior member of the site visit team, had primary responsibility for the data collection effort at the site.
- The **data collector**, often recruited from the same community as the Head Start program, interviewed parents, reviewed the child health files, and assisted the research associate, as necessary.
- The **on-site staffer** was typically recommended by the Program Director to assist the other members of the site visit team. The on-site staffer recruited parents into the study, coordinated the distribution and collection of consent forms, scheduled interviews, and explored potential parent recruitment and scheduling strategies.

3.7 Data Collection Procedures

The procedures used by CDM and Abt to complete the collection of data are described below.

Following the selection of the final sample of programs, the research staff notified the appropriate Administration for Children and Families (ACF) Regional Offices about the study and identified the programs that were selected to participate within their respective Regions. A member of the research staff then telephoned the Program Director at each study site and also sent a follow-up letter. The names and sizes of the centers operating within that program were identified, as were the names and titles of the primary staff working in the Health Component. Centers were selected using a PPS strategy, and the Center Directors/Lead Teachers at the selected centers then faxed rosters of the eligible 4-year-old children to the research office.

Prior to the site visit, the on-site staffer received the list of the selected children and alternates, and implemented procedures for recruiting the sample. The on-site staffer distributed and collected the Parent Consent forms and arranged the parent interview schedule. The researchers obtained signed, informed consent forms from all parents prior to the latter's participation in the interviews and prior to the record reviews. Copies of the consent forms were provided to the local Head Start centers.

For both the program staff and parents, all information that could link individuals with their responses was kept under lock and key by the CDM Project Director at the research office. All information that might link respondents to the data instruments was removed from the forms.

The principal reason for the high response rate (78% of parents identified in the primary sample lists) was the cooperation of the Head Start parents and staff members. To facilitate the interviews, the research associates and data collectors were available to conduct interviews after normal working hours or on weekends for respondents who were unavailable during the work day. Whenever interviews could not be conducted in English, they were completed in the native language of the respondent. To maximize comfort with the interview setting, the research staff gave each parent the opportunity to determine the site for the interview, although parents were encouraged to come to the Head Start center.

3.8 Record Keeping Issues

Because the site visit teams anticipated that the Head Start Child Health Record would be employed for the great majority of children sampled, the record review instrument was based on that form. However, only 58.2% of the records reviewed were actually maintained on the Head Start Child Health Record and these were not always the most recent version. The remainder of the health records were kept on locally developed forms that did not always

provide the information sought on the record abstraction form. This created instances of missing data for certain health conditions or health status reports.

Often, child health records were not helpful in determining the assessment, prevalence, and treatment of conditions that fall under the mental health and dental domains. For example, mental health reports were often included in the child's education file, and the site visit teams did not always have access to these. Also, mental health evaluations and treatment reports were not always maintained in a child's file because of confidentiality issues. Similarly, approximately 45.0% of the children did not have a record of having previously seen a dentist. This does not mean that dental visits were not completed, but rather that this information was not located in the health records. The data collectors made every effort to complete the record reviews, but some results must be interpreted with some caution.

3.9 Data Analysis

This study uses data at two levels. The basic database was constructed at the child level for analyzing data from parent interviews and reviews of the Head Start child health records. These analyses apply to data on immunizations, health conditions, health screenings, exams, referrals, and services provided to the target children. Data at this level are weighted to produce national Head Start estimates. The second level of data is the Head Start program, where staff interviews yielded detailed information about health service delivery, about the barriers and difficulties faced by centers in the provision of required health services, and about staffing of the Health Component.

Wherever possible, staff attempted to collect comments from respondents (staff and parents). These were transcribed and coded for use in quantitative analyses. The transcription of the comments are included in Volume III. As part of the routine of data

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.

3.0	Methodology	3-1
3.1	Overview	3-1
3.2	Description of Head Start Universe	3-1
3.3	The Sampling Plan	3-3
3.4	Description of Study Sample	3-4
3.4.1	Head Start Children and Parents	3-4
3.4.2	Head Start Staff	3-6
3.5	Data Collection Instruments	3-7
3.5.1	Data Sources	3-7
3.5.2	Instrument Development	3-8
3.6	Staffing	3-8
3.7	Data Collection Procedures	3-9
3.8	Record Keeping Issues	3-10
3.9	Data Analysis	3-11

Exhibit 3-1	Summary of Head Start Program Characteristics From PIR* Data	3-2
Exhibit 3-2		
Exhibit 3-3	Demographic Data From the Parent Interviews and Reviews of the Child Health Files	3-6
Exhibit 3-4	Head Start Staff With Completed Interviews	3-7

4.0 PROGRAM STAFFING AND STAFF QUALIFICATIONS

“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

4.1 Overview

A review of the literature over the past two decades uncovers few studies that focus on Head Start program staffing and the qualifications of the Health Component staff who assist families in gaining access to health services. In one, an examination of indices of Head Start program quality (Brush, 1993), researchers noted that programs employing staff with higher levels of education had fewer health items out of compliance with Federal regulations, as measured by data collected on the On-Site Program Review Instrument (OSPRI). In the same vein, a Task Force charged to study and make recommendations to strengthen Head Start’s Health Component urged in its report that Head Start set minimum education and experience requirements for Health Component Staff, and develop career paths and staffing patterns that will promote program quality (Head Start Health Coordinator’s Task Force Report, 1990). Related to this, many Head Start Program Directors, in responding to a General Accounting Office (GAO) survey, reported that they had insufficient qualified staff to meet the complex needs of the children and families that they serve, and that low salaries hampered their ability to hire qualified staff (GAO, 1994).

4.2 Findings

The data presented in this section were obtained primarily from interviews with Head Start program staff. These staff members included: Health Coordinators, Mental Health Coordinators, Nutrition Coordinators, Parent Involvement Coordinators, and Center Directors. It should be noted that, at some Head Start programs, more than one individual was interviewed for a given staff position (i.e., Health Coordinator and Parent Involvement Coordinators) because more than one person was functioning in that role. For other staff positions (i.e., Mental Health Coordinators and Nutrition Coordinators), fewer than 40 interviews are reported upon because not every program had a person filling the role or the staff members was not available. In the case of Center Directors, for some of the programs included in the study, one individual was responsible for both centers visited.

4.2.1 Program Staffing

This section presents data collected on: program staffing, staff roles, and the issue of staff performing multiple roles.

Program Staffing. Exhibit 4-1 presents staff responses regarding their work experience in Head Start. While most staff reported that they had worked for Head Start for approximately 9 or 10 years, Center Directors reported average job tenures of almost 15 years. All staff reported working in their current position for approximately 5 or 6 years on average.

Health Coordinators, Parent Involvement Coordinators, and Center Directors reported being paid to work approximately 39 hours per week, while Mental Health and Nutrition Coordinators reported being paid to work approximately 36 hours per week. All staff, however, reported actually working an average of 5 to 7 hours more than the number of hours a week for which they were paid. Those staff reporting multiple roles were asked how many hours per week they spent working in their primary role. Responses varied from

approximately 25 hours for Health Coordinators to approximately 10 hours for Mental Health Coordinators.

Exhibit 4-1 Program Staffing of the Health Component

	Respondents				
	Health Coordinator	Mental Health Coordinator	Nutrition Coordinator	Parent Involvement Coordinator	Center Director
Mean Number of Years with Head Start	9.0	10.5	8.7	10.7	14.5
Mean Number of Years in Current Position	5.5	5.9	5.0	5.8	6.6
Mean Number of Hours per Week Paid	38.8	36.4	36.2	39.0	38.8
Mean Number of Hours per Week Worked	43.8	42.5	41.2	45.2	45.8
Mean Number of Hours per Week Spent in Capacity of Current Position	24.8	10.1	16.9	23.2	21.6
Average Number of Years Performing Multiple Roles*	4.6	5.3	7.3	5.1	6.4
N	42	37	39	42	59

NOTE: Questions were open-ended.

*Averages are calculated only for those performing multiple roles.

Staff Roles. The Head Start program staff interviewed were presented with a list of tasks that Health Component staff might perform, and were asked to indicate the tasks that they, themselves, performed, and those performed by others. Then, from the list of tasks that they did themselves, staff were asked to identify the three tasks that they performed most

frequently. What emerges from their responses is that most Health Component staff are involved in both the role of “broker” of health services and in the direct provision of services.

Health and Mental Health Coordinators tend to typify the dual role of health service provider/broker. Both staff positions were involved in conducting screenings and examinations, reviewing the results of these tests and consulting with other Health Component staff in assessing their implications for the health needs of the children in their charge. When a health need was identified, both Health and Mental Health Coordinators devoted a great deal of time coordinating the actual delivery of services with other Head Start staff, as appropriate, and working with health care providers both in arranging for treatment and in following up on the treatment provided and its ramifications for further service requirements. Health and Mental Health Coordinators also reported that they spend a significant amount of their time conducting health/mental health education classes for parents and teachers and engaging in interagency collaborations.

Nutrition Coordinators were primarily involved in the planning, purchase, and delivery of food to the children enrolled in the program. They also conduct growth screenings and assist with the identification of child, family and community nutrition problems by conducting nutrition assessments, providing nutritional counseling, and conducting nutrition education classes for teachers and parents.

Parent Involvement Coordinators provide a major link between the parents of enrolled children and Head Start program staff. Parent education appears to be the primary mechanism through which this is accomplished.

Center Directors reported that they had direct involvement in health-related activities, such as providing health education to children in the classroom, as well as conducting parent education and teacher training on health-related topics. Center Directors also reported that they worked with local community health providers both in making arrangements for services

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

constraints as a problem. Insufficient salary for the job demands was also indicated as a problem by many respondents in all staff positions.

Staff responses regarding multiple staff roles appear to be linked to concerns expressed by staff about program-related barriers to care facing Head Start families (see Chapter 5: Program Procedures and Linkages with the Community). When discussing program-internal barriers to care, respondents indicated that limited Head Start and Health Component budgets and staff shortages were common barriers. The fact that substantial proportions of staff perform multiple roles (for which they were hired), and that this situation poses significant time constraints, may be the underlying basis for these staff perceptions. These conditions also may be related to the reports of Head Start Program Directors (GAO, 1994) that they have insufficient qualified staff to meet the needs of the children and families they serve.

4.2.2 Staff Qualifications

Staff Education. Previous research has suggested that programs that employ staff that are more highly educated score better on indices of Head Start program quality (Brush, 1993), and that Program Directors perceive that low Head Start salaries hamper their ability to hire qualified staff (GAO, 1994). Thus, against this backdrop, staff education was a major focus of this investigation. When asked about the highest level of education they had achieved, (see Exhibit 4-2), the proportion of respondents reporting Bachelor Degrees (or higher) varied among the staff positions, from a high of 67.7% among Mental Health Coordinators (66.7% of Nutrition Coordinators also reported a Bachelor degree or higher) to a low of 33.3% among Health Coordinators. Larger proportions of respondents in programs with enrollments of 1,000 or more reported a Bachelor or Nursing Degree (or higher) than did their counterparts in programs with enrollments under 500. Results for the mid-size programs (enrollments of 500-999) were varied. This suggests that larger programs are more successful in attracting more highly educated staff, perhaps because their funding levels allow them to pay the salaries that the higher education credentials claim. Larger programs may also have

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,

when these types of programs were more prevalent. Currently, only a small number of nursing graduates come from these programs (Bureau of Labor Statistics, 1996).

4.2.3 Staff Certification and Training

Staff Certification. Program staff were asked whether they held any current job-related certificates or licenses. Their responses to this (open-ended) question are presented in Exhibit 4-4 (the reader should note that, since respondents could report holding multiple certificates/licenses, column percents in this exhibit may not add up to 100%). The open-ended nature of this question may account for the generally low response rates observed in this table. The certificate/license most often mentioned was First Aid, which was cited by 41.3% of the Health Coordinators. This was followed by Cardiopulmonary Resuscitation (CPR) (14.3%).

Among the other staff interviewed (Mental Health, Nutrition, and Parent Involvement Coordinators), there was little consensus in terms of specific certificates/licenses. There were also several “Other” certificates/licenses reported, each cited by one or two individuals. These account for the substantial proportions appearing in the “Other” category in Exhibit 4-4. The areas in which these “Other” certificates/licenses were held included: Audio Screening, EKG Technician, Emergency Medical Technician, Psychiatric Nursing, Pharmacology, and Family Development.

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.

4.0 Program Staffing and Staff Qualifications	4-1
4.1 Overview	4-1
4.2 Findings	4-2
4.2.1 Program Staffing	4-2
4.2.2 Staff Qualifications	4-6
4.2.3 Staff Certification and Training	4-9

Exhibit 4-1 Program Staffing of the Health Component 4-3
Exhibit 4-2 Highest Level of Education as Reported by Staff 4-7
Exhibit 4-3 Percentage of Health Component Staff Reporting Bachelor or Nursing
Degrees (or Higher) by Type of Sponsoring Agency 4-8
Exhibit 4-4 Percentage of Staff Holding Selected Certificates and/or Licenses 4-10

5.0 PROGRAM PROCEDURES AND LINKAGES WITH THE COMMUNITY

“The program has provided information about community agencies that can help on any problem; it helped in providing information about necessary exams and preventive care..”

Head Start Parent

5.1 Overview

In order to carry out the requirements of the Program Performance Standards, each Head Start program must develop and implement a plan to meet component objectives. Aspects of these procedures are often unique to specific programs, because each program must operate within the restrictions or framework set by their internal organization (e.g., if the grantee is a school system versus a Community Action Agency), the physical size of the program (e.g., the number of enrolled children, the geographic size of the designated service area), and the availability of community resources (e.g., the number of providers, provider acceptance of Medicaid).

Program procedures ensure that enrolled children receive the required health screenings and examinations and that all parents become actively involved in the health care of their children. Procedures also include activities designed to address preventive health issues with children and families.¹ Finally, the health section of the Program Performance Standards (§1304.3) requires that programs implement procedures, including the establishment of a Health Services Advisory Committee (HSAC), which enable staff to be responsive to community health needs that affect the children that they serve. Programs are expected to use

¹ Preventive health issues and procedures are discussed in Chapter 6: Health Education and Chapter 7: Immunizations.

available community resources to benefit Head Start children and families by establishing working relationships with appropriate organizations or institutions in the communities they serve. The establishment and expansion of community linkages was one of the major policy recommendations of the Advisory Committee on Head Start Quality and Expansion (1993).

The Program Performance Standards require that programs identify and address the health problems of their local service areas (§1304.3-3; §1304.3-9). Certain health screens for children may be required based on these periodic assessments of community health conditions (e.g., increases in the prevalence of lead poisoning or intestinal parasites). Additionally, 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 to the maximum extent possible (Program Performance Standards, §1304.3-4) (see Chapter 2: Historical Context of the Health Component). Programs also are required to inform parents about available health resources and assist parents in gaining access to care.

The effective transfer of health care information from the Health Coordinator or a member of the Health Component staff to the family member responsible for connecting the child with the health care system is an essential aspect of program procedures. Health Coordinators serve as brokers for Head Start parents with community-based providers. By assisting with identifying providers, furnishing information and assistance, and securing necessary funding, Head Start staff provide support for parents in negotiating 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 that parents be in a position to assume sole responsibility for these tasks upon completing the program.

It is critical that each Health Coordinator, each member of the health staff, and the HSAC be aware of both the financial and the non-financial barriers to health care facing the families they serve (see Chapter 2: Historical Context of the Health Component). The health staff must navigate the local health care system and facilitate access to care for these families. The HSAC can ease the brokering process by initiating communication with individual providers, hospitals, clinics, and other community resources to provide parents with appropriate bridges to health care in their communities. The HSAC is intended to lend organizational weight to the Health Coordinator in breaking down barriers to access. However, the success of the Head Start system in facilitating access to health care is dependent on the ability of the Head Start staff, the community, and the parents to overcome the challenges they face in obtaining proper health care.

5.2 Findings

The findings in this chapter are based on staff reports about program procedures and community collaborations. Parents' reports of information provided by Head Start are included, as are Head Start staff reports on barriers to care and the activities that their programs use to help families overcome these barriers. Finally, staff perceptions of community health risk factors that may impact on Head Start children are discussed.

5.2.1 Community Resources

Medicaid and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. Since many children enrolled in Head Start are eligible for Medicaid and can receive EPSDT services (see Chapter 2: The Historical Context of the Health Component), Head Start staff and parents were questioned about Medicaid eligibility, enrollment, and utilization.

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.

Health Coordinators at each program site were questioned about procedures employed by the program related to Medicaid enrollment. Almost nine out of ten (85.7%) reported that their programs had a formal process for identifying Medicaid-eligible children enrolled in their programs. This process generally included screening for eligible children at intake, verifying proof of income, and referring eligible children to the appropriate social services agency for assistance in enrollment.

When asked what procedures were used to enroll eligible children in Medicaid, Health Coordinators generally reported that staff explained the Medicaid program to parents and encouraged them to enroll. Staff may then either make appointments and/or take the parent to the Medicaid agency; or they may simply refer parents to the local Medicaid agency.

Thus, the findings suggest a concerted effort by staff, especially at intake, to identify Medicaid-eligible children, and that staff may go as far as taking parents to the Medicaid agency to assure enrollment.

5.2.2 Staff Activities with Community Providers

As noted in Exhibit 5-2, many Health and Mental Health Coordinators and, to a lesser degree, Center Directors, reported having responsibility for selecting and reviewing community providers, developing interagency collaborations, and negotiating payments for services. Most of the Nutrition and Parent Involvement Coordinators also indicated that they had some responsibility for establishing interagency collaborations, but they were not asked about their involvement in more direct service provision. Mental health and nutrition consultants associated with the Health Component had little formal responsibility for establishing relationships between Head Start and community providers.

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.

Community Resource Information. The Program Performance Standards require that programs provide parents with information about available health resources and services in their community (§1304.3-6). Many programs provide resource information to families at the time of enrollment in Head Start in the form of booklets or pamphlets. In this study, although the question was open-ended, almost two thirds of the parents recalled receiving such information from program staff at the time of enrollment. It also is noted in Chapter 6: Health Education, that 75% of the parents reported receiving information from Head Start on “helping agencies” in the community.

5.2.3 Child Health Files

Child health files are created during the intake/health screening/examination process and require regular updating and maintenance thereafter. These files typically include medical information noted during screenings and examinations, health history information provided by a parent or caregiver, the status of current treatments, and information on immunizations and Medicaid status. Usually, the files also include information on dental, mental health, and nutrition status. The Health Coordinators were most often reported as having primary responsibility for health record maintenance (37.3%), followed by the Center Director/Head Teacher (23.7%), and the Family Service Worker (20.3%). Only one third of the Mental Health Coordinators (33.3%) reported that they alone had primary responsibility for documenting follow-up mental health evaluations in children’s health records. The pattern that emerges here is that the responsibility for the maintenance of both health and mental health records may vary among several different staff members, depending upon the circumstances of the situation.

5.2.4 Health Screening and Examination Procedures

Health and Mental Health Coordinators and Center Directors were asked about the procedures that are used if a teacher suspects that a child has a serious health or mental health problem. Virtually all of the respondents, over 97%, indicated that their programs had standard procedures in place. In general, teachers discuss the situation with the Center

Director, who, in turn, contacts the appropriate Health or Mental Health Coordinator, who contacts the parent to further discuss the situation and, if warranted, makes a referral to in-house staff (e.g., a nurse) or to an outside health care provider. The responsible Health or Mental Health Coordinator documents the problem, and provides follow-up as required. In cases of very large programs, some of these tasks are completed by other members of the health staff who are responsible for children and families at specific centers.

Almost all of the Health Coordinators (92.9%) indicated that their programs had a mechanism or process for the early identification and screening of children who appeared to have health problems. The processes described generally included physical examinations at entry into Head Start, on-site screenings and classroom observations, and evaluations or screenings by health consultants.

5.2.5 Treatment Procedures

The services most often provided by programs include informing parents about their children's health service needs and the treatment services that are available. Staff also reported that they identified specific health care providers for parents and helped them coordinate services with providers, as well as followed up with both parents and providers to ensure that the necessary services were actually provided. The picture that emerges is that of the Health Component staff acting as brokers of health services, linking Head Start families with community health care providers.

Health Coordinators also identified the types of treatment available on-site at the Head Start center, and their responses are presented in Exhibit 5-3. What can be inferred from the strong division point in this Exhibit is that most treatment, unless directly linked to classroom activities (communication, behavior, meals, etc.), is not provided at the center.

In general, staff reported that they followed up on treatment by contacting the parents and providers directly, documenting the treatment in the child's health record, and periodically

reviewing the record for completeness. Some staff also reported that they used a computer tracking system to monitor treatment progression.

Exhibit 5-3 Types of Treatment Available On-Site at Head Start Centers as Reported by the Health Coordinators

Treatment Type	Percent
Nutritional Counseling	95.1
Speech Therapy	90.2
Mental Health Counseling	70.7
Physical Therapy	31.7
Supplemental Fluoride Tablet Program	29.3
Immunizations	26.8
Other	22.0
Dental Treatment	14.6
N	42

5.2.6 Barriers to Care

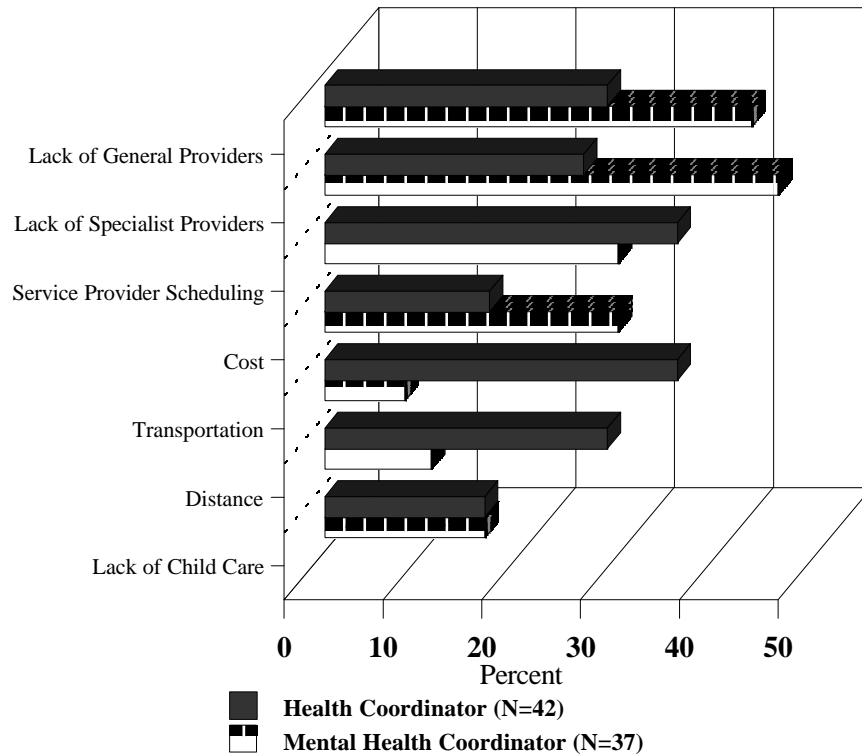
Reports on barriers to health care for families fell into several different categories. Internal barriers are those that existed within programs, while external barriers include both community and personal barriers as discussed in Chapter 2. In this section, all three types of barriers, as reported by Head Start staff, are presented.

Internal Barriers. Internal barriers to care reflect staff perceptions of program-related impediments to the level of services provided to enrolled families. The responses of staff to open-ended questions were categorized using content analysis procedures. Staff from more than 20% of the programs responded that each of four types of internal barriers significantly affected their ability to work with families. These responses suggested that 1)

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.

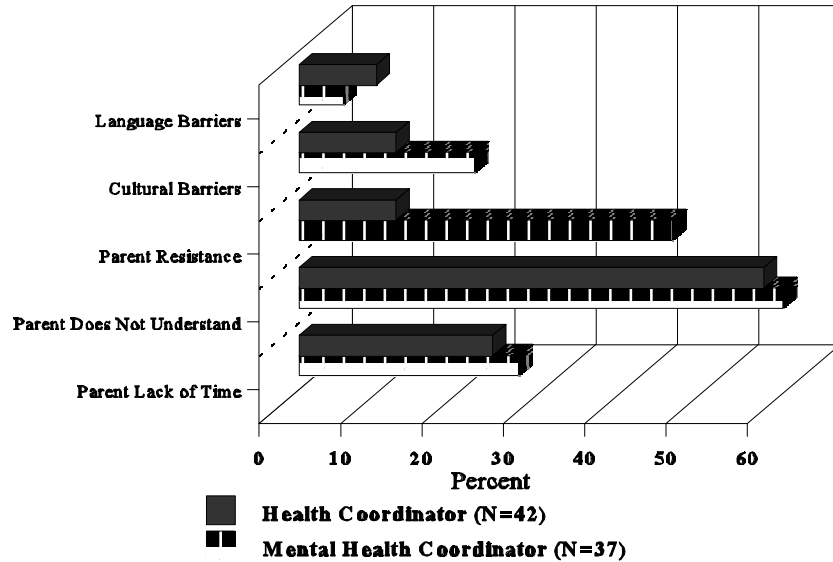
External Barriers. Of particular interest in this study were staff perceptions of the barriers to care directly faced by the families they serve and how Head Start responds to these barriers. Exhibit 5-4 presents staff reports of community-based barriers that affect parents. Parent Involvement Coordinators' 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.

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



Program Responses to Barriers. In order to meet the overall program goals of assuring needed health services for children and increasing parents’ ability to overcome barriers, local staff must respond to these barriers. Although they differed in their perceptions of the barriers facing parents, Head Start staff were remarkably consistent in their views of the services that their programs provide to families in an effort to overcome barriers to care. Services that Head Start staff identified as being helpful to families primarily fell into five categories: providing parent education, helping families with provider scheduling, providing Head Start staff education on recognizing and overcoming barriers, providing transportation, and conducting outreach activities with community providers.

5.2.7 Perceived Community Health Risk Factors

The Health, Mental Health, and Parent Involvement Coordinators and the Center Directors were asked their perceptions of the three most critical community risk factors affecting the health or mental health status of Head Start children. As seen in Exhibit 5-6,

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.

5.0 Program Procedures and Linkages with the Community	5-1
5.1 Overview	5-1
5.2 Findings	5-3
5.2.1 Community Resources	5-3
5.2.2 Staff Activities with Community Providers	5-5
5.2.3 Child Health Files	5-8
5.2.4 Health Screening and Examination Procedures	5-8
5.2.5 Treatment Procedures	5-9
5.2.6 Barriers to Care	5-10
5.2.7 Perceived Community Health Risk Factors	5-13

Exhibit 5-1	Payment Sources for Health Services as Reported by the Parents	5-4
Exhibit 5-2	Responsibilities Relative to Community Collaborations as Reported by Staff	5-6
Exhibit 5-3	Types of Treatment Available On-Site at Head Start Centers as Reported by the Health Coordinators	5-10
Exhibit 5-4		
Exhibit 5-5		
Exhibit 5-6	Community Health Risk Factors as Reported by Staff	5-15

6.0 HEALTH EDUCATION

***“It has started my baby girl on the road to education...
it taught her to care for herself as well as teaching her aunt and mom
how to help her at home.”***

Head Start Parent

6.1 Overview

Health education for Head Start children, parents, and staff is a mandated activity within the health sections of the Program Performance Standards (§1304.3-6). Typical health education activities for children include instruction on basic hygiene, safety, and other health behaviors appropriate for children. Health education activities for children are often integrated within the established activities of the regular Head Start program. Parents are given opportunities to learn the principles of child development, preventive health, safety, and first aid. These activities are clearly linked with a primary goal of Head Start: the development of basic skills and self-sufficiency among the children served and their parents. These activities are also consistent with the Omnibus Budget Reconciliation Act of 1989 (Public Law 101 239, section 6403), which requires that States provide health education as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service for Medicaid-eligible individuals under the age of 21.

The Health Component staff are assisted by individuals responsible for the Parent Involvement Component to help ensure that parent health education is available to participating families. Education occurs through staff-parent, parent-parent, and parent-child communications and activities. By planning and conducting health-related activities, the Parent Involvement Component assumes a critical role in ensuring the effectiveness of Head Start in the area of child health promotion. The greater the level of parent involvement, the more likely that parents will be able to assume full responsibility for the health of their family

after leaving Head Start. Notably, however, one of the most frequently identified health risk factors identified by Head Start staff was the lack of parenting skills (see Chapter 5, Exhibit 5-6).

In addition, Head Start staff are required to receive training in the principles of child health, behavior, nutrition, and the relationship of these principles to child development. This training should include strategies for creating a sound physical, social, and emotional environment that supports the efforts of the children and their families in achieving adequate knowledge of health and safety.

This chapter provides a summary of staff and parent reports on the health education opportunities provided for children and parents through their association with Head Start. Parents also gave their perceptions on how their own health behaviors and the health behaviors of their children changed after enrolling in Head Start. The Health, Mental Health, Nutrition, and Parent Involvement Coordinators described health education strategies, activities, and topics. In addition, findings are presented from center-based meal observations. These observations allowed for an assessment, across programs, of how health education is incorporated into the everyday activities of the centers.

6.2 Findings

This section provides the findings from Head Start staff and parent reports regarding health education opportunities. Further information on parent and child health education issues is provided in Volume III. Staff education issues are covered in Chapter 4: Program Staffing and Staff Qualifications, with additional comments presented in Volume III.

6.2.1 Health Education Provided to Children

Staff Reports of Health Education Topics. Health Coordinators provided information on the specific health topics covered in the classroom curricula. Based on their reports, topics such as nutrition (92.9%), personal hygiene (92.9%), first aid and safety (88.1%), dental health (85.7%), and mental health and emotions (57.1%) were frequently or always presented to the children by most of the programs. The Mental Health Coordinators indicated that self-esteem (94.6%) peer relationships (89.2%), family relationships (81.1%), and emotions (73.0%) were the most common mental health education topics presented as part of the curriculum.

Staff Reports of Health Education Activities in the Classroom. The Health, Mental Health, and Nutrition Coordinators each indicated whether items on lists of potential classroom activities (e.g., classroom discussions, role playing, movies, and videos) were included as part of the regular curriculum at their programs. Almost all of the respondents indicated that their programs incorporated these health and nutrition-related activities into their education program.

Classroom methods used to involve children in health-related activities were also reported by the Health and Mental Health Coordinators. The methods most commonly reported by the Health and Mental Health Coordinators, respectively, were classroom discussions (100%, 94.6%) and role playing activities (97.6%, 83.8%). Having outside visitors come to the classrooms was an often employed strategy, both for presenting health information to children and for building linkages with the local community. The most frequent classroom visitors reported by the Health Coordinators were nurses (76.2%), nutritionists (66.7%), dentists (59.5%), psychologists (54.8%), and health educators (50.0%).

The Health and Nutrition Coordinators also reported on specific classroom activities. The responses of the former, found in Exhibit 6-1, indicate that many health-related activities, such as tooth brushing, hand washing, and talking about safety, occur within almost every

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.

Exhibit 6-2 Topics of Parent-Child Discussions on Health-Related Activities at Head Start as Reported by the Parents

Topic	Percent*
Tooth Brushing	93.3
Washing Hands Before Meals	91.9
Safety at Home	90.6
Good Grooming Habits	87.5
Feelings and Friendships	86.8
Good Nutrition and Healthy Foods	85.8
Safety in the Neighborhood or Playground	85.1
Use of Tobacco or Drugs	77.9
Physical Activity and Fitness	73.3
Disabilities (Their Own, and Other People's)	65.8
N	1,189

*Percentages based on 1,189 parent reports; 1,145 parents (96.3 percent) indicated that they discussed health topics with their children

Parent Reports of Health Behavior Changes. More importantly, parents of Head Start children frequently reported that changes in health-related behaviors had occurred in their children, for themselves, or for both. Two thirds of the parents (N=791) reported that noticeable changes in their family's health behaviors could be identified since their child's enrollment in the program. Exhibit 6-3 shows, for each education topic, the percentage of children and parents who, based on the parents' reports, changed their health behaviors because of their experiences at Head Start. In addition to indicating the areas in which these changes occurred, parents also reported the types of changes that they noted in their children's or their own behaviors.

Exhibit 6-3 Areas of Health Behavioral Changes Since Enrolling in Head Start as Reported by the Parents

Topic	Percent of Children*	Percent of Parents*
--------------	-----------------------------	----------------------------

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.

Exhibit 6-4 Activities Children Were Observed Participating in Around Meal Time/Snack Time

Activity	Percent*
Washing Hands	88.1
Clearing the Table After Meal	87.0
Cleaning Up	63.3
Setting the Table	59.3
Brushing Teeth**	52.5
Discussing Foods in Class Prior to the Meal**	29.9
Serving the Food to Others	23.7
Preparing the Food	1.7
Cooking the Food	0.6
N	177***

*Percent of meals at which research staff observed the activity.

**Staff was not always able to observe whether or not this activity occurred.

***N=the number of observed meals.

6.2.2 Health Education Provided to Parents

Each Head Start program carries out a series of activities directed towards the parents of enrolled children. These activities are designed to empower parents and to facilitate their efforts to interact with their children in appropriate ways. Across the 40 study sites, 97.6% of the Parent Involvement Coordinators reported that program-sponsored activities were available for parents. The one respondent answering “no” on this issue did, however, report positively about parent education activities earlier in the interview. While health education can be provided through a variety of methods (e.g., workshops, field trips, parent-child activities), such activities are referred to as parent classes in this report.

Parent Reports of Education Topics. The parent reports on specific topics that Head Start covered in parent education activities are presented in Exhibit 6-5. The range of

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.

6.0 Health Education	6-1
6.1 Overview	6-1
6.2 Findings	6-2
6.2.1 Health Education Provided to Children	6-2
6.2.2 Health Education Provided to Parents	6-8

Exhibit 6-1	Health-Related Activities Included in Children’s Educational Programs as Reported by the Health Coordinators	6-4
Exhibit 6-2	Topics of Parent-Child Discussions on Health-Related Activities at Head Start as Reported by the Parents	6-5
Exhibit 6-3	Areas of Health Behavioral Changes Since Enrolling in Head Start as Reported by the Parents	6-6
Exhibit 6-4	Activities Children Were Observed Participating in Around Meal Time/Snack Time	6-8
Exhibit 6-5	Topics for Activities and Educational Information Presented by Head Start as Reported by the Parents	6-9
Exhibit 6-6	Parent Education Topics as Reported by Staff	6-10

7.0 IMMUNIZATIONS

“It’s a team effort. To provide services for children everyone has to be involved and know what is going on.”

Head Start Staff

7.1 Overview

Over the past 40 years, immunization has proven its effectiveness as a disease prevention measure. By 1994, infectious diseases that had affected hundreds of thousands of individuals in 1954, such as polio, measles, mumps and pertussis, were virtually non-existent. For Head Start, the Program Performance Standards specify that children 4 to 6 years of age and leaving Head Start to enter kindergarten or first grade should have received all of their age-appropriate immunizations (§ 1304.3-4).

However, the requirements for the complete immunization of 4-year-old children have only recently been clarified. Beginning as early as 1983 and continuing through the 1993-94 Head Start program year, the Program Information Report (PIR) required 4 administrations of diphtheria, pertussis, and tetanus (DPT), 3 administrations of oral polio vaccine (OPV), 1 of measles, mumps, and rubella (MMR), and 1 *haemophilus influenzae* type b (Hib) (referred to as “4-3-1-1”) for a preschool child to be fully immunized. National advisory groups (including the American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the Centers for Disease Control and Prevention (CDC)) have long recommended that a fifth DPT and a fourth OPV be administered between the ages of 4 and 6. The intent of this recommendation is to provide “booster” shots for children prior to their entrance into school. In 1988, the Head Start Bureau issued Information Memorandum (IM) 88-16, specifying immunization recommendations for 4 to 6 year old children. The IM specified that a 4-year-old child who had received 5 administrations of DPT,

4 administrations of OPT, 1 of MMR, and 1 Hib vaccine administration (referred to as “5-4-1-1”) prior to completion of Head Start was considered completely immunized. While the Head Start immunization requirements for

children in transition from Head Start to school were consistent with the recommendations of the AAP, they were also more stringent in that the standards were to be met before leaving Head Start, rather than before the child turns 7 years of age. The 1988 Head Start requirements (IM 88-16) were in effect during data collection for the Descriptive Study of the Head Start Health Component. In July 1994, the Head Start Bureau issued IM 94-13. This IM updated and made the program’s immunization schedule consistent with the schedule recommended by national advisory bodies such as the AAP. It is important to note that this Head Start update was released after the completion of the data collection for this study.¹

Since 1989, organizations advising the nation regarding immunization practices have updated their guidelines several times, expanding the recommendations to include additional vaccines and additional administrations of previously listed vaccines. The AAP, the ACIP, and the CDC jointly published a consolidated immunization schedule in January 1995. For children 4 to 6 years of age (that is, prior to entry into kindergarten or first grade), the joint recommendations included 5 DPT, 4 OPV, 2 MMR, 3 Hib, and 3 Hepatitis B (HepB) vaccine administrations. These recommendations are identical to those required by Head Start IM 94-13.

Thus, the Head Start programs presently have immunization guidelines that are consistent with, but somewhat more stringent than, the recommendations of national advisory groups. At the point of data collection for this study, two additional sources of advice provided conflicting guidance to Head Start staff regarding complete immunizations for 4-

¹ Both Head Start IM 88-16 and IM 94-13 include catch-up schedules for under-immunized children entering Head Start. In the present study, that schedule was applicable to only a small proportion (1.9%) of the children whose parents were interviewed.

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.

7.2 Findings

7.2.1 Head Start Child Health Records

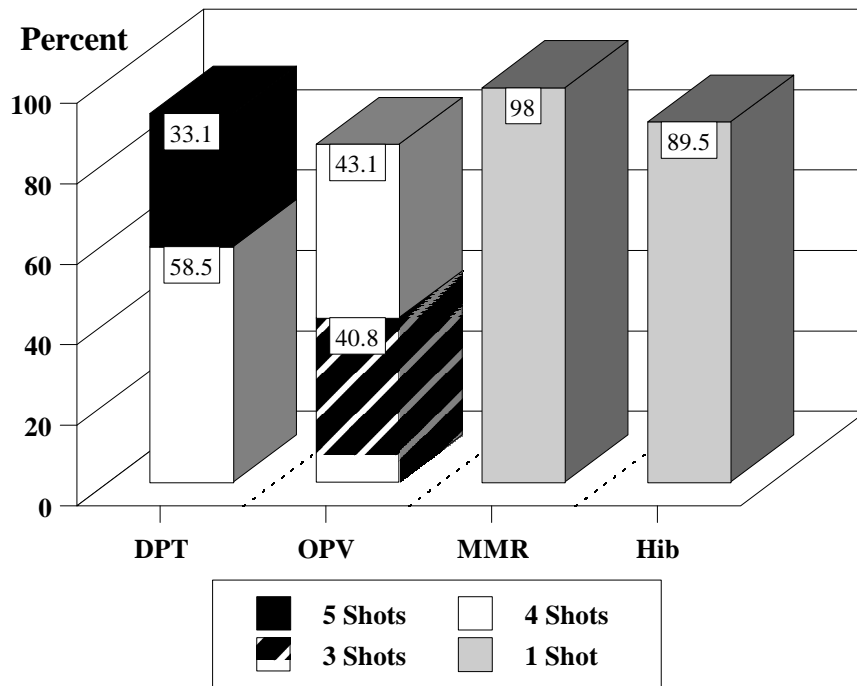
The present study found that 81.7% of the 4-year-old children met the PIR reporting requirements, a similar percentage to that reported in the Head Start PIRs.² However, only 29.3% of the immunization records reviewed met the requirements of the 1988 Head Start immunization policy. As with the OIG study, the primary problem in meeting Head Start performance criteria was associated with the additional DPT and OPV immunizations required for children past their fourth birthdays.³ Exhibit 7-1 shows the percentage of 4-year-old children with 4 or with 5 or more DPT immunizations and the percentage with 3 or with 4 or more administrations of OPV. As shown, the final DPT and OPV immunizations were not administered to a substantial number of 4-year-old children.

The total number of immunizations received by 4-year-olds was analyzed as a proportion of those required under the 1988 criteria (5-4-1-1=11). The results showed that children had received 82.8% of the required immunizations. This translates to children having received 9 of the 11 required immunizations at the time of the study. The implication of this percentage is that Head Start children are not severely under-immunized. Rather, those who are not fully immunized are usually missing only one or two administrations, and these are almost always the fifth DPT and/or the fourth OPV required after the fourth birthday. Actual occurrences of health conditions associated with the lack of these immunizations were not apparent in the review of health conditions from either the parent interviews or the child health files.

² The Head Start PIR data has remained in the range of 88-90 percent range since 1990-91 (the year in which the OIG study was initiated).

³ The percentage provided in the OIG study may have been higher due to the fact that it included an unspecified number of 3-year-old children who would not be affected by the requirement for additional DPT and OPV immunizations.

Exhibit 7-1 Percentage of 4-year-old Children with DPT, OPV, MMR, and Hib Immunizations as Noted in the Child Health Records.

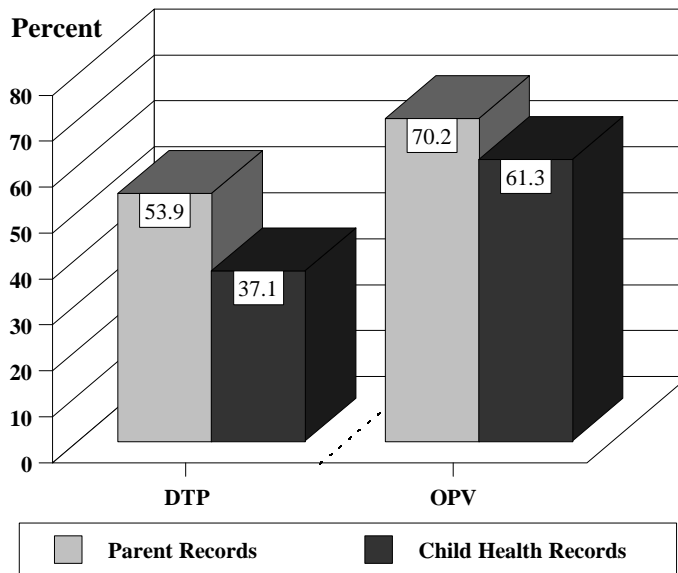


7.2.2 Parent-Provided Immunization Records

The design of the study allowed for an examination of the factors that might contribute to the relatively low proportion of 4-year-old children found to be completely immunized based on the 1988 requirements. For this study, parents were asked to bring copies of their child's immunization records to their interviews. Approximately 35% (n=411) of the parents with 4-year-old children did so. While it is not known how well such parents represented the entire Head Start sample, a comparison of the records provided by these parents and those found in the child health files (see Exhibit 7-2) revealed that 16.8% of the children had additional DPT immunizations recorded on the records provided by the parents and that 8.9% of the parent records recorded additional OPV immunizations. This finding raised the possibility that Head Start records were not being systematically updated during the school year. Additional analyses determined that, if the parent records that were available were

considered in evaluating the 4-3-1-1 standard, the percentage of 4-year old children achieving that standard was 87.3%. A recently reported national survey completed by the CDC found that only 75% of preschool children had been immunized at that level (MMWR, February, 1996).

Exhibit 7-2 Percentage of Children Fully Immunized as Noted in the Parent Records and the Child Health Records



The number of children meeting the 5-4-1-1 requirement was also checked using combined data from the parent-held records and the health files. It was found that the percentage of children meeting this requirement increased to 37.1%, as opposed to the 29.3% noted in the health records only.

7.2.3 Health Coordinators' Knowledge of Immunization Requirements

During interviews with the Health Coordinators, the respondents discussed their understanding of the requirements for the full immunization of 4-year-old children. They reported which immunizations were required for 4-year-old children and how many

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.

8.0 THE MEDICAL HEALTH DOMAIN

***“They help move the mountain when I can’t get health care.”
“The health check and dental check would never have been done without
Head Start’s help.”***

Head Start Parent

8.1 Overview

Overall, the health of the Nation’s children has improved in recent decades. Promising statistics include a reduction in infant and child mortality rates and a reduced incidence of preventable childhood diseases. However, poverty continues to have a pervasive effect on the health of children. Children from low-income families are likely to encounter more health risk factors and, when they do become ill, they get sicker and die at higher rates than other children (Starfield, 1992). Health problems can be particularly disruptive to an individual child’s learning and can interfere with the learning experiences of classmates as well (AOA, 1994).

Head Start plays a significant role in working with families to ensure that children receive regular medical screenings and examinations. The Head Start program requirements for medical screenings and examinations are detailed in the Program Performance Standards (§1304.3-3). Screenings and examinations may take place at Head Start centers or Head Start staff may assist families in scheduling appointments with community health providers. To fulfill the requirements of the Program Performance Standards, Head Start children are first screened for all of the health conditions covered by these Standards in order to provide a preliminary indication of any health problems. These screenings include: growth assessment (height, weight, and age), vision testing, hearing testing, hemoglobin and hematocrit determinations, tuberculin (TB) testing where indicated, urinalysis, assessment of current immunization status, and, based on community health problems, other selected screenings where appropriate (e.g., sickle cell anemia, lead poisoning, and intestinal parasites). The

Program Performance Standards guidance suggests that some of the screening activities may be performed by non-professional workers who are trained in these areas (§1304.3-3). These screening activities include collecting medical and dental health histories, growth assessments, immunization status assessments, and vision, hearing, and speech screenings. The physical examinations must be carried out by trained professionals.

Subsequent to finding health conditions during medical screenings and examinations, the Program Performance Standards require that programs provide or arrange for treatment services where necessary (§1304.3-4). Each Head Start program is responsible for developing a plan to assure treatment and follow-up services. Head Start staff assist parents in securing the necessary services and in identifying funding sources to pay for the services.

8.2 Findings

This chapter presents unweighted data obtained from staff interviews. Also, because of the interest in having national estimates of the health status of Head Start children, the percentages for parent reports and the review of child health records were weighted (see Chapter 3: Methodology). Where available, similar data for 4-year-olds are presented from the 1991 National Health Interview Survey (NHIS), Child Health Supplement (National Center for Health Statistics, 1993). The majority of the child health records provided data on the results of specific health tests and measurements that took place during the health screenings.

8.2.1 Staff Reports of Perceived Health Problems

All of the Health Coordinators and Center Directors were asked to report on the three most serious health conditions their programs faced during the current program year. Similarly, the Mental Health Coordinators reported on the three most serious mental health

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.

Exhibit 8-1 The Most Serious Health Conditions as Reported by the Health Coordinators and the Center Directors

Health Coordinators (N=42)		Center Directors (N=59)	
Condition	Percent	Condition	Percent
Dental/Oral Health Problems	48.2	Childhood Illnesses (e.g., Chicken Pox, Measles)	27.8
Asthma	23.2	Lice	27.8
Blood Disorders	23.2	Dental/Oral Health Problems	25.0
Lice	19.6	Flu/Colds	18.1
Childhood Illnesses (e.g., Chicken Pox, Measles)	16.1	Asthma	11.5
Malnutrition	12.5	Lack of Immunizations	11.5
Hearing Problems	10.7	Speech/Language Problems	11.5
Lack of Immunizations	10.7	Hyperactivity/ADD	9.7

8.2.2 Health Histories and Child Health Files

Health Histories. The Health Coordinators and Center Directors both reported that they used immunization records frequently or always (100.0% and 95.2%, respectively) as well as interviews or oral histories from the parents (95.0% and 90.5% respectively) were in compiling health histories.

Child Health Records. Most commonly, the Health Coordinators (37.3%), Family Service Workers (20.3%), or Center Directors (16.9%) had the responsibility for reviewing and maintaining health records.

The Health Coordinators reported that 88.1% of the programs completed a Head Start Child Health Record for all children, and that 52.4% of the programs used another standard form in the children’s health files, either by itself or accompanied by the Head Start Child

Health Record. In contrast, only 58.2% of the child health files reviewed in this study used the Head Start Child Health Record forms. Health Coordinators may not have been clear as to what actually comprises a Health Record. For example, sometimes programs used outdated versions of the form, locally designed forms or an edited version of the current Head Start Health Record that they refer to as the Head Start Health Record.

8.2.3 Timing and Methods of Completing Physical Examinations

Timing of the Physical Examinations. The Program Performance Standards require that an undressed physical examination/assessment be performed every 2 years beginning at age three (§1304.3-3). However, physical examinations and hearing and vision tests need not be performed for enrolled children who have had these examinations within the required schedule, provided that the program has records of the results.

Physical examination dates were abstracted from the children's health records. The median month for physical examinations was July 1993, while the mode was August, 1993. Usually during these months Head Start staff are working with parents to ensure a smooth transition into the Head Start year and it is likely that Head Start has influenced the percentage of timely examinations. Overall, the parent reports in addition to the child health files indicated that 98.5% of all children received a physical examination. This percentage is consistent with the PIR reports.

Parent Reports on Physical Examinations. Of those parents reporting that their children had physical examinations during the past year (n=1,130), 74.4% responded that they arranged the physical examinations themselves and 21.5% stated that Head Start arranged the examinations.

Health Coordinator Reports on Physical Examinations. Exhibit 8-2 lists screening tests and their inclusion or exclusion as part of the physical examination as reported by the Health Coordinators. Since it was possible for the Health Coordinators to answer that the

screening tests were both part of the examination and provided separately, the categories in Exhibit 8-2 are not mutually exclusive.

Exhibit 8-2 Specific Screening Tests and Their Inclusion in the Physical Examination as Reported by Health Coordinators

	Percent		
	Test Is Part of the Physical Examination	Test Is Provided Separately From Physical Examination	Test Is Not Provided At All
Blood Pressure	90.5	21.4	0.0
Vision	69.0	50.0	0.0
Hearing	66.7	52.4	0.0
Tuberculin Test	64.3	31.0	7.1
Lead Testing	47.6	19.0	28.6
Urinalysis	45.2	14.3	35.7
Sickle Cell	35.7	23.8	35.7
Ova and Parasites	21.4	21.4	50.0

Note: N=42 Health Coordinators. Health Coordinators could report tests as being both part of initial physical examination and as subsequent screening tests.

8.2.4 Medical Conditions and Injuries

Parent Interview Summary Procedures. Parents reported on the health status of their children in different ways. They responded to both limited-choice and open-ended questions regarding the findings of specific health screenings and assessments. The research staff developed and applied coding categories based on parent responses across all of the health condition questions. After the responses to each question were coded, the results were summarized across all questions to provide a single list of health conditions for each parent interview. This process optimized the chances of detecting health conditions during the

interview while eliminating the potential problem of a parent reporting the same health condition multiple times.

Review of Child Health Record Summary Procedures. The primary source of information typically used in studies of the health status of Head Start children is the health section of the children's individual Head Start files. Much of the information contained in the health files is derived from interviews with parents shortly before the child began attending Head Start. Other information in the records is added as the medical screenings and examinations are completed. As with the parent interviews, the study instrument design used for the child health file abstractions accommodated multiple opportunities for the detection of the same health conditions among the children.

The findings from the record review were coded into the same categories used with the parent data and summarized into a single indicator (yes-present/no) of parent-reported and health record recorded prevalence for each category. Conditions classified as injuries are discussed later in this chapter.

The Most Reported Medical Conditions. The weighted estimates of the most common conditions based on parent reports and reviews of the health files are presented in Exhibit 8-3. All of the health conditions mentioned by the parents were reported for less than 10% of the children. These health conditions include ear problems (9.1%), speech and language problems (8.5%), lower respiratory problems (8.2%), and gastrointestinal problems (8.2%). For almost 70% of the children, parents reported one or more health conditions that they considered to be serious. Information from the health files indicated that about 40% of the children had one or more of the defined serious health conditions.

As shown in Exhibit 8-3, the seven most common parent-reported categories were the same as the seven conditions most frequently reported in the children's health files, although in a somewhat different order. However, the percentages of children identified with each

condition was much lower in the child health files. Problems with ears, the condition most commonly reported by parents, were noted in only 4.1% of the records. Among the other most commonly recorded conditions noted in the records were lower respiratory problems (4.6%), upper respiratory problems (3.8%), blood disorders (3.6%), and asthma (3.1%).

Exhibit 8-3 The Most Reported Health Conditions From Parent Interviews and the Child Health Files

Parent Interviews			Child Health Records		
Condition	Unweighted n	Weighted Percent	Condition	Unweighted n	Weighted Percent
Ear Problems	107	9.1	Ear Problems	59	4.6
Speech/Language Problems	104	8.5	Upper Respiratory Problems	49	4.1
Gastrointestinal Problems	101	8.2	Lower Respiratory Problems	47	3.8
Lower Respiratory Problems	100	8.2	Blood Disorders	46	3.6
Asthma	94	7.9	Asthma	39	3.1
Upper Respiratory Problems	71	6.0	Speech/Language Problems	37	2.8
Blood Disorders	66	5.4	Gastrointestinal Problems	28	2.3
Psychosocial/Behavioral Problems	62	5.0	Hernia	23	1.9
Allergies	42	3.8	Heart Problems	18	1.5
Nutrition	45	3.8			

Note: Ear Problems included insertion of tubes and drainage problems.
Gastrointestinal Problems included dietary problems, ulcers, food allergies, pyloric stenosis, enlarged colon, lactose intolerance, and digestive problems.
Lower Respiratory Problems included chronic cough, bronchitis and pneumonia.
Upper Respiratory Problems included problems with the adenoids, glands, tonsils and croup and sinusitis.
Blood Disorders included sickle cell, hemophilia and anemia.
Psychosocial/Behavioral Problems included social delay, emotional problems, failure to thrive and bed wetting.

The National Health Interview Survey (NHIS). The 1991 NHIS (National Center for Health Statistics, 1993) included a Child Health Supplement, which provided a summary of the health conditions of children in the study. Data were available on 603 4-year-old

children who were part of a representative national sample of households. The NHIS children were more representative of the general U.S. population and of all economic groups than the Head Start children in this study. The NHIS health conditions, although not based on the same coding system as applied in this study, were similar to the coded health conditions reported above. Respiratory conditions and diseases were the most frequently reported medical problems in the NHIS survey. The proportion of 4-year old children reported to be affected by chronic respiratory conditions in the NHIS survey (21.3%) is similar to the total of parent reported serious respiratory conditions (upper: 6.0%; lower: 8.2%; asthma: 7.9%; total: 22.1%) in the present study. It is important to note that behavior problems were not assessed in the NHIS. However, in this study, parents reported behavior problems (5.0%), but no indication of behavior problems were indicated in the records. The health conditions encountered by Head Start children appear to be similar to problems encountered by a national sample of preschool children.

Multiple Health Conditions. Some children are more prone to health problems than other children. The coding procedures mentioned above allowed checking for multiple health problems among the children in the study sample. According to the parent reports, 31.3% of the children had not experienced any serious health conditions, while 38.2% had experienced only one serious health condition. About 20% reported two different conditions, and the final 10% experienced three or more serious health problems. As might be expected, the review of the child health files showed fewer children with multiple health conditions. A single health condition was noted for 27.3% of the children, about 9% indicated two conditions, and only about 4% identified three or more conditions. Injuries, which are addresses separately, were not included in the listing of health conditions.

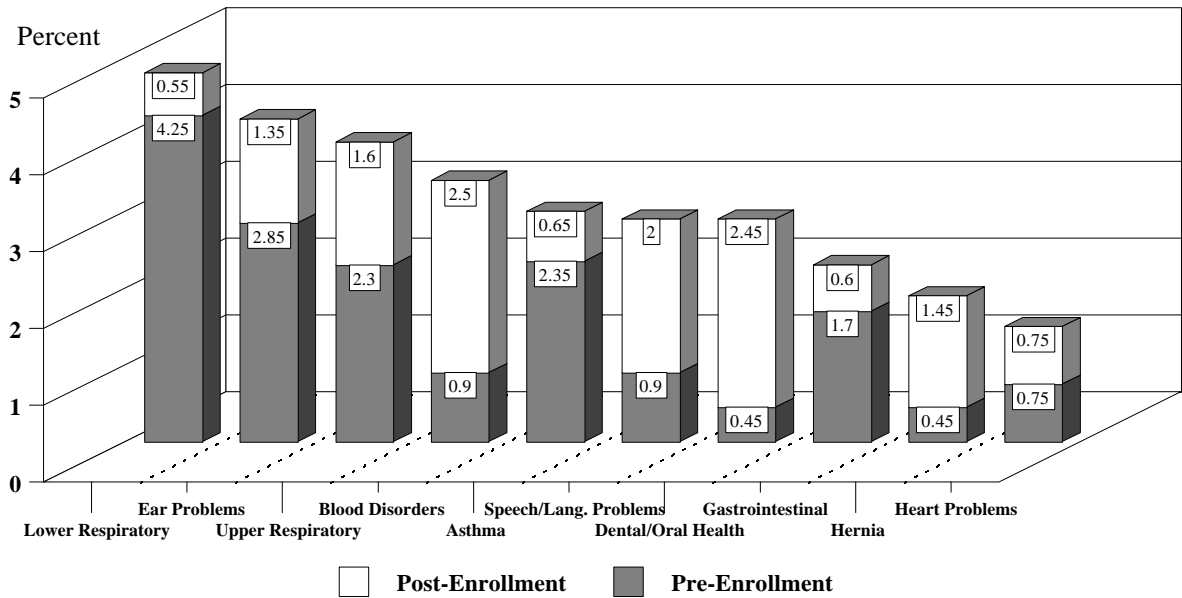
Pre-Head Start/Post-Head Start Enrollment Comparison. One strategy for assessing the potential impact of the Health Component on the detection of health conditions is to determine how often specific conditions were reported prior to or after enrollment in Head Start. Documentation of actual Head Start enrollment dates for children was

inconsistent, incomplete, or kept in files not made available to the research team. By July 1, 1993, however, most of the children had been interviewed and enrolled for the upcoming Head Start program year. That date provides a reasonable estimate of the point when most of the families had come under the influence of Head Start and the Health Component staff. Because certain background health information was collected from the caregiver at the initial Head Start enrollment interview, these reports were viewed as providing information on health conditions prior to Head Start. Subsequent reports of examinations from the health files were considered as having happened during the period of Head Start influence.

Health conditions from the review of the child health files, split into those noted before July 1, 1993, and those noted July 1 or later, are summarized in Exhibit 8-4. While 4.8% of all children were reported to have had lower respiratory problems, 4.3% of the children had this condition noted before Head Start enrollment. Similarly, asthma, ear problems, and gastrointestinal problems were also more likely to have been detected before entry into Head Start. Note that these estimates are conservative, since a significant proportion of 4-year-old children could have first entered and been screened by Head Start when they were 3 years old.

However, several categories of health conditions were often detected during health screenings or examinations following entry into Head Start. As shown in Exhibit 8-4, conditions such as blood disorders, speech and language problems, dental/oral health conditions, and hernias were 2 to 5 times more likely to be detected in these later screenings and examinations. These findings may reflect the increased age of the children at the time of the examinations, as well as the expanded scope of the physical examination administered under Head Start's guidelines.

Exhibit 8-4 The Most Reported Health Conditions from the Child Health Files: a Comparison of Pre- and Post- Head Start Enrollment*



*Head Start enrollment estimated as of July 1, 1993.

Serious Injuries. One item on the parent interview form specifically addressed serious injuries:

(6,34)Has your child experienced a serious accident? Please describe the injury and any resulting health condition.

As with the earlier questions, this item was open-ended and the parents applied their own interpretation of the term “serious.” The data were coded into a series of injury categories.

Approximately 11% of the parents (n=130) reported at least one serious injury to their child. The injuries most reported included abrasions, cuts, and stitches (35.6%); orthopedic injuries (e.g., broken ankle, leg, arm, wrist) (23.7%); head injuries (13.7%); and burns (9.7%). The review of the child health files showed that over 8% of the health records indicated serious injuries. The major categories included abrasions, cuts, and stitches (36.8%) and orthopedic injuries (27.1%). Note that the data from the parent interviews and health files indicated a much better correspondence for injuries than for health conditions. Unlike health

conditions identified during examinations and screening tests, these injuries, which in most cases required medical attention immediately, were reported more often in the health files.

Multiple Serious Injuries. According to the parent reports and child health files, few of the children in the sample experienced multiple serious injuries. Only 2.1% of the parents reported that their children had experienced multiple serious injuries, of which 1.6% experienced two and 0.5% experienced three. The health files indicated that 1.1% of the children experienced multiple serious injuries, of which 1.0% experienced two and 0.1% experienced.

8.2.5 Findings From the Health Assessments

The Head Start Child Health Record includes a number of general assessments completed by the individual conducting the health examination. Because of differences in the types of health records used, not all categories of assessments were available for each child, resulting in a percentage of health files with results not being recorded.

Specific Health Assessment Findings. Systolic and diastolic blood pressure readings were available in the child health files for 84.4% of the children (n= 1,004). The mean systolic blood pressure (SBP) was 88.7 mmHg, while the mean diastolic blood pressure (DBP) was 54.52 mmHg. Based on recently established blood pressure cutpoints (90th percentile) (Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure, 1993), 3.0% of the children were above the cutpoint, while 7.2% were above the SBP cut point for DBP.

Among the Head Start children, 13.8% had results of a lead test in their file. Of those tested, the mean result was a lead level of 10.4 mcg/dl, while 18.9% of the levels were higher than 15 mcg/dl, which would require medical attention. However, the study was unable to collect specific data on whether treatment was prescribed for those children with high lead

levels. In the U.S., 17% of preschoolers have a blood lead greater than 15 mcg/dL (CDC, 1991).

Results of **hearing and vision tests** were recorded in the health records. Overall, 3.5% of the Head Start children (n=42) had a hearing problem with either or both ears. For 3.5% of the Head Start children (n=40), a vision problem with one or both eyes was recorded.

The **Tuberculin test** (TB) results are required under many State health policies or where community prevalence rates exceed 1%. The disease remains concentrated in the growing population of socioeconomically disadvantaged persons, and TB screening is recommended for children who are in contact with adults at risk for the infection (Levin, Gums & Grauer, 1993). Over half the children in this study have recorded TB test results. Test results were positive for 0.7% of all the children. In 1991, the number of TB cases among children under 5 years of age in the United States was 1,006 (Khan and Starke, 1995).

A small group of children had **sickle cell test** results in their files. Only 0.8% of the children had positive test results, 14.1% were negative, and 85.1% did not have a test result recorded. Similarly, a low percentage (0.8%) of study children had positive **urinalysis tests**, while 32.2% had negative tests, and 67.8% had no test result recorded in the health file. Finally, 0.7% of the children had reports indicating that **parasites** were present, 5.6% had results showing an absence of parasites, and 93.7% had no parasite test results in the file. Overall, the child health files indicated that 22.4% of the children (n=271) had one or more abnormal findings based on their screening tests.

8.2.6 Medical Treatments

Sources of Data. Parents reported on the findings of initial health screenings or examinations and any subsequent medical tests.

The child health files were a second source for the same information. Although the record review form was constructed to capture health conditions reported during the initial

health screening or examination and any subsequent medical tests, the variable state of the health files within and across sites made it difficult to determine when many conditions were actually identified. Therefore, treatments reported from the health records were not separated from those for conditions identified during physical examinations for entry into Head Start or those identified through later screenings or subsequent tests apart from the initial physical examination.

The types of treatments were reported by parents for the conditions identified during the physical screening/examinations and subsequent tests and from child health files, respectively. Medication was the most common treatment reported by parents (47.2%, initial screening or examination; 20.3%, subsequent tests) and from the child health files (28.7%).

Treatment Status. Less than 1.0% of the parents indicated that they did not seek treatment for their child's health condition, while the majority of parents reported that the treatment was in progress or ongoing (38.5%, initial screening or examination; 39.1%, subsequent tests). Unfortunately, because of some inconsistencies in the probes used by the researchers regarding treatment status, the resulting percentages for missing data were higher than anticipated.

Few of the files indicated if the treatment was completed (10.6%) or if it was in progress or ongoing (7.2%); the majority of the child health files (82.2%) did not indicate whether the child received any treatment. On the other hand, the 1993-1994 PIR reported that, across all programs, medical treatment was provided to a mean of 96.2% of the children who needed it. Two possible explanations for this difference are: 1) Head Start programs are not following up on medical treatment services for those children requiring treatment; or 2) treatments are being followed up, but the findings are not being documented in the child health files. The problems in keeping up-to-date records seem to have particularly affected the area of recording treatment status. Since the expenditure of time is so great in trying to find,

provide, and arrange payments for treatment services for each child, it seems likely that recording treatment services in the children's health records receives a low priority.

8.0 THE MEDICAL HEALTH DOMAIN	8-1
8.1 Overview	8-1
8.2 Findings	8-2
8.2.1 Staff Reports of Perceived Health Problems	8-3
8.2.2 Health Histories and Child Health Files	8-4
8.2.3 Timing and Methods of Completing Physical Examinations	8-5
8.2.4 Medical Conditions and Injuries	8-6
8.2.5 Findings From the Health Assessments	8-12
8.2.6 Medical Treatments	8-14

Exhibit 8-1 The Most Serious Health Conditions as Reported by the Health Coordinators and the Center Directors 8-4

Exhibit 8-2 Specific Screening Tests and Their Inclusion in the Physical Examination as Reported by Health Coordinators 8-6

Exhibit 8-3 The Most Reported Health Conditions From Parent Interviews and the Child Health Files 8-8

Exhibit 8-4 The Most Reported Health Conditions from the Child Health Files: a Comparison of Pre- and Post- Head Start Enrollment 8-11

9.0 THE DENTAL HEALTH DOMAIN

“They helped me get a dentist appointment. I hadn’t been able to find a dentist who would take a medical card.”

Head Start Parent

9.1 Overview

Few studies have considered the impact of a family’s economic status on the impact of the oral health of children under the age of 6 years. Studies of older children, however, show that dental disorders are higher among low-income children than other children. In 1984, Fosburg noted that one fourth of Head Start’s children involved in a study of health services were urgently in need of dental care (Fosburg, 1984). According to a 1987 Children’s Defense Fund (CDF) survey (1991), 53% of the children between 6 and 8 years of age had cavities and 27% had untreated cavities. The same study reported that among a sub-sample of children who were from low-income families, 70% of the children had cavities and 43% had untreated cavities. Only 10% of the dentists accept patients enrolled in Medicaid, and millions of low-income families with children live in communities with no dentists.

Head Start plays a significant role in working with families to ensure that children receive regular dental screenings and examinations. The Head Start requirements for dental examinations are detailed in the Program Performance Standards (§1304.3-4). The guidelines for the Program Performance Standards indicate that a dental screening should be performed for each child, but this screening is not required. The dental screening is a general inspection of the mouth to observe oral health problems in order to establish priorities or categories for the subsequently required dental examination and treatments as needed. Screenings and examinations may take place at Head Start centers or Head Start staff may assist families in scheduling appointments with community health providers. Dental screenings may be

performed by a dentist, dental student, dental hygienist, dental assistant, or trained Head Start staff member, while the dental examinations must be performed by dentists. The primary source of support for examination services for Head Start children is Medicaid.

Subsequent to the findings of dental screenings and examinations, the Head Start Program Performance Standards require that Head Start programs provide or arrange for treatment services where necessary (§ 1304.3-4). Each Head Start program is responsible for developing a plan for staff to assure treatment and follow-up services are part of the competent and continuing care which is received until the conditions are remedied or until a pattern of continuing care has been well established. Head Start staff typically play the role of broker in assisting parents in securing the necessary services and in identifying funding sources to pay for the services.

An understanding of the dental conditions of Head Start children which program staff must address is an important step in examining the patterns of delivery and the use of all health care services by these children. This chapter presents data from dental screenings and examinations, reported dental conditions and subsequent treatments among children in the study sample.

9.2 Findings

Data in this chapter are from both the parents' reports and the child health files. Because of the interest in having national estimates, the percentages were weighted (see Chapter 3: Methodology). Staff reports are unweighted.

9.2.1 Timing and Methods of Completing Dental Examinations

Timing of Dental Examinations. The Program Performance Standards require that annual dental examinations be oral diagnostic procedures conducted by a dentist. Examinations may include diagnostic radiographs (X-rays), but only if the dentist determines that they are absolutely necessary (§1304.3-3).

Dental examination dates have been abstracted from the children's health records. The median month for dental examinations was August 1993 and the mode was September 1993. During these months Head Start staff are usually working with parents to ensure a smooth transition into the program, and it is very likely that Head Start has had some influence on the percentage of examinations completed within this timeframe.

The review of child health files found that 456 dental examination dates were missing. However, similar information collected during the parent interviews for those children with missing dental examinations dates from their health records indicated that 413 (90.6%) of the children did have dental examinations in the past year. Researchers in the field noted that, when available, the forms for recording the dental information were inconsistent and confusing, often containing unused or poorly used mouth charts where conditions and treatments could be noted. Without cross-checking the child health file data with information given by parents, it would falsely appear that many children did not receive the required dental examinations. Overall, the parent reports in addition to the child health files indicated that 96.4% of all children received a dental examination. This finding is consistent with the PIR reports.

Parent Reports on Dental Examinations. Of those parents reporting that their children had a dental examination in the past year (n=1,099), 54.1% responded that they had arranged the examination themselves and 44.2% reported that Head Start arranged the examinations.

Health Coordinator Reports on Dental Examinations. It was reported by 92.9% of the Health Coordinators that their programs provided or arranged for dental examinations. Dental examinations were mostly conducted off-site (60.5%) or a combination of both on-site and off-site locations (26.37%). Health Coordinators reported that a private practitioner (individual, group, or HMO) primarily conducted the dental examinations (84.6%).

9.2.2 Dental Conditions

Summary Procedures. The general health status questions at the start of the parent interviews were supplemented by questions regarding the specific results of dental examinations. The dental health section in the Head Start Child Health Record provided the framework for the dental questions on the record review form. Unfortunately, missing forms and variations in the format of the child health files both across and within grantees resulted in considerable missing data on the status of dental health. Indeed, some children's dental records were only maintained in the office of the dental care providers, where researchers did not have authorization to gather information. Responses to the parent interviews and details from the review of health files were coded into the same summary categories.

Conditions. In the parent interviews, 41.9% of the respondents indicated that their children had an identified dental condition. The dental condition reported by most parents was dental caries (82%). Other conditions, noted at much lower frequencies, included broken or dead teeth (5.7%) and lack of preventive care (5.3%).

Where available, the data from the child health files were more detailed regarding the status and number of filled, decayed, or missing teeth because of the reporting requirements of the Head Start Child Health Record. Only 11.3% (n=145) of the health files indicated that a child had a reported dental problem. Unfortunately, dental reports were unavailable for many children: 42.2% of the files had no recording of whether or not the child had dental problems. Therefore, oral health conditions are expected to be under-reported across the Head Start health files. For the subset of children with recorded dental concerns, the information in the

records indicated that 5.3% had teeth extracted, 6.2% had fillings present, and 17.3% had teeth with signs of decay, a much lower proportion than suggested by the parents during their interviews. The mean number of extracted teeth was 3.07 (range = 1 to 8), and the mean number of filled teeth was 3.6 (range= 1 to 9). The children with dental reports had a mean of 4 teeth with indications of decay (range= 1 to 12). In most files, the presence or absence of these three conditions was not recorded.

Pre-Head Start/Post-Head Start Enrollment Comparison. One strategy for assessing the potential impact of the Health Component on the detection of dental conditions is to determine how often these conditions were reported prior to or after enrollment in Head Start. As discussed earlier, July 1993 provides a reasonable estimate of the point when most of the families had began interacting with the Health Component staff. Because certain background health information was collected from the caregiver at the initial Head Start enrollment interview, these reports were considered as providing information on dental conditions prior to Head Start. Subsequent reports of examinations from the health files were considered as having happened during the period of Head Start influence. Dental/oral conditions from the review of the child health files were split into those noted before July 1, 1993 and those noted July 1 or later. Of the approximately 3% of identified dental/oral conditions, 2.45% were identified following entry into Head Start.

9.2.3 Dental Treatments in the Study Sample

Sources of Data. The parents responded to one question relative to dental treatments, and information was also drawn from dental health information in the child health files. The status of dental information in the child health files resulted in data that were different in format from the questions asked of the parents. Therefore, parallel data are not available from the child health files and the parent interviews.

Treatments. Of those parents reporting a dental condition for their children (n=488), 53.9% indicated that someone from Head Start spoke to them about needed treatments.

Exhibit 9-1 presents parent reports of dental treatments. The most common dental treatment reported by parents was fillings (70.5%), while each of the remaining treatments was reported by less than 20% of the parents. Over half (54.9%) of the children had completed treatment, and 21.1% of the children had treatment ongoing or still in progress, while 24.0% of the parents reporting dental problems did not or could not specify the status of their child's dental treatments. Only 38.9% of the child health files specifically indicated that the child had no dental conditions requiring dental treatments. The remaining treatments, fluoride (27.5%); cleaning (32.5%); and restoration, extraction, filling, crown, and bridge (26.4%), were recorded less often in the child health files than they were reported by parents.

**Exhibit 9-1 Treatments for Conditions Noted During Dental Examinations
as Reported by the Parents**

Treatment	Unweighted n	Weighted Percent
Fillings	343	70.5
Cap/Crown	75	16.0
Tooth Extracted	57	12.3
Preventive Care (Fluoride, Cleaning, Sealants)	56	10.6
Other	17	3.1
Orthodontic Repairs	14	3.0
Root Canal	9	1.7
Not Recorded	11	1.3
n	582*	

*Sample size is based on 582 dental conditions reported by 488 parents whose children had one or more dental conditions reported during the dental exam.

9.0 The Dental Health Domain	9-1
9.1 Overview	9-1
9.2 Findings	9-2
9.2.1 Timing and Methods of Completing Dental Examinations	9-2
9.2.2 Dental Conditions	9-4
9.2.3 Dental Treatments in the Study Sample	9-5

Exhibit 9-1

Treatments for Conditions Noted During Dental Examinations as
Reported by the Parents 9-7

10.0 THE MENTAL HEALTH DOMAIN

“Thanks to Head Start, [my] girl is able to go the psychologist.”

“Head Start helped my child establish better social skills.”

Head Start Parents

10.1 Overview

Left undiagnosed or untreated, mental and emotional disorders can lead to impaired social functioning, adaptation, and productivity. In 1986, the Office of Technology Assessment (OTA) estimated that 12% to 15% of the Nation’s children suffer from one or more mental disorders severe enough to require treatment. Even though the number of children receiving mental health services in a given year has increased significantly since 1980, the OTA (1986) estimated that up to 70% of the children and adolescents needing such services were not receiving care. Disruptive behavior disorders (e.g., attention deficit hyperactivity disorder (ADHD), conduct disorder) were the most frequently noted forms of childhood mental illness. However, more than 5% of all school-age children suffer from depression, anxiety disorder, or serious learning disabilities (OTA, 1986).

More recent data provide somewhat different figures, estimating that 3% to 5% of school children have a serious behavioral or emotional disorder (Knitzer, Steinberg & Fleisch, 1990). However, the Center for Mental Health Services (1994) reports that the lack of national epidemiological studies on mental disorders in children in the United States has created a need for valid prevalence or incidence indicators.

Low-income children may experience more mental and emotional problems than other children (Gould, Wunsch-Hitzig & Dohrenwend, 1981). Poverty places children at greater risk for “a host of biologic insults that threaten the integrity of the central nervous system,”

and epidemiologic studies have shown an association between organic brain dysfunction and psychiatric disorder in children (Hertzog, 1992).

Head Start's comprehensive model for mental health reflects a positive, holistic approach, with a primary emphasis on normal child development in the context of daily living skills and social competence (Hansen & Martner, 1990). Mental health objectives are grouped into three levels of intervention: prevention, identification and referral, and treatment. This holistic approach is designed to address all of an individual's needs: physical, emotional, social, cognitive, occupational, and spiritual (Hansen and Martner, 1990). The Program Performance Standards outline the objectives of the mental health portion of the Health Component (§1304.3-7).

As part of this philosophy, individual staff have a significant role in working with families to ensure that children receive mental health screenings and, if necessary, treatment services. The actual program requirements for the mental health domain are detailed in the Program Performance Standards (§1304.3-8). These Standards require that a trained mental health professional be available to each program to provide the following services:

- (6,34) Assist in planning mental health activities;
- (6,34) Train staff and provide education to parents about mental health issues;
- (6,34) Observe and perform screenings for classrooms or for individual children;
- (6,34) Assist parents and staff in treatment activities; and
- (6,34) Facilitate linkages with community mental health resources.

This professional does not have to fill the role of Mental Health Coordinator and may be available on a consultant basis. The accompanying guidance to the Program Performance Standards provides a list of appropriate mental health professionals (e.g., a child psychiatrist, a licensed psychologist, a psychiatric nurse, or a psychiatric social worker).

Recently, a report on the mental health aspects of Head Start was completed by the Task Force on Head Start and Mental Health for the American Orthopsychiatric Association (AOA, 1994). The Task Force's report described the mental health program in terms of the diversity and complexity of the needs of Head Start families, particularly as changes take place in many of the local communities served by Head Start (e.g., increased violence, reductions in available services). The Task Force also noted the need to update how mental health issues are addressed in the Program Performance Standards. It expressed concerns about the limited and traditional strategies that are employed, inadequate staffing, organizational and fiscal constraints on the provision of family support and mental health services, a lack of focus on the dissemination of appropriate mental health information to parents and staff, and a record of inconsistency in collaboration between Head Start and other Federal programs.

10.2 Findings

The prevalence of mental health conditions noted among children in the study sample, both in parents' reports and in the child health files, is presented in this chapter. Percentages based on the parent interviews and reviews of the child health files are presented as weighted estimates (see Chapter 3: Methodology), unless noted otherwise. Percentages based on the Mental Health Coordinator interviews are reported unweighted.

10.2.1 Issues Encountered While Studying the Mental Health Domain

Definitions. The mental health domain was the most difficult aspect of the Health Component to study. One reason may have been the lack of clarity among staff and parents regarding the scope of the mental health domain and its place within Head Start. As noted by Hansen and Martner (1990), mental health is defined by people in two ways. The first refers to the normal developmental processes of children, while the second is focused on mental illness. In a blending of these two perspectives, the AOA Task Force (1994) defined mental health within the Head Start context as "promoting the healthy emotional development of

children, supporting family strengths, identifying early signs of emotional and behavioral difficulty in children, and assisting families with special needs.” The AOA Task Force also cited practices found at some Head Start programs in which mental health problems are deliberately identified as developmental concerns rather than specific mental health problems. This is done to minimize potential concerns related to the stigma of having mental health conditions listed in files which are available to Head Start staff or forwarded to the new schools when children leave Head Start.

Within these contexts, parents were likely to report developmental conditions (e.g., speech and language delays) and mental health conditions (e.g., behavioral problems) as part of the serious **medical** health conditions faced by their children. Parents also included findings from their children’s medical examinations as part of their responses on mental health screenings or developmental assessment reports. This problem was compounded by a sensitivity on the part of the research staff to avoid the potential negative impact from the misuse or misinterpretation by parents of the phrase “mental health problem.” While the parent interview was designed to minimize parental discomfort and improve responses by emphasizing developmental assessments rather than mental health problems, there was no way to be sure how parents were defining specific terms when providing their responses.

Terminology. The differences between group screenings (observations of classroom or socialization group activities) and individual screenings is also a topic which appeared unclear among the respondents. While no data were collected to support this notion specifically, the observations of the interviewers suggested that there was a lack of consistency among staff within a program and between parents and staff as to what screenings and assessments entailed. It was also apparent that many parents were not aware that group screenings occurred unless the screening detected a potential problem that required further evaluation.

Record Keeping. As noted by the AOA Task Force (1994), many programs make strong efforts to assure the confidentiality of mental health records in order to minimize the potential stigma that could come from misinterpretation of the reports on mental health screenings and examinations. This practice resulted in a number of difficulties in the collection and interpretation of information related to mental health issues for this study. Even if the appropriate documentation was made in a child's file, there was no standard place across programs for mental health professionals or other staff to document conditions and the status of treatments. Documentation in the health files related to screenings and examinations was often not complete, while other times the relevant documents were placed in an education file or in a completely separate mental health file to which the research team did not have access. Often this happened when children's records were held in alternate sites. The implication of these practices for this and other studies is the lack of useful information in children's health records, particularly with regard to treatment issues (see Chapter 3: Methodology).

10.2.2 Staffing the Mental Health Domain

The Mental Health Coordinators overseeing the mental health domain did not generally devote full time to this area. Of the 37 Mental Health Coordinators interviewed, 78.4% indicated that they had other responsibilities. Those with multiple roles reported that they spent an average of only 26.2% of their paid time as Mental Health Coordinator.

In addition, only 37.8% of all the Mental Health Coordinators reported experience providing mental health services to children or families prior to working in Head Start. Their experience was predominantly in providing child counseling or therapy (21.6%) and providing family counseling or therapy (16.2%). Child- or family-related mental health training was received by 78.4% of the Mental Health Coordinators between the beginning of the program year (September 1993) and the time of the interviews. The mean time spent as Mental Health Coordinator was 4.9 years (range = 1 to 19 years). As noted in Chapter 4, the Mental Health Coordinators had the highest percentage of college or graduate degrees among the health staff.

10.2.3 Perceived Mental Health Problems

The Mental Health Coordinators' reports on serious mental health conditions they face within their programs (see Exhibit 10-1) typically included behavior disorders, which were mentioned by almost 50% of the respondents. Other categories, each mentioned by approximately one quarter of the Mental Health Coordinators, were hyperactivity or Attention Deficit Disorder (ADD), family discontinuity (change), physical or sexual abuse, and children suffering the impact of substance abuse by others. A further breakdown of the behavior disorders category indicates that aggressive behaviors, discipline problems, and withdrawal were clearly the most frequent conditions reported in this category.

Exhibit 10-1 The Most Serious Mental Health Conditions as Reported by the Mental Health Coordinators

Condition	Percent
Behavior Disorders	48.6
Hyperactivity/ADD	27.0
Discontinuity/Change Within a Family	27.0
Physical/Sexual Abuse	24.3
Effects of Substance Abuse by Others	24.3
Emotional Problems (General)	18.9
N	37

Note: The question was open-ended.

10.2.4 Screenings and Assessments

Individual Screenings. Almost ninety percent (89.2%) of the Mental Health Coordinators reported that some children received individual mental health or developmental

screenings. For both formal and informal individual screenings, 45.9% of Mental Health Coordinators reported that teachers referred children to the program's mental health consultant, and 24.3% reported that the teacher actually conducted the screening. The screening instruments most often mentioned in relation to individual screenings included: the Brigance Preschool Screen for 3- and 4-Year-Olds, the Chicago Early Assessment Individualized Education Program, and the Denver II. A summary of the screening tests cited in the health files is provided in Volume II, Chapter 10. Most of the screening instruments named are general developmental screens rather than instruments designed specifically to address mental health issues.

Mental Health Coordinators were questioned about the methods used to disseminate information to the parents regarding upcoming screenings, as well as how often efforts were made to encourage parents to attend the screenings. Most information regarding the time and place of screening tests was provided to the parents directly, through telephone calls (81.1%), home visits (51.3%), or during discussions held at the center when the parent came to drop off or to pick up a child (51.3%). Less direct methods included sending letters to the parents (43.2%) or mailing letters to the home (24.3%).

Head Start staff often seek to encourage parents to attend their children's individual mental health or developmental screenings. The most common methods used to encourage parents to accompany their children to the mental health screening were to provide information about the screening (91.9%), schedule the screenings at times that accommodate the parents' schedules (83.8%), provide screenings on-site (67.5%), provide transportation (64.8%), and discuss screenings during home visits to the families (59.4%).

A summary of the services related to mental health which are provided by programs is found in Exhibit 10-2. The responses indicate a higher level of support for informing parents and arranging services with providers than for follow-up efforts to ensure that families actually receive services.

Exhibit 10-2 Mental Health Services Frequently or Always Provided by Programs as Reported by the Mental Health Coordinators

Service	Percent
Inform Parents of Service Needs Suggested by Screenings and Examinations	100.0
Inform Parents of Available Treatment Services	100.0
Identify Service Providers	100.0
Follow-up to Ensure Services Were Provided	97.3
Help Parents to Understand What Mental Health Services are Available for Preschool Children	91.9
Coordinate Service Arrangements with Parents	78.4
Arrange Services with Providers	72.9
Arrange Transportation	50.0
Help Families Enroll in Medicaid	50.0
Inform Parents of Payment Options	48.6
Arrange Payment with Providers	45.9
Arrange for Interpreters to Accompany Families to Treatment	38.9
Provide Escorts for Families	34.3
Arrange Child Care	27.0
N	37

Group Screenings. As noted earlier, 70.3% of the Mental Health Coordinators reported that all children in the program routinely were observed as part of a group-administered mental health screening. Group screenings, which are observations of classroom or socialization activities, were most often conducted by a program’s mental health professional or the classroom’s head teacher. When asked how involved they were with the mental health screening and examination planning process (e.g., helping to select providers, scheduling visit time), 56.8% of the Mental Health Coordinators said they were very involved, 27.0% were somewhat involved, and 16.2% were not very involved. In conducting the actual screenings, the individuals most likely to be involved were teachers (86.1%), parents (75.6%),

outside mental health professionals (75.6%), and Mental Health Coordinators (64.9%). It was not clear what role parents played in the screenings; they may be involved in contributing to the documentation of the mental health history for their children.

Mental Health Coordinators were also asked about the frequency of routinely using formal and informal screening procedures with the children. Programs were reported to frequently or always use informal screenings (75.6%), a combination of both formal and informal screenings (62.1%), and formal screening assessments (54.0%) on a routine basis. It was reported that 32.4% of the Mental Health Coordinators were primarily responsible for documenting follow-up evaluations in the child's health file while Health Coordinators (21.6%), mental health professionals (10.8%), Center Directors (5.4%), and teachers (5.4%) were also responsible for documenting follow-up activities in some programs.

Parent Reports. Researchers attempted to be sensitive to the concerns of mental health “labeling” when interviewing the parents. Terms such as “mental health” were not emphasized; rather, processes were described as developmental assessments, using words that were less stigmatizing and stressed Head Start's focus on fostering normal child development. The interview forms were designed to ask questions of parents using terminology that program staff were also likely to use. Parents were informed that a developmental assessment might include screening and evaluation of any of the following:

- Physical coordination and development;
- Intellectual development;
- Emotional development;
- Social development;
- Psychological development; and
- Behavior.

Only 6.9% of parents (n=82) reported that someone from the center had suggested their children be evaluated for possible problems with behavior or feelings. Information on how parents were informed of this suggestion was gathered from the parents who actually received recommendations that their children be evaluated. The information came primarily from two sources: telephone calls from Head Start staff (20.0%) and parent notification by staff during individual discussions when parents visited the center to pick up or drop off their children (29.3%).

Parent Involvement. Of the 82 parents who said that a developmental assessment was recommended for their children, 71.0% said the Head Start staff specifically asked for their permission to conduct the assessment. Of these parents (n=58), 53.1% responded that they gave written permission and 33.6% gave permission verbally. The developmental assessment was completed for 62.2% (n=51) of the children for whom it was recommended. For children with a completed assessment, 73.8% (n=38) of the parents reported that they were invited to attend the assessment and 58.8% (n=30) actually attended. The majority of the parents responded that the assessment indicated a need for treatment services (60.8%, n=31). Of parents who actually attended the assessment (n=30), 93.6% said that the results of the assessment were explained to them.

10.2.5 Conditions

Summary Procedures. Parents who indicated that their children had a developmental assessment (n=51) were asked the results of the assessment. These responses were coded into summary categories to determine the reported prevalence of specific mental health or developmental problems. As noted, referral and follow-up information on mental health assessments or developmental assessments were often not available in the child health files that were reviewed for this study.

Conditions Across Parent Interviews and Review of the Health Files. Only 4.3% of all the parents (n=51) reported that their children had received a developmental assessment,

and 2.6% of all parents (n=31) reported that the assessment had identified a specific problem. This is slightly higher than the 0.5% rate reported by the AOA Task Force (1994). However, as noted in previous chapters, parents' reports tend to have higher incidence rates for conditions than Head Start records, possibly as a result of the emphasis on overall development. The most common problems reported by this small group of parents were speech and hearing problems (40.8%), cognitive or developmental delays (29.8%), emotional disorders (25.3%), social behavior problems (15.8%), and hyperactivity or ADD/ADHD (13.3%).

When the parents' responses across the entire interview were reviewed (using reports of medical conditions and of mental health conditions noted in the developmental assessments), mental health conditions were noted by 12.5% of the parents, with multiple conditions being found for less than 2.0% of the children. These conditions included reports of speech and language problems.

The review of the children's files indicated that 51.8% of the children had a record of a developmental assessment. As indicated in section 10.2.1, problems with incomplete records and access to all necessary files, as well as confidentiality issues, make estimates of mental health conditions in the overall population problematic. Mental health conditions were noted in 3.9% of the files, with multiple conditions noted in only 0.3% of the files. Although the frequencies of mental health conditions were low for both parents' reports and the file abstractions, in only 16 cases, or approximately 1.0% of all children, did both the parent and the health record provide evidence of a mental health condition for the same child.

10.2.6 Treatments

Sources of Data. Parents who indicated that their children had developmental assessments also indicated the treatments and the status of these treatments. As noted, such information was not always available consistently across the child health files.

Treatments. The most common treatment reported by parents (n=42) was speech therapy (33.5%), followed by psychotherapy (29.8%) and special education (28.2%). Parents indicated that the majority of the mental health treatments were in progress or ongoing (50.2%).

Mental Health Coordinators were asked how often parents and teachers were given instructions by mental health professionals in “child guidance techniques for children receiving mental health services.” Approximately four out of five Mental Health Coordinators indicated that this type of training was provided frequently or always (78.3% for parent instruction and 81.0% for teacher instruction) by their program.

10.0	The Mental Health Domain	10-1
10.1	Overview	10-1
10.2	Findings	10-3
10.2.1	Issues Encountered While Studying the Mental Health Domain	10-3
10.2.2	Staffing the Mental Health Domain	10-5
10.2.3	Perceived Mental Health Problems	10-6
10.2.4	Screenings and Assessments	10-7
10.2.5	Conditions	10-10
10.2.6	Treatments	10-12

Exhibit 10-1 The Most Serious Mental Health Conditions as Reported by the Mental Health Coordinators 10-6

Exhibit 10-2 Mental Health Services Frequently or Always Provided by Programs as Reported by the Mental Health Coordinators 10-8

11.0 THE NUTRITION DOMAIN

“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

11.1 Overview

The link between health and nutrition is well recognized. Poor nutrition during childhood can have lifelong effects on the health and functioning of an individual. Nutrition problems (e.g., iron deficiency anemia) are often associated with poverty. Children from low-income families are generally found to have lower values than other children for height, weight, and triceps skinfold thickness (Rosenbaum, 1992). Poor nutrition contributes to childhood obesity in instances where low cost food, often high in fats and caloric content, is the obvious choice over no food at all. Studies of growth trends among low-income children have provided some mixed results and suggest the need for targeted research in this area.

Head Start plays a significant role in working with families to ensure that children receive nutrition screenings and treatments when necessary. The Head Start program requirements for nutrition screenings and services are detailed in the Program Performance Standards (§1304.3-10). This requirement is met through nutrition assessments (height, weight, hemoglobin/hematocrit), the collection of information on individual child and family eating habits, and assessments of community nutrition needs. Subsequent to the findings of the nutrition screenings, the Program Performance Standards require that Head Start programs provide or arrange for treatment where necessary (§1304.3-4), much as they do when conditions are noted within the other health domains.

In order to assure a degree of good nutrition for enrolled children, the Program Performance Standards also require that children in part-day programs receive meals and snacks

which provide at least one third of the children's daily nutrition needs. For children attending full-day programs, the required proportion increases to between one half and two thirds of the daily nutritional needs. The Standards require that if the nutrition services are not overseen by a qualified nutritionist, that one be used to provide an ongoing review of the meals and nutrition services provided by the program.

11.2 Findings

In this chapter, percentages based on data from the parent interviews and the reviews of the child health files are presented as weighted estimates (see Chapter 3: Methodology), unless noted otherwise. Percentages using the Nutrition Coordinator's interviews are reported unweighted.

11.2.1 Screenings

Of the 39 Nutrition Coordinators who completed an interview, 87.2% reported that children enrolled in their Head Start Program received individual nutrition screenings, although such screenings are not required by the Program Performance Standards. It was not indicated whether all children served by these Nutrition Coordinators received such screenings.

11.2.2 Conditions

The nutrition conditions reported in this section are those which parents reported had been identified during the initial screenings or examinations required for entry into Head Start, and through subsequent tests that were not part of the initial screening or examination. The child health files were a second source of information on nutrition conditions.

Parent reports of medical problems included several health conditions related to nutrition. Obesity was mentioned for 1.3% of the children, being underweight was noted for 0.8%, and general nutrition concerns were reported by 3.7% of the parents. On the Head Start Child Health

Record, the nutrition section includes a review of the child’s status concerning nutrition. A summary of these status reports is included in Exhibit 11-1. The most reported nutrition concern in the health files was the suspicion of dietary problems or inadequate food intake, but this was noted in a relatively small percentage of records (5.3%).

While the percentages for these conditions were low (all criteria were noted for about 5% or less of the children), programs not using the updated Head Start health forms for data management often did not have space to specifically note nutrition conditions. Therefore, nutrition-based conditions may be under-reported in the child health files. However, note that these conditions were reported more often by parents, in contrast to medical and dental conditions, which were reported more frequently in the health files than by the parents.

Exhibit 11-1 Nutrition Referrals Noted in the Child Health Files

Criteria for Referral	Unweighted n	Weighted Percent
Suspicion of Dietary Problem or Inadequate Food Intake	67	5.3
Hemoglobin Less Than 11 Grams or Hematocrit Less Than 34%	46	3.9
Overweight	35	3.0
Weight for Height Greater or Less Than Typical	31	2.6
Underweight	28	2.2
Short for Age	18	1.5
N		1,189

Note: The categories are not mutually exclusive

11.2.3 General Status

Height and Weight. Height and weight measurements are often indicative of the physical and nutritional health status of children, and should be regularly assessed according to the

health guidelines of the Program Performance Standards. Many programs maintained height and weight records on growth charts similar to those found in the Head Start Child Health Record (1992 version). Height charts were found for 65.0% of the children, weight charts for 64.5%, and height by weight charts in 54.2% of the files. The mean height for the children was 41.0 inches (standard deviation (sd) = 3.2 in), and the mean weight was 39.0 lbs (sd = 7.7 lbs).

Hematocrit/Hemoglobin Screenings. According to the child health files, 44% of the children had a hematocrit and 36% had a hemoglobin test to screen for anemia. The remaining 19% either had no test or had a test that was not recorded in the child's health file. The mean hematocrit was 36.5%, with 11.5% of the children having a hematocrit less than 34%. For hemoglobin, the mean was 12.7 grams, and 8.4% of the children had a hemoglobin level less than 11 grams.

11.2.4 Treatments

As noted, nutrition conditions and treatments were reported during the parent interviews as part of the questions asked about medical conditions and treatments. Parents were asked what treatments were recommended for identified health conditions and the status of these treatments (completed, in progress or ongoing, not stated, or did not seek treatment). Conditions and treatments also were available from the child health files, but there were no parallel questions between the parent reports and the health files that can be compared. Dietary alterations were recommended for 10.9% of the treatments resulting from the initial examination, for 12.9% of the conditions identified during subsequent tests, and for 5.5% of the conditions reported in child health files. In reviewing the treatments mentioned by the parents, adherence to these specific treatments could not be determined.

When children needed nutrition services, over half of the Nutrition Coordinators reported that they most frequently used cooking activities (69.3%), dietary restrictions (69.2%), diet management (53.8%), and parent education (51.3%) as methods for meeting these needs (see Chapter 6: Health Education).

11.2.5 Head Start Meals

The meals and snacks provided at Head Start serve a variety of purposes. Beyond meeting nutritional needs through the provision of healthful foods, the Program Performance Standards also direct staff to use meals to integrate education and socialization opportunities (§1304.3-10) into the classroom routine. Meals provided the research staff in this study with an opportunity to observe nutrition education across all of the study sites. The education activities associated with Head Start meals were discussed earlier in Chapter 6: Health Education.

Head Start staff were observed sitting with the children for 97.2% of the meals, and 87.6% of the time they ate with the children. This suggests an excellent opportunity for staff to offer nutrition information to the children. Usually through family style service, children had a hand in serving themselves 68.4% of the time. At 61.4% of the meals, staff were observed providing children with information about the foods on the table. Children were encouraged to take the available foods 74.6% of the time, and were encouraged by staff to taste specific foods at 77.7% of the meals. Classroom discussions about the meals were observed 36.4% of the time. While nutritional content is another important issue to be assessed, the measurement of this aspect of the meals was beyond the scope and resources of this study.

11.0 The Nutrition Domain	11-1
11.1 Overview	11-1
11.2 Findings	11-2
11.2.1 Screenings	11-2
11.2.2 Conditions	11-2
11.2.3 General Status	11-3
11.2.4 Treatments	11-4
11.2.5 Head Start Meals	11-5

Exhibit 11-1 Nutrition Referrals Noted in the Child Health Files 11-3

12.0 SUMMARY AND RECOMMENDATIONS

“I go around to the young mothers with children who are eligible and I tell them about Head Start.

I see the benefits that Head Start has for these kids.”

Head Start Parent

12.1 Overview

The purpose of this study was to provide a "national snapshot" of how local Head Start centers implement the Health Component of their programs to meet the medical, dental, nutrition, and mental health needs of the children and families that they serve. As noted in the *Head Start Research and Evaluation Report: A Blueprint for the Future* (1990), the Head Start Bureau needs information on how local programs implement the mandated activities in the health section of the Program Performance Standards (§ 1304.3) prior to making policy decisions on how to support the efforts of these programs.

The final pictures that develop from this effort reflect a program that brokers health services and assists families in developing the skills to meet their future health needs. While this study was not designed to measure the impact or effectiveness of the Health Component activities at the participating sites, it does highlight a range of ongoing health-related activities, provides important data on the health status of Head Start children, and establishes a sound base for future research and evaluation efforts focusing on the Health Component. This Final Report includes a summary of the historical context of the Health Component, a detailed review of the study methodology, and descriptive findings covering the following aspects of the Health Component:

- Health Component staff and their qualifications;

- Internal program procedures and linkages with communities;
- Preventive care (health education and immunizations); and
- A summary of screenings, examinations, conditions, and treatments across the four health domains of Head Start (medical, dental, mental health, and nutrition).

12.1.1 Study Background

From the very beginnings of Head Start more than 30 years ago, the program developers viewed "social competence" as being the result of facilitating development in many areas, not just education. This notion was made clear in the original *Recommendations for a Head Start Program* (Cooke, 1965) which set the vision for what Head Start has become today and has been reinforced through the work of Edward Zigler and his colleagues (Zigler et al., 1994). As part of this perspective, Head Start has always recognized the relationship between children's health and their ability to learn. Head Start is committed to a policy of ensuring that children who participate in the program enter school with no undetected health conditions that might impair their potential for success.

The program's Health Component objectives, detailed in the Program Performance Standards (Head Start Bureau, 1992), are to arrange or facilitate health screenings, diagnoses, and treatments across the domains of medical, dental, mental health and nutrition conditions and to provide parents with the information they need to ensure that their children obtain appropriate health services, both while attending Head Start and after leaving the program. Within this two-generational program, the Health Component staff use health education both in and out of the classroom to better prepare children and their families to maintain proper health and well being after they leave Head Start.

As noted in the most recent re-authorization legislation (1994) and in the *Final Report of the Advisory Committee on Head Start Quality and Expansion* (1993), Head Start needs to develop policies and procedures that are responsive to the population of families and conditions faced by local programs. In order to accomplish this goal, program decision-

makers require accurate and up-to-date information on which to base policy. This descriptive study was undertaken because little current information was available regarding program procedures and how they address the health conditions that are common among Head Start children. There was also a lack of information concerning community health risks faced by families participating in Head Start, and about the health resources available in communities served by Head Start.

12.1.2 Study Procedures

This descriptive study was conducted with a national probability sample of 40 Head Start programs across 23 States and Territories to find out how programs are implementing the Health Component. The programs were selected as part of a random sample stratified on the basis of three variables—Geographic Region (Northeast, Midwest, South, and West), Urbanicity (whether or not the Head Start program office zip code was located inside an Urbanized Area), and the percentage of minority children (greater than or equal to 50% minority enrollment versus less than 50% minority enrollment). Across these 40 programs, data were collected on 1,189 children from 81 Head Start centers.

The primary objective of the sampling design was to provide a national probability sample of children enrolled in Head Start. This allowed the child-level data to be weighted for the purpose of providing valid, national estimates (see Chapter 3: Methodology). Because this is a descriptive study in which data were collected at one point in time (the Spring of 1994), outcome measures that focus on the causal relationship between changes in health and the use of specific health services over time as the result of Head Start participation were not possible.

All data were collected during the Spring of 1994, at the end of the Head Start program year. During the site visits, which had durations of between one and two weeks each, the research staff interviewed approximately 200 Head Start staff responsible for the administration and implementation of their program's Health Component. These staff included

Health, Mental Health, Nutrition, and Parent Involvement Coordinators as well as Center Directors. Researchers interviewed Head Start parents regarding their children's health status and their use of health services, and then reviewed the Head Start health records for these children. Observations of 177 Head Start meals (breakfast, lunch, snacks) also were completed during the site visits.

12.2 A Review of the Key Study Findings

This section summarizes the key study findings. These findings are discussed in terms of responses to questions adapted from the original research questions which drove the development of the study (see Chapter 1: Introduction).

12.2.1 What Are the Qualifications of the Health Component Staff?

Head Start programs are supported by staff from a broad range of backgrounds, and include a number of individuals who spent many years working within Head Start and have moved up into and through various positions within the Health Component. Depending on the position, staff reported being in their current positions for between 5 and 7 years. No less than one half of each of the Coordinators interviewed (Health, Mental Health, Nutrition, and Parent Involvement) reported having multiple roles within their program. This situation was most likely to occur within the smaller programs (fewer than 500 children enrolled).

Generally, about one third of the Health Coordinators held college degrees or higher, and nearly another one third held nursing diplomas without a degree. Coordinators from smaller programs (fewer than 500 children enrolled) were generally less likely to have Bachelor's or nursing degrees. The highest percentage of graduate degrees was found among the Mental Health Coordinators. The Health Coordinators held the highest number of special certificates among the staff interviewed, with a high concentration of these being nursing-related certificates or licenses.

12.2.2 What Kinds of Training Do the Health Component Staff Receive?

Training for Health Coordinators and their staff is one potential area for evaluating Head Start support for local programs. A majority of Health Coordinators reported that they had received training during the past year on a number of child development, health, and family-related topics, either from other program staff or from local consultants or community providers. More than half of the Health Coordinators reported having received training in the past year on the following topics: substance abuse, child neglect/abuse, disabilities, first aid/safety, children with special needs, CPR, general health, child growth and development, nutrition, family violence, universal precautions, mental health, dental health, social-emotional development, and eating habits.

12.2.3 What Are the Primary Community Health Risk Factors Faced by Head Start Programs?

The major community health risk factors that programs must address daily were noted during interviews with Head Start staff. The primary risk factors included substance abuse, lack of parenting skills, lack of available support services for families, poor nutrition, and poverty. Child abuse and neglect and community violence also were mentioned, particularly by staff responsible for mental health services. Virtually all of the program staff noted that parent education and community outreach activities are provided to address specific community risk factors.

12.2.4 How Does Head Start Provide or Access Health Services for Children and Their Families?

Broad-based procedures for involving parents in obtaining the health services their children need include providing general information on Head Start supported activities, either at intake, at parent meetings, or through newsletters. Occasionally, circumstances dictate that specific parents need to be notified privately, either through telephone calls, letters sent home with the children, or discussions at home or at the center. Most Parent Involvement Coordinators reported that they encouraged parents to attend health screenings by scheduling

screening times to accommodate parents' schedules, by providing more on-site screenings, and by providing transportation when necessary. Obtaining parental consent for screenings and examinations was not a problem in most cases.

Medicaid is the primary source of funding for health services for a majority (68%) of Head Start families. Almost nine out of ten (85.7%) Health Coordinators reported that their programs had a formal process for identifying Medicaid-eligible children enrolled in their programs. This process generally included screening for eligible children at intake, verifying proof of income, and referring eligible children to social services for assistance in the Medicaid enrollment process. Health Coordinators generally reported that staff explain the Medicaid program to parents and encourage them to enroll. Staff may then either make appointments and take parents to the Medicaid agency or simply refer the parents to the local Medicaid agency.

12.2.5 What Health Services Are Provided at Head Start Centers?

The services most often provided at centers include informing parents of the health service needs of their children and of the treatment services that are available. Staff also reported that they identified specific health care providers for parents and helped coordinate arrangements for services with these providers. Many staff follow up with parents and providers through various means to ensure that the necessary services were actually provided, although this information is not always updated in the health files. Once again the picture that emerges is one of the Health Component staff serving as brokers of health services to link Head Start families with their community health care providers.

Health Coordinators reported that the types of treatment most often available on-site at the centers are nutritional counseling, speech therapy, mental health counseling, physical therapy, immunizations, and dental treatments (e.g., supplemental fluoride tablet program). In general, staff reported that they followed up on treatment by contacting the parents and

providers directly, documenting the treatment in the child's health record, and periodically reviewing the record for completeness.

12.2.6 What Are the Community Resources That Are Used Most by Head Start Programs?

Each program is charged with the responsibility of linking with the service providers in their community and of being responsive to the needs of these communities. Head Start staff reported that many services are provided by organizations, rather than individual providers. Examples of these organizations include public health agencies, private group providers, community mental health organizations, and public interest/service organizations. The services most often provided include medical screenings and services, vision screenings and eye care, immunization services, dental services, and nutrition and meal planning services.

Most of the parents reported receiving information from Head Start to facilitate their use of community services. This information was provided through both parent education activities and materials distributed during the enrollment process. The parents could also be informed on an individual basis as well, whenever specific services were needed.

12.2.7 How Do Other Federal and State Programs Play a Role in the Health Component?

It became apparent during the study that an important factor in the creation of community linkages is the active integration of Head Start with other Federal resources, such as Medicaid, the United States Department of Agriculture (USDA) (i.e., the school lunch program, the Women, Infants, and Children (WIC) program, and Temporary Assistance for Needy Families (TANF). In its work to assist families and foster the development of social competence among enrolled children, it is clear that Head Start does not work as a "stand alone" Federal program. Programs serving low-income families are interdependent, meaning that changes in one may affect service delivery in others. For example, Head Start depends on Medicaid/EPSTD (Early and Periodic Screening, Diagnostic, and Treatment program) to

provide funding for health services for children, while Head Start has proven itself to be a resource for the Medicaid program by recruiting local health care providers to participate. Head Start's dependence on other Federal resources is at a point where cuts in these other resources would have a serious impact on how local Head Start health staff decide to allocate their limited resources.

12.2.8 How Are the Costs of Health Services Covered?

Based on interviews with parents, approximately two-thirds (68.1%) of the children in Head Start have the costs of their health services covered by Medicaid. Other sources of payment were private insurance and direct payments. Free care (not provided by Head Start) was reported by only a small percentage of parents. Of the Medicaid enrolled children, almost two thirds were enrolled at or near the time of their birth (1988-90) and an additional 21% became enrolled during the time they were participating in Head Start (1993-94).

The parents whose children were not covered by Medicaid indicated that they either had other insurance or that they were not eligible or both. Only a very small percentage of the parents indicated that they had not heard of Medicaid or did not understand how to enroll. The Head Start staff members routinely query parents about Medicaid enrollment at the time of Head Start enrollment, and facilitate Medicaid enrollment as needed. Head Start program funds are considered "the dollar of last resort," and are used to cover the cost of health services only when all other options have been explored and funds are still necessary.

12.2.9 What Are the Barriers to Obtaining Health Services for Head Start Children?

Based on the staff interviews, barriers to obtaining health services fall into three categories: community, personal, and internal to the program. In confronting community barriers, staff must address issues such as the lack of child care or transportation, the distance between families and providers, the costs of care, the lack of needed providers, and inconvenient provider schedules. Personal barriers most often reported included parental lack of understanding, parental resistance, lack of time for parents to obtain services, and cultural

barriers. Internally, program staff reported a shortage of time and program resources to put into assisting families in overcoming barriers. However, each program reported active engagement in steps to assist families in overcoming their primary barriers to care.

12.2.10 How Does Head Start Incorporate Health Education into the Program?

One mission of the Health Component is to assist children and their families to become better prepared to meet the challenges of maintaining proper health and well being after they leave Head Start. This is the goal of Head Start health education.

Nutrition, personal hygiene, first aid and safety, and dental health were the classroom health education topics most often reported by the Health Coordinators. The Mental Health Coordinators were most likely to report that self-esteem and peer relationships were mental health topics addressed in the classroom curriculum. Both the Health and Mental Health Coordinators listed discussions and role playing activities as the activities most often used to incorporate health education into the classrooms.

Nearly all programs offer parent classes, according to the Parent Involvement Coordinators. Classes were held at least once a week by a quarter of the programs, and less than once a month by approximately 10% of the programs. Parent education topics most often recalled by parents included parenting, child growth and development, and nutrition and meal planning.

Almost the entire sample of parents noted that they discuss 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 by parents as showing a general improvement in their health behaviors. One tenth of the parents felt they had developed an increased awareness of the health behaviors of their children. Over 40% of the parents reported that they had become more aware of the impact of their own health behaviors on those of their children and that

their children now engaged in proper health behaviors more frequently. One tenth of the parents indicated that the child helped change the health behavior of other children or adults in their home.

12.2.11 How Successful Is Head Start in Encouraging Parents to Get Their Children Immunized?

Taken together, Head Start health records and parent-held immunization records indicate that at least 87% of the 4-year old children in Head Start are immunized at the minimum age-appropriate levels recommended by national advisors on immunization. Recently, the Centers for Disease Control and Prevention (1996) noted that only 75% of all preschool children were immunized at the same level. Further, at least 37% of the children leaving Head Start have already been immunized up to the levels recommended for kindergarten entry by those same groups, although it should be noted that many States require fewer immunizations for school entry than are recommended by national advisory groups (e.g., the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP)). Children attending Head Start programs in the South were twice as likely to be fully immunized for kindergarten (by Head Start standards) as children from programs located in other regions of the country.

A review of the parent-held records indicates that 10-15% of the children had additional immunizations that were not noted in the child health records, including additional DPT (diphtheria, pertussis, and tetanus) and OPV(oral polio vaccine). Parents obtained these immunizations for their children after the initial Head Start immunization screening, but before they left Head Start to enter kindergarten. This finding points to the benefits of drawing from multiple sources of data when assessing child health status.

Fewer than one tenth of the Health Coordinators reported accurately that 5 DPT immunizations were necessary for a 4-year-old child to be considered fully immunized under Head Start policy at the time of project data collection and only one quarter correctly noted

that 4 OPV vaccinations were also required. Finally, the community health risk factor most frequently mentioned by Parent Involvement Coordinators was lack of immunizations. Both of these findings suggest that difficulties in understanding the differing levels of immunization requirements (e.g., Head Start, State, and local requirements) may require additional training and education for both staff and parents.

12.2.12 What Are the Primary Medical Health Problems of Head Start Children?

Head Start may have positively affected the number of children receiving physical examinations in the past year by providing examinations, arranging for examinations, or assisting the families in getting the children to examinations. Parent reports, in conjunction with reviews of the child health files, indicate that 98.5% of the Head Start children received physical examinations during the past year. Over four fifths of the Health Coordinators reported that their programs provide or arrange physical examinations for children enrolled in Head Start and that over one half of these reported that examinations are conducted off-site. A review of the child health files indicated that several conditions (blood disorders, speech and language problems, hernias, and dental problems) were more likely to be identified after enrollment in Head Start.

Although data collection procedures are not quite comparable, the prevalences found for specific conditions appear to be consistent with those reported in the Child Supplement of the National Health Interview Survey (CDC, 1991). The health conditions most reported by parents were ear problems, speech and language problems, gastrointestinal problems, lower respiratory problems, and asthma. No individual condition was reported by more than one tenth of the parents. Parents of approximately 30% of the children indicated that their children had experienced two or more serious health conditions by the time of the study. The health conditions noted in the reviews of the child health files were similar to those cited by the parents, but the frequencies among the reports were generally lower than those provided

by the parents. Less than 13% of the child health files indicated multiple health conditions, while almost one third of the parents reported multiple health conditions for their children. Approximately one tenth of the parents reported that serious injuries had ever occurred to their children. Injuries most reported were cuts, abrasions, and stitches for more than one third of the children, and orthopedic injuries for just under one quarter of that group. Reports of injuries were noted in less than 8% of the child health files.

Medication was the most common treatment. However, the child health files contained little documentation about whether treatments were completed or if they were in progress or ongoing. Over 80% of the health records which reported a health condition had no follow-up data on the status of the recommended treatments.

12.2.13 What Are the Primary Dental Health Problems of Head Start Children?

Head Start positively affected the number of children receiving dental examinations in the previous year by providing examinations, arranging for examinations, or assisting the families in getting the children to examinations. Overall, parent reports, in conjunction with reviews of the child health files, indicate that 96.4% of the Head Start children received dental examinations in the past year. Over 92% of the Health Coordinators reported that their programs provide or arrange dental examinations for children enrolled in Head Start and that most of the examinations are conducted off-site. Dental conditions were among the health conditions more likely to be detected after Head Start enrollment.

Almost 42% of the parents reported that their child had an identified dental condition and over 80% of the identified conditions were dental caries. Of those parents reporting dental problems, almost 54% of the dental treatments recommended for the child's dental condition were fillings. Over 40% of the health files had no record of the findings from dental examinations. This, along with the lack of information on treatment status, point to the need for increased emphasis on follow-up by Head Start staff.

12.2.14 How Does the Health Component Integrate Mental Health Services?

One of the unique and most important aspects of the Health Component is that programs are required to foster the mental health of children, parents, and staff. Head Start's approach to mental health is primarily from a perspective of promoting normal growth and development. However, Head Start is responsible for assuring that children receive screenings and treatment services, as needed. These services are provided either under the auspices of a Mental Health Coordinator or a trained mental health professional affiliated with each program.

Approximately 70% of the Mental Health Coordinators said that all the children in their program are screened for mental health concerns through observation of classroom or socialization group activities, and almost 90% reported that children in their programs receive individual mental health screenings if necessary.

Less than 7% of the parents reported that someone from the Head Start center had suggested that their children be evaluated for possible behavioral or emotional problems, and less than one half of these parents reported that conditions were noted by the assessments. These conditions were most likely to be speech and language problems, cognitive or developmental delays, and emotional disorders. Many parents, however, also listed speech and language concerns under medical conditions. The most common treatments following a child's mental health examination or developmental assessment, as reported in each case by one third of the parents of children needing services, were speech therapy, psychotherapy, and special education. Parents indicated that about half of the mental health treatments were in progress or ongoing.

There were several difficulties encountered in studying the mental health domain (see Chapter 10: The Mental Health Domain); however, these findings support those of other groups concerned with mental health services within Head Start (AOA, 1994) and help assure that future research on the mental health domain will be successful in painting an accurate

picture of the current mental health procedures and mental health status of Head Start children. It is clear from this study and the work of the American Orthopsychiatric Association Task Force (1994) that unwritten policies are in place that protect information on the mental health of enrolled children. These policies need to be explored to determine fully how the mental health domain operates and serves the best interests of Head Start children.

12.2.15 What Is the Nutritional Status of Head Start Children?

Almost 90% of the Nutrition Coordinators reported that all the children enrolled in their Head Start programs received individual nutrition screenings. However, nutrition summaries were available in only a small percentage of the child health files. Approximately 5% of the children had notes in their records indicating a need for nutrition services. The conditions noted in the records included the following: general suspicion of dietary problem or inadequate food intake; hemoglobin less than 11 grams or hematocrit less than 34%; the child being overweight or underweight; and the child's ratio of weight for height being greater or less than typical. Very few parents (less than 5%) reported their child being obese or underweight as a health condition. General nutrition concerns were noted by a very small percentage of the parents.

12.3 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. This sample, in conjunction with similar data from the National Health Interview Survey (CDC, 1994), provides unique insights into the health status of Head Start

children, such as the observation that the prevalences of specific conditions found for these children do not appear to be different from those found in the general population of preschool children in the U.S.

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 program 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 the activities within the Health Component on the families would be very useful to staff in determining the distribution of program resources. The same resource limitations also precluded the collection of provider or clinic health records to supplement those held by parents or programs, as well as having direct health checks on the children.

An attempt was also made to collect budget information from the program budget managers. Unfortunately, budget practices varied greatly across programs, resulting in information that was not comparable from program to program. This precluded any opportunity to develop an understanding of the financial aspects of the Health Component.

12.4 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.

12.4.1 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 relationships with health professionals outside the program to assist center staff in carrying out specific health-related functions.

12.4.2 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 additional immunizations noted on the parent-held records that 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 Program Information Report (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.”

12.4.3 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.

12.4.4 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 indicates 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.

12.4.5 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.

12.4.6 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 (WIC) program, and Temporary Assistance for Needy Families (TANF, formerly Aid to Families with Dependent Children). 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.

12.5 Recommendations for Future Research

As intended, this study has helped generate ideas for future research on both the Health Component and the Head Start program in general. The following suggestions are made to help guide future research activities at Head Start programs.

- **Determining the Impact of the Program.** It is important to learn what skills families bring to Head Start, how programs can best build upon and refine these skills, and how different these skills are when they leave the program. Such findings are only possible through longitudinal research.
- **Investigating Community Links.** It was difficult in this study to clearly understand the level of formality of the Head Start-community links that have been established. It also 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. It will be important to define the barriers that inhibit the development of these links.
- **Sampling Considerations.** The development of any sampling plan intended to include appropriate representation of urban and rural programs must be able to adjust for the fact that many programs include centers that represent both types of areas. Because many program offices are located in urban areas, there may be an under-representation of rural areas in the sampling plan, and an under-representation of urban areas in the actual data collection. More information is required on individual Head Start centers and the geographic areas or populations of families they serve at the time of the drawing of the sample to ensure accurate representation.
- **Instrument Development.** A review of the findings for this study has lead the research team to conclude that instrument development activities in future projects must consider the following issues:
 - (1) The costs and benefits associated with **open-ended versus limited choice questions** in the interviews;
 - (2) The use of **multiple data sources** for understanding differences across staff roles and to provide comparisons across sources;
 - (3) Exploration of the possibility of accessing the **provider health records** for a sub-sample of study children. Although this would be costly and time-

consuming, actual medical records may be the closest a research team comes to accessing a "gold standard" measure of health status and medical care.

12.6 Conclusions

It seems that, in serving 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. The Health Component provides the opportunity for all families to benefit by ensuring that children are as healthy as possible before they enter kindergarten through prompt diagnosis and treatment of health problems. 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 these families develop the skills necessary to access appropriate care independent of Head Start.

The elements discussed in this report, including children, families, local Head Start programs and center staff, and local communities served by Head Start, fit together in an integrated view of the forces that impact on how the medical, dental, nutrition, and mental health needs of Head Start children are met. As noted in Chapter 2, Head Start children are the core of a dynamic relationship among a triad of forces (Head Start, families, and health care providers) that impact on child development. The interactions among these forces are facilitated by pathways and hindered by barriers. One primary focus for Head Start, Head Start families, and local health care providers should be to work together to develop strategies to overcome barriers so that health services can be accessed by the children who need them. This perspective may be oversimplified, but is provided to put the pieces of this report into the context of how the Health Component of the Head Start program serves to advance the overall development of low-income children.

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 support a continued emphasis on improving the health-related activities of programs and will generate useful questions to drive future research activities. This research team completes this project with admiration and respect for both the Head Start families and the local Head Start staff members who work tirelessly, often under less than ideal working conditions, to serve children and their families. It is hoped that information gathered during this descriptive study will directly benefit their work.

“I’ve seen kids come on their first day and I’ve gone home and cried because I didn’t think there could be anything done with those children...and I’ve seen Head Start bring them around.”

Head Start Parent

12.0	SUMMARY AND RECOMMENDATIONS	12-1
12.1	Overview	12-1
12.1.1	Study Background	12-2
12.1.2	Study Procedures	12-3
12.2	A Review of the Key Study Findings	12-4
12.2.1	What Are the Qualifications of the Health Component Staff?	12-4
12.2.2	What Kinds of Training Do the Health Component Staff Receive?	12-5
12.2.3	What Are the Primary Community Health Risk Factors Faced by Head Start Programs?	12-5
12.2.4	How Does Head Start Provide or Access Health Services for Children and Their Families?	12-5
12.2.5	What Health Services Are Provided at Head Start Centers?	12-6
12.2.6	What Are the Community Resources That Are Used Most by Head Start Programs?	12-7
12.2.7	How Do Other Federal and State Programs Play a Role in the Health Component?	12-7
12.2.8	How Are the Costs of Health Services Covered?	12-8
12.2.9	What Are the Barriers to Obtaining Health Services for Head Start Children?	12-9
12.2.10	How Does Head Start Incorporate Health Education into the Program?	12-9
12.2.11	How Successful Is Head Start in Encouraging Parents to Get Their Children Immunized?	12-10
12.2.12	What Are the Primary Medical Health Problems of Head Start Children?	12-11
12.2.13	What Are the Primary Dental Health Problems of Head Start Children?	12-12

12.2.14	How Does the Health Component Integrate Mental Health Services?	12-13
12.2.15	What Is the Nutritional Status of Head Start Children?	
	12-14
12.3	Strengths and Limitations	12-15
12.4	Implications for Head Start Program Practices	12-16
12.4.1	Staff Training and Support	12-17
12.4.2	Immunizations Records and Knowledge	12-17
12.4.3	Mental Health Issues	12-18
12.4.4	Treatment Follow-Up	12-19
12.4.5	Record Keeping	12-19
12.4.6	Collaboration Activities	12-20
12.5	Recommendations for Future Research	12-20
12.6	Conclusions	12-22

